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I am not my addiction: Patients' perceptions of why they relapsed during or after treatment at Westview clinic.

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I am not my addiction: Patients' perceptions of why they relapsed during or after treatment at Westview clinic.

A report on a study project presented to

The Department of Social Work

School of Human and Community Development

Faculty of Humanities

University of the Witwatersrand

In Partial Fulfilment of the requirements

for the Degree Bachelor of Social Work

By

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December, 2016

DECLARATION

I, Magaret Nkosha Ngoepe declare that this research report is my own, unaided work. It is submitted in partial fulfilment of the requirements for the degree Bachelor of Social Work in the Department of Social Work, School of Human and Community Development, at the University of the Witwatersrand. It has not been submitted for any other degree or examination at this or any other institution.

_____

Magaret Nkosha Ngoepe

_____

Date

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I dedicate this research report to Kagiso Mokoape who passed on recently. May his Soul Rest in Peace.

ABSTRACT

Relapse after or during treatment is a problem experienced by many addicts and individuals view recovery in different ways. Certain things are expected from addicts when they are undergoing treatment, which one of them is complete sobriety. The research study was based on the perceptions of patients about what factors led them to relapse before or after treatment at Westview clinic. The aim of the study was to explore the patients' perceptions about the reasons for their relapse. A case study qualitative research design was selected, whereby face to face interviews were conducted, using a structured interview schedule. The sampling method that was used for the study was availability sampling and 14 participants were used in the study. From the findings it was discovered that the causes of relapse were both internal factors like emotions of anger, loneliness and denial and also lack of self-awareness and external; factors like family, peer-pressure, unemployment and easy accessibility of the substances. It was also discovered from the findings that there many challenges that individuals experience when relapsing and also the major thing that they needed in order not to relapse was support whether it is from the family, community, organisation and social workers. This study will hopefully not only benefit the patients and the organisation but it will also hopefully benefit social work as a profession in that it will enhance the treatment and counselling that is offered to patients and bring more knowledge within the study about the factors of relapse and also the effects it has on addicted individuals.

Key words: Relapse, Substance use, Addiction, Treatment

TABLE OF CONTENTS

DECLARATION……. i

ACKNOWLEDGEMENTS……... ii

ABSTRACT……... iii

CHAPTER 1: INTRODUCTION

1.1. INTRODUCTION…… 1

1.2. STATEMENT OF PROBLEM……... 2

1.3. RATIONALE……..... 3

1.4. AIMS ANDOBJECTIVES……. 4

1.4.1. Primary aim……... 4

1.4.2. Secondary objectives……..... 4

1.4.3. Research questions……..... 4

1.5. OVERVIEW OF THE RESEARCH DESIGN METHEDOLOGY…….……... 4

1.6. LIMITATIONS OF STUDY……... 5

1.7. ANTICIPATED BENEFITS……... 5

1.8. KEY CONCEPTS……..... 6

1.9. OVERVIEW OF RESEARCH REPORT……..... 6

CHAPTER 2: LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1. INTRODUCTION…… 8

2.2. DISCUSSION……... 8

2.3. THEORETICAL FRAMEWORK……. 9

2.4. HISTORY OF SUBSTANCE ABUSE……. 10

2.5. GLOBAL CONTEXT OF SUBSTANCE ABUSE…….. 10

2.6. SOUTH AFRICAN CONTEXT OF SUBSTANCE ABUSE……. 11

2.7. SUBSTANCE ABUSE AND USE……. 12

2.8. ADDICTION……..... 12

2.8.1. What is addiction?..... 12

2.8.2. Factors that increase the risk of substance addiction ……... 14

2.9. TREATMENT OF SUBSTANCE ABUSE AND RELAPSE……..... 14

2.9.1. Change model of addiction……. 14

2.9.2. Cognitive behavioural model of addiction……..... 15

2.9.3. Relapse prevention……... 16

2.10. BEHAVIOURAL MODELS THAT HAVE BEEN USED TO EXPLAIN RELAPSE…….. 16

2.11. RELAPSE……. 18

2.12. FACTORS THAT CONTRIBUTE TO RELAPSE…….. 18

2.12.1. Parental Use……... 18

2.12.2. Distal and proximal factors……... 19

2.12.3. Stigmatisation……..... 20

2.13. CONCLUSION……..... 20

CHAPTER 3: METHODOLOGY

3.1. INTRODUCTION…….. 22

3.2. AIMS……... 22

3.2.1. Primary aim…….. 22

3.2.2. Secondary objectives…… *22*

3.2.3. Research questions……..... *23*

3.3. RESEARCH DESIGN……... **23**

3.4. RESEARCH METHOD…… **24**

3.4.1. Population sampling…… *24*

3.4.2. Research tool…… *24*

3.4.3. Pre-test……... *25*

3.4.4. Data collection method…… *25*

3.4.5. Data analysis…… *26*

3.5. LIMITATIONS OF RESEARCH DESIGN…… **27**

3.6. TRUSTWORTHINESS……. **27**

3.6.1. Credibility…….. *28*

3.6.2. Transferability……... *28*

3.6.3. Dependability…… *29*

3.6.4. Confirmability……... *29*

3.7. ETHICAL CONSIDERATIONS…….. **29**

3.8. PROCESS OF RESEARCH STUDY……... **31**

3.9. CONCLUSION…….. **31**

CHAPTER 4: RESULTS

4.1. INTRODUCTION…….. **33**

4.2. PARTICIPANTS PROFILES……... **33**

4.3. PARTICIPANTS WHO INITIATED TREATMENT……... **35**

4.4. DENIAL OF ADDICTION PROBLEM…….. **37**

4.5. PSYCHOLOGICAL FACTORS…….. **38**

4.6. SOCIAL FACTORS OF RELAPSE…… 39

4.7. FAMILY DYNAMICS CONTRIBUTION TO RELAPSE……... 42

4.8. PARTICIPANTS PERCEPTIONS ABOUT RELAPSE……... 43

4.9. EFFECTS OF RELAPSING ON INDIVIDUALS…….. 45

4.10. WAYS IN WHICH RECOVERING CLIENTS CAN BE SUPPORTED…….. 47

4.11. WESTVIEW……. 49

4.11.1. Role of the organisation in helping recovering addicts from relapse…….. 49

4.11.2. Form of Treatment Received…… 50

4.12. ROLE OF SOCIAL WORKERS IN HELPING SERVICE USERS TO AVOID RELAPSING WHILE IN THE RECOVERY PROCESS…… 51

4.13. CONCLUSION…… 52

CHAPTER 5: DISCUSSION

5.1. INTRODUCTION…….. 54

5.2. SUMMARY OF MY STUDY……... 54

5.3. MAIN FINDINGS…….. 55

5.3.1. To identify subjective factors that are inclined to make participants vulnerable to relapsing……. 55

5.3.2. To explore challenges faced by patients after relapsing……. 56

5.3.3. To obtain participants recommendations of how the problem of relapse could be addressed by Westview clinic in the treatment programme…….. 56

5.3.4. To obtain participants recommendations of how they could avoid the possibility of relapse as individuals through the help of the community and families……. 57

5.4. CONCLUSION…….. 58

5.5. RECOMMENDATIONS……... 58

5.5.1. Participants……... 58

5.5.2. Westview……... *59*

5.5.3. Social Workers…….. *59*

5.5.4. Future Research……... *60*

5.6. CONCLUDING COMMENTS……. **60**

REFERENCES…….. **61**

APPENDICES

APPENDIX A: INTERVIEW SCHEDULE……... **68**

APPENDIX B: PARTICIPANT INFORMATION SHEET……. **70**

APPENDIX C: CONSENT FORM……. **71**

APPENDIX D: CLEARANCE CERTIFICATE…… **72**

LIST OF TABLES

Figure 4.2.1: Demographics (N=14)

Figure 4.2.2: Types of Substances Used (N=14)

LIST OF FIGURES

Figure 4.3: Referrals to Treatment (N=14)

Figure 4.4: Denial of Addiction Problem (N=14)

Figure 4.5: Psychological factors of Relapse (N= 14)

Figure 4.6: Social factors of Relapse (N= 14)

Figure 4.7: Family Dynamics Contribution to relapse

Figure 4.8: Patients Perception about Relapse (N=14)

Figure 4.9: Effects of relapsing on individuals

Figure 4.10: Ways in which Recovering Clients can be Supported (N=14)

Figure 4.11.1: Role of the Organisation in Helping Recovering Clients from Relapse

Figure 4.11.2: form of Treatment Received (N=14)

Figure 4.12: Role of Social Workers in Helping Service Users to Avoid Relapsing while in the Recovery Process

CHAPTER 1

INTRODUCTION

1.1. INTRODUCTION

Why do people use substances? This was a question that was asked by Russil Durrant and possibly many other theorists who have had an interested in substance abuse. There are many responses when it comes to answering that question. Some people stated that they used substances because it makes them feel good, or some use them for fun, some to remove stress and some because of substance abuse (Durrant & Thakker, 2003). This shows that there are many reasons behind why people take or use substances.

Substance related problems represent major health challenges and that has resulted in an increased interest in addiction treatment (Kvamme, Asplund, & Bjerker, 2015). Some substances like alcohol are socially accepted in western societies however they still remain a major public health problem (Boekel, Brouwers, Weeghel & Garretsen, 2013). The problem that arises with substance abuse are not only health problems but there are also other risk factors that result from substance use, like absenteeism at work, accidents and loss of productivity (Boekel, Brouwers, Weeghel & Garretsen, 2013).

According to the Prevention and Treatment of Substance Abuse Act of 2008 no70, the word substance means chemical, psychoactive substances that are likely to be abused, which includes things like tobacco, alcohol and even over the counter drugs (Republic of South Africa, 2009). In addition, abuse is regarded as the sustained or excessive use of substances (Republic of South Africa, 2009).

Furthermore, addictive activities and addictive substances cause changes in the nervous system that produce the feeling of being high which results in a rush of euphoria or pleasure. Many people become addicted to various substances, many of them end up seeking treatment whether it is voluntarily or involuntarily, while some people just rely on self-help strategies. The individual responses to treatment are different and more than once episode of relapsing is common to treated substance users and is a normal part of

rehabilitation (Panebianco, Gullupe, Carrington Colozzi, 2016). However even though relapsing is a normal part of rehabilitation, relapse continues to be a major problem and many relapse interventions have been put into place to try and deal with the issue of relapsing (Rassool, 2011). Some of those interventions focus on teaching the skills to cope with temptations of substance use (Rassool, 2011).

Other relapse interventions that have been used are the psychological interventions, whereby relapse is viewed as being caused by chain reaction to high-risk situations (Barber, 1995). Another intervention of relapse has focused on the level of family, work and social support networks, where it is stated that for example the employment status of someone is one of the best predictors that can cause an individual to relapse (Barber, 1995). Lastly other relapse interventions have been on a level of social policy and culture (Barber, 1995).

This chapter will discuss the statement of the problem, the rationale, the aims and objectives of the research, the overview of the research design method, key concepts and the overview of the research report.

1.2. STATEMENT OF PROBLEM

Relapse is an issue when it comes to individuals who have gone to rehabilitation or treatment for substance use. Individuals receiving treatment have a high possibility of relapsing during rehabilitation or after rehabilitation which is caused by many factors. People are sent to rehabilitations or sent for treatment with the hope that the individuals will change or even let go of their habits of engaging in substance use; but that is not always the case.

According to Tims & Leukefeld (1986) relapse and recovery are key issues; however, relapse is an even bigger problem and the notion of cure remains hard to pin down. Substance abuse careers are episodic, where there is a period of abstinence, reduction of use and relapse which is an existing pattern often which is caused or influenced by external factors like the availability of drugs and societal pressures (Tims & Leukefeld, 1986).

Vaillant (1988) mentioned that treatment of addiction has been a challenge and that even after several researches have been done there is still a gap in preventing relapse. There are several reasons why there is uncertainty about how to prevent relapse. The first reason is that the control that drugs have over an individual’s behaviour does not depend that much

upon the treatment that the individual receives. The second reason is that relapse to drugs is self-regulating of conscious freewill and motivation (Vaillant, 1998).

1.3. RATIONALE

The rationale was to explore the perceptions of the clients with the hope that it would assist to explore possible strategies that could help to reduce relapses in patients who are attending Westview clinic. Relapse is a problem because it can provoke a variety of responses in a person which are mostly perceived as negative responses (Brownell, Marlatt, Lichtenstein & Wilson, 1986). Relapse has emotional negative effects like disappointment, frustration, and self-condemnation and at time leads to family members and friend who are unhappy and angry (Brownell, et al, 1986). Although treatment programmes that are designed to reduce substance use come across as being promising, up to 50% of patients relapse after six months of treatment and up to 40% go through periods of relapse, treatment re-entry and recovery (Moore, Seavey, Ritter, McNulty, Gordon & Stuart, 2014).

In addition, the majority of patients being treated for substance abuse experience one or more relapses after treatment and this can bring harm and so much suffering to the individual (Kvamme, Asplund & Bjerker, 2015). Health care professionals, families and other people many find the persons relapse to be so dramatic and upsetting and many might question if the individual has the sufficient will or motivation to change (Kvamme, Asplund & Bjerker, 2015). The problem with substance use is that individuals who suffer from substance use disorders have experienced difficult demands of pulling themselves together and which was followed by the stigmatisation and given responsibility to pull themselves together (Kvamme, Asplund & Bjerker, 2015). The other problem that is experienced by patients is that they have been discharged from ongoing treatment because they have relapsed (Kvamme, Asplund, & Bjerker, 2015). Several articles have been written about factors that may predict and prevent relapses, studies done on the quality of life found that relapses lead to a lower quality of life and that there is physical discomfort and suffering as well as guilt and shame that is associated with relapsing (Kvamme, Asplund & Bjerker, 2015).

The challenges associated with substance abuse continue to be perpetuated by socio-economic and developmental factors (Ramlagan, Peltzer & Matseke, 2010). South Africa is one of the largest producers of some drugs like cannabis which is shipped to other

countries and also drug consumption and trafficking are very active in the country (Ramlagan, Peltzer & Matseke, 2010). Substance use and abuse was highlighted as a problem in the country in 1994 when Nelson Mandela mentioned it in his opening to address the parliament and since then there has been an increase in establishment of treatment services (Ramlagan, Peltzer & Matseke, 2010).

1.4. AIMS AND OBJECTIVES

1.4.1. Primary Aim

The primary aim was to explore patient's perceptions about why the reasons that they relapsed during or after treatment.

1.4.2. Secondary Objectives

- To identify subjective factors that are inclined to make patients vulnerable to relapsing.
- To explore the challenges faced by patients after relapsing.
- To obtain participants recommendations of how the problem of relapse could be addressed by the Westview clinic in the treatment programme.
- To obtain participants recommendations of how they could avoid the possibility of relapse as individuals through the help of the community and families.

1.4.3. Research Questions

1. What were the subjective factors that are inclined to make patients vulnerable to relapsing?
2. What are the challenges faced by patients after relapsing?
3. According to the participants how could Westview clinic address the problem of relapse in their treatment programme?
4. According to the participants how could they avoid the possibility of relapse during or after treatment with the help of the family and community?

1.5. OVERVIEW OF THE RESEARCH DESIGN METHODOLOGY

The research design method that was used was the qualitative method. The reason why the qualitative method was chosen was because it allows one to collect in depth data whether it is in a form of written, spoken language, observations that are later recorded in language and analysed by identifying themes (Blanche, Durrheim & Painter, 2006). The research perspective that was used was a case study which is important for

exploring the programme, event, process or one or more individuals in depth (Creswell, 2009).

The population of the study was not easily identifiable due to the fact that only participants who were used in the study had relapse and they were currently undergoing treatment Westview Clinic or had previously received treatment at Westview clinic. However, the sampling method that was used for the study was the availability sampling. The sampling consisted of both males and females that were 18 years and above. There were 14 participants that were interviewed. The participants were contacted on behalf of the researcher by the contact person at Westview Clinic. The research tool that was used was a structured interview schedule. Interviews were conducted using face to face interviews and for the analysis of the data thematic analysis was used.

1.6. LIMITATIONS OF THE STUDY

- Language barrier was a problem at times because some of the participants did not understand English and as a result the researcher had to ask the questions in a language that the participants could understand. Another problem with translation is that it may removes the true meaning of the question being asked.
- Getting hold of the participants was a bit of a challenge because not all of them were treated under in-patient, some were out patient and were not receiving treatment so and some of them had either relocated or had changed numbers.
- The study did not include other rehabilitations and other patients from other treatment centres and as a result the ability for the data that were collected cannot be generalised.

1.7. ANTICIPATED BENEFITS

- This research study will enable individuals who are undergoing recovery to be able to identify the factors that might cause one to relapse.
- Relapse will not only be seen as a negative thing but it can also be viewed by relapsed individuals as a learning curve.
- The research study will also enable individuals be aware of relapse and also acquire the needed knowledge behind relapse and also how to avoid it from occurring during recovery.

1.8. KEY CONCEPTS

Addiction: It is a chronic, relapsing brain disease that is characterised by uncontrollable drug seeking and use, no matter what harmful consequences it can lead to. Addiction is regarded as a disease because drugs can change the brain, the structure and how it works. The change that is caused in the brain can be long lasting and can result into harmful behaviours (The National Institution of Drug Abuse, 2008).

Dependence: A person is regarded to be dependent on a substance when it becomes difficult and seems impossible from them to refrain from taking the substance, without receiving the help that they need. After taking it for a long period of time the dependence may be physical or psychological or both (Republic of South Africa, Department of Social Development, 2013, p. 17).

Substance abuse: This is when a substance is misused or abused. It can be the use of illegal or legal substances like alcohol, prescription medication, nicotine, indigenous plants, solvents, and inhalants (Republic of South Africa, Department of Social Development, 2013).

Substance abuse disorder: "Continued Compulsive use of a substance despite problems in work, school, relationships and health" (Brook & McHenry, 2015, p. 85).

Relapse: a recurrence of symptoms of a disease after a period of improvement or it is also an act or instance of backsliding, worsening, or subsiding, which means that one could have possibly relapsed by mistake (Brownell, et al, 1986).

Treatment: it is the biological and psychosocial interventions that eliminate the problems that are linked to substance abuse or dependence (Durrant & Thakker, 2003).

1.9. OVERVIEW OF RESEARCH REPORT

Chapter one consisted of the introduction, whereby the statement of problem, rationale, aims and objectives, overview of research design method and the key concepts were discussed. Chapter two will incorporate the literature review whereby the history of substance abuse will be discussed. Substance abuse will also be discussed globally then narrowed down to the South African context. Addiction and dependence will be discussed. Furthermore, the literature review will discuss relapse and the different factors that lead to relapse. The theoretical framework of the research will also be discussed in depth.

Chapter three will focus on the research methodology whereby there will be a discussion of the research design that was used for the research and the research

methodology. Furthermore, chapter four will discuss the results of the data collection that was done and lastly chapter five will be based on discussion whereby the main findings, conclusions and recommendations will be discussed.

CHAPTER 2

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1. INTRODUCTION

The knowledge of factors that are associated with relapse after treatment for substance use enables clinicians to offer better individualized treatment and also helps clinicians to predict which patients are likely to relapse and that way they may be able to offer the individuals effective and appropriate treatment (Kuria, 2013). Alcohol and other drug use can be understood by recognising the contributions of the substance itself, including the individual who takes the substance and the environment where the substance is taken (Rickwood, Magor-Blatch, Mattick, Gruenert, Zavrou & Akers, 2008).

Factors like the social, cultural, and historical context in which the substance is taken can affect the experience and the consequences for an individual or group of people (Rickwood, et al, 2008). There are many theories and models that have been used to understand substance abuse and relapse. Chapter 2 will be discussing the argument for the research; furthermore, it will discuss the history of substance abuse, the global and South African context of substance abuse, substance abuse and use, and addiction. Furthermore, this chapter will discuss what relapse is and also the factors that contribute to relapse. Lastly the theoretical framework of the research will be discussed. Understanding substance use needs a framework that can consider a wide range of biological, psychological, social, and cultural factors (Rickwood et al., 2013). To make sure that all these aspects are met the theoretical framework that was used in the study is the bio psychosocial framework.

2.2. DISCUSSION

Relapse is a taboo concept to many people and is never seen as something that is a process and is part of the treatment of substance abuse. There are many reasons that have been

stated by theorists behind the reason of why people relapse. Understanding relapse and recovery has been a problem for years and it has been worsened by the discouraging statistics on outcomes after treatment (Niaura, Rohsenow, Binkoff, Monti, Pefraza & Abrams, 1988).

Relapse is an old and still challenging aspect. Relapse is a return to a problematic behaviour and traditionally relapse has been a challenge and obstacle of addiction treatment for all different kinds of dependency problems like alcohol and heroin; and also relapse and relapse prevention has been the biggest problem that professionals had to face (Connors, DiClemente, Velasquez, 2013). Miesto (2006) also mentioned that understanding and preventing relapse is the biggest obstacles that are faced by those who work within the field of addiction (Connors, DiClemente & Velasquez, 2013).

2.3. THEORETICAL FRAMEWORK

The theoretical framework that will be used is the Bio-psychosocial theory. The bio-psychosocial theory considers genetic inheritance, psychological differences, family, community, peer or social pressure (Rassool, 2011). In order for the social worker to understand the person in perspective using the bio-psychosocial theory, there are three elements that they need to consider. The first element that is important is the knowledge about the person; these consist of issues like the individual characteristics, biological conditions, development, behaviour, patterns of adaptations and beliefs (Compton, Galaway & Cournoyer, 2005). The second aspect is to consider having knowledge about the situation, that consists of groups, organisations, communities, cultures, formal and informal social systems assets and resources (Compton, Galaway & Cournoyer, 2005). The last aspect is having knowledge about things such as the clients.

With the bio-psychosocial model, social workers attempt to understand the nature of human beings as individuals and as members of families, groups, organisations, communities and societies (Compton, Galaway & Cournoyer, 2005). In this research study this theoretical framework will be used with the aim to understand the background of the participant and what led to them engaging in substance use and also according to them what they think contributed to them relapsing. This theoretical framework will also help the student social worker to understand and identify the perceptions that individuals have regarding relapse. The Bio-psychosocial model states that there are multiple pathways to

addiction and the significance of these pathways depends on the individual (Rassool, 2011).

2.4. HISTORY OF SUBSTANCE ABUSE

Substance abuse and issues that are related to substance abuse have been part of human lives for years and different ways have been used to conceptualise and understand substance abuse across literatures and history. The problems of substance abuse have been perceived as the moral feelings of the individual, a medical disease and a psychological syndrome (Jackson & Sartor, 2016).

Substance consumption is something that has been done by individuals for many years and these substances that are consumed are psychoactive because they produce subjective feelings of intoxication and most of the time it is self-administered and mostly it produces cognitive and behavioural changes in the individual (Jackson & Sartor, 2016). Throughout history and across many cultures humans have used so many different kinds of psychoactive substances like cannabis, caffeine, and coca, to name a few, however the quick spread of psychoactive substances in the western societies over the past 500 years has led to a limited handful of psychoactive substances (Durrant & Thakker, 2003).

2.5. GLOBAL CONTEXT OF SUBSTANCE ABUSE

According to the World Health Organisation substance use disorder is one of the largest public health issues in the world. Recent Figures from the World Health Organisation show that 3.3 million people die from alcohol use disorder each year and plus or minus 15.3 million people have substance use disorder (Can & Tanriverdi, 2015). Substance use disorder can lead to severe disruptions in family, social, physical, mental, and occupational functioning (Can & Tranriverdi, 2015).

The escalating use of alcohol and other substances has shown to be a big public health problem worldwide. The United Nations Office for Drug Control and Crime reported that approximately 185 million people worldwide are drug users, which means that demand for treatment will continue to increase (Witkiewitz, Marlatt & Walker, 2005).

Furthermore, it has been estimated that a total of 246 million people or 1 in every 10^{th} person who range between the ages of 15 and 64 years, used an illicit drug in 2013, which shows an increase of 13 million from the previous year (World Drug Report, 2015).

When it comes to opioids statistics have shown that the prevalence of the use ranges to 0.7% of the worlds adult population and 32.4 million users. The use of opiates is estimated to be 0.4%, which makes it 16.5 million users (World Drug Report, 2015). With cocaine it has been estimated that the prevalence of it globally is estimated to be used by 0.4% of the adult population (World Drug Report, 2015). On the other hand cannabis is increasing and continues to escalate in west and central Africa and also in the western and central Europe (World drug report, 2015).

2.6. SOUTH AFRICAN CONTEXT OF SUBSTANCE ABUSE

In the past substance abuse data in South Africa has been limited, and until the 1900s information came from a cross sectional studies from single locations and some from police based on the arrests, drug seizures, mortuaries and school surveys (Heerden, Grimsrud, Seedat, Myer, Williams & Stein, 2009).

In South Africa alcohol is still the major substance of abuse and cannabis is the most illicit drug that is used especially amongst the youth (Heerden et al, 2009). The South African Drug statistics for 2016 have recorded that 7.06% of the population abuse narcotics of some kind. In addition there is one in every 14 who are regular users making it an estimated 3.74 million people (Reagon, 2016). There are 3.65% of the population who abuse cannabis regularly and 1.02% of the South African population who regularly abuse cocaine and 1.02% who abuse opioids and opiates, lastly ecstasy abuses make up to 0.4% of the population (Reagon, 2016).

Substance abuse is still a major problem in South Africa and according to the South African Depression and Anxiety group, illegal substance consumption is double the world norm (Steven, 2013). Jordan (2013) also stated that substance abuse and use in the country has been regarded as twice the world norm. Furthermore, substance abuse is the result of the increase in the crime rate within the country, especially among the youth who are poor and unemployed. Figures that were provided by the South African Police Services show that drug abuse is the result of 60% of all committed crimes and the central drug authorities have reported that up to 15% of South Africans use drugs (Steven, 2013). Studies have also shown that individuals that start consuming alcohol before the age of 15 are more likely to become alcoholics and that school learners who use substances are more likely to be involved in crime (Jordan, 2013).

Steven (2013) Identified some factors that contribute to the escalating levels of substance intake as being due to poverty, modernisation and a reduction in traditional and social relationships; another factor that contributes is drug trafficking in and out of the country.

2.7. SUBSTANCE ABUSE AND USE

Substance related problems represent a major health challenges and that has resulted in an increased interest in addiction treatment (Kvamme, Asplund, & Bjerker, 2015). Some substances like alcohol are socially accepted in western societies however they still remain to be a major public health problem (Boekel, Brouwers, Weeghel & Garretsen, 2013). The problems that substance use arises is not only health problems but there are also other risk factors that result from substance use, like absenteeism at work, accidents and loss of productivity (Boekel, Brouwers, Weeghel & Garretsen, 2013).

In the past substance use has been thought of as an individual problem however frequently substance abuse affects the whole family and the reason for that is because most of the alcohol and drug abusers live within a family setting and families are important stake holders who both aid the process of change and benefit from the improvement of an addiction problem (Gruber & Taylor, 2006). The family mostly aims at getting individuals who are engaging in substance use into rehabilitation, maintaining participation and improving their substance use related outcomes and also they aim at reducing the negative impact and harm to the family (Gruber & Taylor, 2006).

Substance abuse in families cause a lot of problems. For example, child abuse and neglect; substance abuse is often associated with child abuse and inadequate parenting skills, social isolation and the behaviour of the children are likely to be influenced by the parent's substance intake. Another example is violence within the family, whereby the violence can result in homicide or it can also lead to partner aggression (Gruber & Taylor, 2006).

2.8. ADDICTION

2.8.1. *What is addiction?*

Substance abuse is an addiction that defined differently by people. Scientifically substance or drug addiction can be defined as "a chronic, relapsing brain that is characterised by compulsive drug seeking and use, despite the harmful consequences" (National Institute on Drug Abuse, 2007, p. 5). Drug addiction is considered as a brain disease because it changes the structure of the brain and how it works (National Institute on Drug Abuse,

2007). The National institute on drug abuse also known as NIDA (2007) states that people take drugs for many different reasons. Firstly, people take drugs because they want to feel good. Drugs are known to produce intense feelings of pleasure. The problem with people engaging in drug taking too make them feel good is that at first they see it as a positive thing and they have the belief that they can control their use but soon it becomes part of their lives and they always need to take the drug in order feel normal (National Institute on Drug Abuse, 2007).

Secondly to feel better, whereby people who suffer from things like social anxiety, stress-related disorders, and depression start to use drugs as an attempt to lessen feelings of distress. Thirdly, improve performance or accomplishments, some people feel that they have to have some kind of chemical enhancement for them to do well in their athletic or cognitive performance, and because of that they can end up engaging in drug abuse. Lastly curiosity, the fact that other people are doing it. Here adolescents are the one who are mostly vulnerable because things like peer pressure play a role and are also more likely to engage in thrilling and daring behaviours (National Institute on Drug Abuse, 2007).

In addition addiction has also been defined as a state of physiological adaptation of a drug in the body so that the absence of the drug in the body leads to physiological dysfunction, like having withdrawal symptoms (West & Hardy, 2005). In this case an addict is regarded as someone who needed to take a drug in order to maintain normal physiological functioning. Addiction is also known as a syndrome whereby there is impaired control over a behaviour that can lead to significant harm (West & Hardy, 2005). This means that there is impaired control in the addicted individuals which gives them the feeling of wanting to engage in substance abuse and it ends up becoming a priority in their lives (West & Hardy, 2005).

When people first engage in substance use, they may view it as something that is positive, with positive outcomes and they may also believe that they have total control over it but eventually the substance usage can take over their lives (National Institute on Drug Abuse, 2007). Even though the decision to engage in substance use is entirely a voluntary one, the continued use of the substance can alter people's ability to have self control over their lives and this inability to have self-control is the hallmark of addiction (National Institute on Drug Abuse, 2007). To show that one is addicted to a substance there will be changes in

the area of the brain that is important for judgement, decision making, learning, memory and behaviour control (National Institute on Drug Abuse, 2007).

2.8.2 *Factors that increase the risk of substance addiction*

There are various factors that can lead to an increase in addiction towards drug use. These factors can also be the reason why an individual would relapse during or after treatment. Environmental factors like home and family and peer pressure and school (National institute on drug abuse, 2007). Other factors that increase the risk of substance abuse is early use, and method of administration. Research has shown that the earlier a person begins to use drugs the more likely they are to progress to more serious abuse. With regarding to the method of administration; smoking a drug or injecting it into a vein increases the potential of addiction.

When one smokes there is a powerful rush of pleasure that is felt the minute that it enters in the brain, however the downside to it is, that feeling of pleasure can fade within a few seconds, resulting in lower and more normal levels. Hence scientists believe that this is the drive that causes individuals to take drugs continuously with the attempt to recapture that high pleasurable state that they felt (National Institute on Drug Abuse, 2007).

2.9. TREATMENT OF SUBSTANCE ABUSE AND RELAPSE

Treatment is the application of planned procedures which locate and change patterns of maladaptive behaviour, destructive behaviour and health injuries, it is also a restoration of the levels of physical, psychological and social functioning that is appropriate (Connors et al., 2013)

2.9.1. *Change Model of Addiction*

People who have an addiction problem have a desire to change at some point however the readiness to change differs from one person to another. The resistance of treatment can be frustrating point for professional who work with addicts. Prochaska and DiClemente (1992) came up with a change model that could help to address the problem of matching an individual's treatment to his or her willingness to change (Connors et al., 2013).

Prochaska and DiClemente proposed 5 stages of change. Firstly, is the pre-contemplation stage, this is where individuals are either ignoring or they are unaware of the fact that they have an addiction problem. Reasons that one could find themselves in this stage is because many individuals are not educated about the effects of substance abuse on themselves and

they are not aware of the dangers that come with substance use and abuse and these behaviours are usually associated with denial and resistance (Connors et al., 2013).

Secondly, the contemplation stage is when the individual has begun considering to change but has not made the decision to change, however they are really considering on quitting or reducing the substance use. They are beginning to realise the problem and they are working on making sense of it (Connors et al., 2013). Thirdly, the preparation stage is where change is initiated in the future or one has learned a few lessons from their previous attempts to change and the decision of whether one wants to change or not is taken here. Next is the action stage, individuals overcome their problems through the modification of their behaviours, experiences and environment; they take the decision to change and also come up with a change plan. Lastly, the maintenance stage starts with sustenance and incorporating changes that were acquired during the action stage, and in this stage an individual has accomplished some change and they are working on the stable pattern of non-using behaviour (Connors et al., 2013).

2.9.2. *Cognitive behavioural model of addiction*

The cognitive behavioural treatment, relapse prevention was designed as an addition to existing treatment and has been mostly used as a standalone treatment and serves as the base of quiet a few other cognitive and behavioural treatments (Witkiewitz, Marlatt & Walker, 2005). Based on the foundation that maladaptive drinking and drug use are behaviours that are learned, cognitive behavioural therapy provides a framework around whereby interventions attempt to identify situational, social, affective and cognitive participants of pathological substance use (Witkiewitz, Marlatt & Walker, 2005). What is important about Marlatts model is the ability of the individual to identify high-risk situations and acquire coping mechanisms to deal with those high risk situations and at the same time having positive expectations that the usage of those coping mechanisms will result in an outcome that is successful (Larimer, Palmer & Marlatt, 1999).

With the cognitive behavioural therapy first identifies the possible causes of maladaptive behaviour and once that has been done the individual may decide to reduce the quantity or frequency of substance use or can even decide to stop using the substance completely (Witkiewitz, Marlatt & Walker, 2005). According to this model if a working and effective coping strategy is identified and used, then the individual will experience an increase in self-efficiency and will be less likely to consume the substance that they used to consume

(Witkiewitz, Marlatt & Walker, 2005). However if an ineffective coping strategy is used the individual may have a declination in self-efficiency and is most likely to have an increase in the consumption of the substance (Witkiewitz, Marlatt & Walker, 2005).

2.9.3. *Relapse Prevention*

The cognitive behavioural model also consists of the basis of relapse prevention and this intervention aims at describing, understanding, preventing and managing relapse in individuals who have received or are receiving treatment for substance use disorder (Witkiewitz, Marlatt & Walker, 2005). The prevention treatment combines behavioural skill training with cognitive interventions which are created to prevent or limit the chances of relapsing (Witkiewitz, Marlatt & Walker, 2005). The relapse prevention model is based on the principle that an individual's drug use, despite the negative outcomes that it has had on the person's life, has become a valuable function in their life (Jackson, 2014). In addition, the treatment approach that is used is based on the assessment of the environmental and emotional aspects of the problem that has a possibility of being associated with relapse. After the assessment the therapist works by analysing the individual's responses to these problems and also examining the lifestyle factors that increase the individual's exposure to high risk situations (Larimer, Palmer & Marlatt, 1999). In this case the role that is played by the therapist is to help the individuals to identify their personal reasons for using the substance and also for wanting to stop using it (Jackson, 2014).

Miller (2015) stated that the relapse prevention model attempts to take a realistic and practical route to recovery and views relapse as being a normal part of recovery. This assists professionals to step out of the parental and authoritarian shoes when working with service users and also that focusing on the fact that relapse is a possibility creates a platform for professionals and service users to develop prevention plans, so that relapse does not occur (Miller, 2015).

2.10. BEHAVIOURAL MODELS THAT HAVE BEEN USED TO EXPLAIN RELAPSE

There are several behavioural models of relapse which are based on different learning theories which have been used to understand relapse, some of those models include conditioned withdrawal relief theories, conditioned compensatory response theories, conditioned appetitive motivational theory, and social learning formulations (Niaura,

Rohsenow, Binkoff, Monti, Pedraza & Abrams 1988). All these models focus on understanding relapse by looking at factors that influence and follow the relapse episode itself like looking at the environmental, cognitive, physiological, and behavioural events (Niaura et al., 1988).

The conditioned withdrawal model used the respondent and operant conditioning factors to explain relapse to drug use. According to this model the consumption of drugs by a very dependent individual is associated with alleviation of withdrawal symptoms and being exposed to substance cues would elicit conditioned withdrawal and the individual would have high chances of relapsing to relieve these symptoms (Sobell, Wilkinson & Sobell, 2012).

When it comes to conditioned compensatory response model, it stated that research on the development on drug tolerance may have played a role in the understanding of the mechanisms associated with relapse (Niaura et al., 1988). This was the reason behind the development of the theory regarding the influence of contextual factors on tolerance development (Niarua, 1998). This theory also states that the same drug dependence learning mechanisms may also contribute to drug withdrawal symptoms (Niaura et al., 1988). The model also includes the range of stimuli considered to induce withdrawal and craving by considering factors like emotional states like depression and anxiety (Niaura et al., 1988).

Furthermore, the Conditioned appetitive motivational model argues that the compulsive drug use is maintained by appetitive motivational processes (Niaura et al., 1988). This model was developed from observations that concluded that responding to drugs can happen in the absence of deprivation, acute withdrawal distress and without experiencing drug withdrawal (Niaura et al., 1988). The contribution of appetitive motivation is evident in stimulant drugs like cocaine and amphetamines and also in opioids like heroin and morphine. Environmental stimulus that is previously associated with the ingesting of these drugs elicits appetitive motivational states (Sutker & Adams, 2013).

In addition, the social learning model which is used by theorists like Marlatt and colleagues, states that the explanation of relapse must start by examining addictive individuals responses to high risk situations (Niaura et al., 1988). The high risk situations can fall into two categories. The first category consists of acute drug withdrawal and conditioned drug withdrawal which can be drawn out by drug related stimuli (Niaura et al.,

1988). The second category is based on the emotional state and social and other situations that are seen stressful in their own right (Niarua, 1998). Furthermore, in high risk situations cognitive factors are seen as the primary factor that determines the chances of relapse and that means that if a non-drug related coping response is not immediately available to the individual, it is likely to result in a decrease of the subjective judgement that the high risk situation can be self-efficient (Niaura et al., 1988).

2.11. RELAPSE

Substance abuse is a global problem with variations in patterns of abuse when it comes to different geographical factors and substance abuse prevalent areas play a great role when it comes to understanding the factors of relapse (Sharma, Upadhyaya, Bansal, Nijhawan, & Sharma, 2012). Relapse serves as an early warning, as a sign of failure to maintain desired behavioural changed (Chung & Maisto, 2006). Relapsing is defined as a recurrence of symptoms of a disease after a period of improvement or it is also an act or instance of backsliding, worsening, or subsiding, which means that one could have possibly relapsed by mistake (Brownell, et al, 1986).

2.12. FACTORS THAT CONTRIBUTE TO RELAPSE

There are various factors that have been identified which have been seen as contributors towards people relapsing after treatment. One of the factors that contribute towards one relapsing is stress. This notion that stress leads to relapse in addicts is not something new, many theories of addiction support the notion that stress plays a big role in increasing drug use and relapse (Sinha, 2001). Many studies that have been conducted have also supported the claim that stress can lead to drug self-administration (Sihna, 2001). Sihna (2001) stated that even though studies have shown that stress can lead to one relapsing, there is lack of information regarding mechanisms by which stress exposure can enhance drug use and increase relapse.

2.12.1. *Parental use*

In a study that was conducted by Lian and Chu (2013) it was seen that parental use was the biggest predictor of leading their children to engaging in substance abuse, the stronger the parent-child relationship the greater influence it will have on the child (Lian & Chu, 2013). The reason for that could be that a child who has a stronger relationship would end up adapting to the habits that they see their parents engage in and also end up engaging in that

behaviour themselves. At times substance use might be seen as something normal for the child to engage in because that is the kind of environment that the child was raised in. Research done on cigarette smoking amongst families found that both maternal smoking and parent-child interaction influence the risk of life time smoking by the child (Swadi, 1999).

2.12.2. *Distal and proximal factors*

The systems model views relapse as a complex process which involves links between the distal and proximal processes which occur during high risk situations which increase the risk for one to relapse (Moore, Seavey, Ritter, McNulty, Gordon, & Stuart, 2013). Distal factors are stable characteristics of an individual or his or her environment that are likely to increase the risk of relapsing (Moore et al., 2013). These are factors whereby there are high engagements of substance intake within families, peer-pressure, and a community where it is easy to access substances and where the rate of substance use in the environment is high because that means that the individual will have more exposure to alcohol.

In addition, other environmental factors that contribute to substance use are poverty, racism, community and interpersonal violence, lack of education and job opportunities (McWhirter, McWhirter, McWhirter & McWhirter, 2013). In economically depressed communities people usually use drugs in response to the bleakness of the economic and social conditions, including traumatic events, poor neighbourhoods, bad school conditions, and negative peer influences (McWhirter et al., 2013).

The reason why it is stated that peers influence is stated as a factor that contributes to substance use is because, peers can have a strong influence on each other regarding the use of drugs. Peers provide information about drugs, shape each other's attitudes towards them, and create a social context whereby they can use them, give reasons for using them, and also make them available (McWhirter et al., 2013).

On the other hand, proximal risk factors are the temporary immediate precursors to relapse like cravings (Moore et al, 2014). High risk situations can also be the cause of patients relapsing. According to the model of relapse prevention a person who has taken a decision to have behaviour change should have increased self efficiency and mastery over their behaviour (Larimer, Palmer, & Marlatt, 1999). But a barrier of this is that certain situations can cause threat to a person's self-control which can lead to episodes of relapsing (Larimer, Palmer & Marlatt, 1999). Some factors that contribute to episodes of relapsing

are negative emotional states like anger and anxiety, even boredom; situations that involve another person or group of people like being involved in some form of conflict with someone close to you (Larimer, Palmer & Marlatt, 1999). The other factor that leads to one relapsing is social pressure which is persuasion or pressure that comes directly or indirectly, like being around people who are drinking and positive emotional states like being exposed to alcohol related stimuli or even testing oneself control state (Larimer, Palmer & Marlatt, 1999).

2.12.3. *Stigmatisation*

As many other issues which result from stigmatisation, there is a lot of stigma towards individuals who are highly dependent and addicted to subatances. Stigmatisation is a social phenomena and plays a huge role in stigmatised people health and wellbeing (Can & Tanriverdi, 2015). According to Can and Tanriverdi (2015) the stigma that is attached to individuals with substance used disorder causes loss of social functioning in individuals, which in the process results in reduction of the patient's quality of life and affect the systems in the patient's life, like the family, recreational and work (Can & Tanriverdi, 2015). The perception of stigma towards the individual can interfere with the treatment process of the patient and that is because once the patient's awareness of the stigma arises it can lead to decreased intentions of seeking therapy and that can lead to them relapsing (Can & Tanriverdi, 2015). They relapse because even though they go for therapy the compliance with what is needed for the success of treatment is reduced and therapeutic interventions end up not being successful.

In addition, the way that health care professionals work with people who engage in substance abuse can determine the success of treatment but also have influence in a patient relapsing. The stigma that health care professionals have towards people with substance use problems can affect the health care delivery negatively and can result in treatment avoidance and also patients relapsing (Boekel, Brouwers, Weeghel & Garresten, 2013). The reason behind poor service delivery and also relapsing is because the stigma leads to poor communication between the health care professional and the patient and misattribution of physical illness symptoms to substance use problems (Boekel, Brouwers, Weeghel & Garresten, 2013).

2.13. CONCLUSION

Substance abuse and the use and dependency of it is global problem, however it is also a bigger problem when we narrow it down and look at it from a South African context. Substance use is something that has always been engaged in throughout history till the present time, however the harm it can cause started being realised as the usage of it by individuals started to exceed. In addition, the more one uses a substance the more likely they are to become addicted to the substance and ending up have less self-control over the substance. Addiction is what leads people to getting treatment, however because it is not always guaranteed that the person will abstain completely from the substance do to the environment and other factors that the individual can be affected by, there is always a possibility of relapsing. Relapse is a complicated phenomenon; however, literature has been developed over the years to create an understanding of the reason that people relapse. When looking at every aspect of a person's life one gets to see that the person and the environment that they are in do play a key role in relapse, hence the bio-psychosocial model has been selected as the appropriate theoretical framework to use when research or doing a study on relapse.

This chapter started off by discussing the history of substance abuse and then after that looked at substance abuse in a global context and also in a South African context. Furthermore, substance use and abuse were defined and explained, then after that the chapter also discussed what addictions was and the factors that contribute to addiction. The literature was narrowed to the focus of the study which is relapse and the concept of relapse was discussed and also factors that have been found by different studies to be the reasons why people relapse, was also discussed.

CHAPTER 3
METHODOLOGY

3.1 INTRODUCTION

According to Fouche and Schurink, (2011) authors a design is based on the decisions a researcher makes when it comes to planning the study. Research approaches are plans and procedures for research that stipulate the steps from broad assumptions to detailed methods of data collection, analysis, and interpretation (Creswell, 2009). The choice of the research design approach is based on the nature of the research problem that is being addressed (Creswell, 2009).

This chapter will be providing the full explanation of the research design and methodology that was used in the study. A brief overview of the chapter has already been explained in the first chapter, however, this chapter will discuss the research design in more depth. This chapter will discuss the overall approach that was used in the study, which will state the procedures that were followed to execute the study.

3.2 AIMS

3.2.1 Primary Aim

The primary aim was to explore patients' perceptions about the reasons that they relapsed during or after treatment.

3.2.2. Secondary Objectives

- To identify subjective factors that are inclined to make patients vulnerable to relapsing.
- To explore the challenges faced by patients after relapsing.
- To obtain participants recommendations of how the problem of relapse could be addressed by the Westview clinic in the treatment programme.
- To obtain participants recommendations of how they could avoid the possibility of relapse as individuals through the help of the community and families.

3.2.3. Research Questions

1. What are the subjective factors that are inclined to make patients vulnerable to relapsing?
2. What are the challenges faced by patients after relapsing?
3. According to the participants how could Westview clinic address the problem of relapse in their treatment programme?
4. According to the participants how could they avoid relapse during or after treatment with the help of the family and community?

3.3 RESEARCH DESIGN

The research method that will be used in the research is the qualitative method. The reason why the qualitative method is best for this research is because qualitative methods allow one to collect data in depth whether it is a form of written, spoken language, observations that can be recoded in any language and analysed by identifying themes (Blanche, Durrheim & Painter, 2006). Not only do qualitative methods allow one to study selected situations in depth but is also allows the researcher to study selected issues in openness and in more detail as they identify and attempt to understand the information that rises from the data that is being collected. Using the qualitative method, the researcher will get first-hand information about why they think that they relapsed and also what should happen in order for it not to happen again.

The qualitative approach that was used is a case study. A case study is a strategy of inquiry whereby the researcher explores in depth a program, event, activity, process, or one or more individuals (Creswell, 2009). The cases are bound by time and activity and researchers collect detailed information using a variety of data collection procedures over a sustained period of time (Creswell, 2009). The reason why this research was based on case studies is that it made the research more credible and reliable in that it did not only rely on what literature has to offer but it was also based upon the perceptions of individuals who have experienced relapse. Furthermore, the research consisted of more than one participant whereby throughout the study there was constant comparisons of data and also placing them in similar themes and concepts.

3.4 RESEARCH METHOD

3.4.1 Population sampling

The population of the study was not easily identifiable and will be comprised of people who have relapsed. The reason for that was because the participants that were individuals who had relapsed and were receiving treatment from Westview Clinic or had previously received treatment from Westview Clinic. The kind of sampling that was effective for the research was availability sampling. Availability sampling falls under non-probability sampling and is based on relying on available subjects for one's study. Sometimes it is known as convenience sampling (Rubin & Babbie, 2010). The reason for using the availability sampling was because the research was focused on both in-patients and out-patients and the people that were included in the sample were individuals who have relapsed, both males and females and who are 18 years and above. The total number of 14 participants were interviewed, the reason for choosing 14 participants is because it gave the researcher a broader view of the perceptions of why the participants relapsed and also helped with placing the data in themes and commonalities. The researcher had to first ask for permission to do the research at the organisation and then the social worker called the participants on behalf of the student to ask the participants to be part of the study. In addition to that, there were individual meeting with the participants whereby consent needed to be signed by the participants to show that they agreed to be part of the research.

3.4.2 Research tool

The research instrumentation that was be used is a structured interview schedule. A structured interview schedule is a set of questions with structured answers that guide an observer, interviewer, researcher, or investigator. It is a set of questions which are asked to all participants (Miller & Brewer, 2003). The reason for that was because there was a number of questions that were asked that the participants had to answer. These questions were not changed, all the participants were asked the same question and the researcher also probed on those questions which ensured the reliability and credibility of the information that was being gathered. The questions that the participants were asked covered a bit of the history of their substance use and also information about the treatment that they had received and also focused on the reasons that they relapsed and the factors that caused them to relapse. Furthermore, the questions focused on the role that the family, community, social workers and organisation can play in ensuring that rates of relapse in recovering addicts are reduced.

3.4.3 Pre test

The pre-test was conducted at Westview clinic. Two participants were used for the pre-testing. These participants were 18 years and above and had relapsed during or after treatment. The pre-test was to used ascertain whether the research tool that was used for the research data collection, which is a structured interview schedule, addressed the questions that were needed to answer the aims. In the interviews the student social worker explained to the participants that the interviews were a pre-test and that they would not be used in the main research project. At the end of each interview the participants gave an evaluation of the interview. The evaluation was used to determine if the questions asked would be easily understood by the chosen sample and also to determine if there were any modifications that had to be done.

The evaluation that was done was the research had to be more relaxed when conducting the interviews that way she will be able to hear the story of the participants clearly and not rush through the interview. Being relaxed would mean that the researcher will allow the participants more room to guide the interview and not get answers that will be biased. However, both participants stated that the questions were easily understandable and also not complicated for the participants to answer. The research also saw it fit to add the question of whether the participants view relapsing as being a normal process and something that is part of the rehabilitation process or the perceive it as being a taboo and something that is not expected. This question was added because the researcher saw that the individuals had different views on that aspect when she asked questions about relapse during the pre-test.

3.4.4 Data collection method

In addition, the form of tool that will be used to collect the data was face to face interviews and the reason was because there was an opportunity for information to be gathered in depth and because the questions did not have to always remain the same, if something interesting comes up in can always be added into the interview and probed to get more information. Interviews were be used as an approach which was aimed at exploring, describing and analysing the meaning of the lived experienced based on how people perceive, describe, feel about, judge, remember, make sense and talk about a situation (Guest, Namey &Mitchel, 2013).

3.4.5 Data Analysis

According to Padgett (1998) there is no single approach to qualitative data analysis; researchers usually pursue what works best given the data at hand. The research data was collected through one on one interview that were then audio taped and after transcribed into similar themes and concepts. Clarke and Braun's thematic analysis approach was used to analyse the data. The thematic analysis consists of six phases. The first one is the familiarisation with the data, the researcher had to become intimately familiar with the data, it is important to read and re-read that data; coding is the second phase of the thematic analysis, and it involved generating labels for important features of data of relevance to the research question guiding the analysis (Clarke & Braun, 2013). The third phase is the searching of themes, which is like coding the codes to identify similarities in the data and once that is done the fourth phase follows whereby the researcher had to review the themes. This involved checking that the themes worked in relation to the coded extracts and the full set of data, furthermore checking that the themes told a convincing and compelling story about the data (Clarke & Braun, 2013). The second last phase is defining and naming the themes which required the researcher to conduct and write detailed analysis of each theme and also the identification of the essence of each theme. Writing up is the last phase and this was based on weaving together the analytic narrative and extracts of data to tell the reader a clear and convincing story about the data and contextualising it in relation to the existing literature (Clarke & Braun, 2013).

The researcher started off with line by line coding which was reading and re-reading every line of text searching the meaning behind each of them. Coding qualitative is a process of identifying bits and pieces of information and linking them to themes and concepts that would be organised in the final report (Padgett, 1998). The data was collected using face to face interviews because it provided a platform for the research to gain more information and also get more in touch with the participant's feelings regarding their experiences and also perceptions about relapse. Placing the information in themes also made it easier since audio taping was used, because it was easier to transcribe the data after every interview that was conducted.

3.5 LIMITATIONS OF RESEARCH DESIGN

- People might have not wanted or felt comfortable to speak about their relapse. To ensure that the participants spoke freely about their experiences and perceptions, the researcher ensured them that pseudo names would be used in the research report and as a result no one would know what they said. The researcher also notified the participants that the audio tapes would be stored in a safe and secure place and that no one would have access to them except the researcher and the researcher's supervisor.
- The study was not able to be completely generalised because it is mainly focused on a certain organisation and only a certain amount of people was interviewed. To ensure that generalisability would be a possibility the research did not only rely on what the participants had to say to produce the report, however literature from books, journals, thesis or dissertations and articles were used.
- Only Westview patients were used and as a result the perceptions were narrowed down to these participant's perceptions of relapse and experiences. Since only a certain amount of participants was used, the researcher had to make sure that the data collected was not ambiguous. To do that the researcher probed on some of the answers that were provided by the participants to ensure that data was collected in depth.
- Some participants may have been reluctant to talk about their experience of relapsing with the fear of going back to using substances again. To easy the participants fears the researcher had organised two social workers from Westview Clinic to offer free counselling services to the participants if they felt that they needed it. The names and numbers of those social workers was provided on the participant information sheet.

3.6 TRUSTWORTHINESS

Quality is as important to qualitative research as it is to quantitative research. It places concern on the person who reads the research on whether or not to use the results, it also convinces others that the findings that are reported are worth paying attention to and that they are credible, dependable, confirmable and transferable to other situations (Tappen, 2011). The study had to be credible. To ensure credibility the researcher was the one that had to conduct the interviews. The other way that credibility was be ensured was that more than one participant was interviewed; meaning that there was

more than one view about the perceptions on relapse and also audio taping and verbatim quotations were used. In the study there also had to be transferability. The data that was collected had to be compared in order for themes and concepts to be identified.

The trustworthiness of a qualitative research is sometimes questioned by positivists and the reason for that is because the concepts of validity and reliability cannot be addressed in the same way in naturalistic work (Shenton, 2004). However there are authors and researchers who have discussed how one can deal with issues of reliability and validity (Shenton, 2004).

3.6.1. Credibility

The credibility of a research is based on ensuring that the study measures and tests what is actually intended and in qualitative research is based on answering the question of how fitting the findings are with reality (Shenton, 2004). The important aspects that have to be put in consideration to make sure that the study is credible is the line of questioning used in the data gathering sessions and also the method that is used for data analysis (Shenton, 2004). The questions that were asked were structured however there was room for flexibility in that the participants could answer honestly and freely and that probes could be used depending on how the participants answered the questions, to expand more on the issue.

3.6.2. Transferability

Transferability is based on the extent of a study's findings to be applied to other situations. It is based on the generalisation of the work being applied to a wider population (Shenton, 2004). This research study may be concentrated on a small group of participants however it can also offer information that a wider population might also experience when it comes to relapsing during or after treatment. Shenton (2004) mentioned that each case may be unique but it is also an example within a broader group and as such the possibility of transferability should also be considered.

3.6.3. Dependability

In order to address dependability when conducting a qualitative research, the process within the study must be reported in detail, which will enable future researchers to repeat the work or build on the study that has already been conducted (Shenton, 2004). To ensure that this happened the researcher had to describe in the research report how the process of the research occurred and was executed on a strategic level when it comes to the research design and how it would be implemented (Shenton, 2004).

3.6.4. Confirmability

Confirmability is the degree by which the results on an inquiry can be confirmed or corroborated by other researchers, it is mainly aimed at ensuring that data and the interpretations of the findings are not figments of the inquirers imagination but that they are taken from the data (Anney, 2014). To ensure confirmability the researcher stored the audio tapes in a safe place and also before analysing the data and recording the findings, the researcher wrote down transcripts of all the interviews that she conducted and that way it would ensure confirmability of the results that were recorded in the research report.

3.7 ETHICAL CONSIDERATIONS

The following ethical principles were adhered to in the study:

- The principle of “deception and disclosure” whereby it includes not telling the participants that they are being observed and also concealing the nature of the study and the investigators role (Padgett, 1998). To avoid this in the research the researcher had to make sure that she remains honest with participants and also notify them of anything that concerns them in the study, beforehand.
- Another principle to consider was “to do no harm”. It is possible that during the interviews the interview may trigger some of the participants past painful experiences that led to them engaging in substance use and this can lead the participant to being distressed. The researcher had to make sure that there were social workers available to offer free counselling for the participants that need counselling. The social workers that were from Westview Clinic.
- The principle of “Confidentiality” is guaranteed when the researcher can identify a given person’s responses but promises not to do so publicly (Babbie, 2008). If the participants do not trust the researcher or have no clarity of how confidentiality works and the limits of the confidentiality, then the information given about the

research would not be valuable and there would be a lack of honesty in the relationship. However, in the research the researcher could not guarantee anonymity because the participants were already known by the interviewer (Padgett, 1998). To avoid this ethical issue, the researcher had to notify the participants from the beginning that there would be confidentiality but there would not be complete anonymity because the researcher will be having face to face interviews with the individuals and she also had a supervisor who would be able to have access to the information collected during data collection.

- In addition, beneficence would also be another ethical issue when it comes to research. The research must be aimed at doing good and not to bring harm to people (Orb, Eisenhauer & Wynaden, 2001). This ethic could be broken if the researcher prevented the participants to be self-directed or independent and also to have freedom of choice (Orb, Eisenhauer & Wynaden, 2001). This could have become an ethical concern if the researcher directed the interviews to go in her favour or became bias whiles doing her interviews not putting in mind how the outcomes would affect the participants. Whatever the researcher does he or she must always have the participant's best interest in mind (Orb, Eisenhauer & Wynaden, 2001). The researcher had to make sure that the participants had freedom of choice and what they said would be recorded exactly in that manner and nothing would be changed or adjusted to benefit her as the researcher.
- Participants consent was another ethical issue that one needs to look into. In any research the participant must have been informed of the aims of the research, the methods that were used to gather information, the sources of funding, any possible conflict of interests, the anticipated benefits and potential risks of the study and any discomfort that it may have resulted in (Paula, 2010). In the consent the participants had to be informed of the right to withdraw from participation in the study or also withdraw from participating at any time without any form of punishment or penalty (Paula, 2010). Before working with any participant or involving any participant in any research, the researcher had to get the participants freely-given informed consent, preferably in writing and if it cannot be written the consent needs to be formally documented and witnessed (Paula, 2010). Before any participant could be part of the study the researcher made sure that they went through the participant information sheet together and then also through the consent form and make sure

that all the information that they needed to know about the study was given to them and nothing was hidden.

3.8 PROCESS OF RESEARCH STUDY

- The researcher had to propose a topic to the department, from then onwards she was appointed a supervisor who would guide her throughout the study.
- Next the researcher submitted a proposal to the supervisor of what her research would entail.
- A permission letter was requested from the organisation where the researcher conducted her research.
- Once the permission was granted and the proposal was complete, it was sent to the ethical board who brought back the proposal for minor changes and once those changes were done the proposal was approved.
- As soon as ethics approved the proposal the researcher could go ahead and do her data collection.
- The researcher conducted a pre-test to test her research approach and research tool that she would use to conduct the research.
- The participants were contacted by the social worker at the organisation on behalf of the researcher and also set an appointment whereby they would meet with the researcher.
- The researcher also had to organise with two social workers at the organisation to be available if any of the participants needed counselling.
- Throughout the data collection the researcher would go over the participant information sheet again and also a consent form was signed by the participants before the interviews were conducted.
- Eventually the researcher combined a report that consisted of her research study.

3.9 CONCLUSION

Using the qualitative approach for this research study was the best option because this research approach helped the researcher to get the perceptions of the participants in a more understandable way. The research became more credible and reliable because the participants were allowed freedom to tell more about their life

story regarding their experience of relapse. A structured interview schedule was used to direct the research in the correct direction, however there was always room for probing and more flexibility for the participants to add information that they perceived as being important to share. The pre-test that was conducted offered the researcher an opportunity to re-evaluate her research tool and also work on the changes provided by the volunteers. The usage of face to face interviews as a data collection and also thematic analysis offered the researcher an opportunity to understand the participant's perceptions about relapse in depth.

The ethical considerations that were mentioned in this chapter are morally accepted principles that provide rules for behavioural expectations for the correct conduct towards the participants (Strydom, 2011). The important ethical considerations that were mentioned were the process of data collection, deception and disclosure, confidentiality, beneficence, and also the consent that the participants have to give before doing the study.

CHAPTER 4
RESULTS

4.1. INTRODUCTION

The occurrence of relapse to substance abuse process is a global issue and at times it can be seen as being part of the recovery process however, it is still a great challenge in the treatment of addictive behaviours (Appiah, Danquah, Nyarko, Ofori-Atta & Aziato, 2016). Substance abuse leads to serious health problems, criminal activities and for those who are employed; it creates problems within the working environment (Clack, 2002). Furthermore, substance abuse has reached epidemic levels nationally and internationally and as a result treatment demands and re-admissions are continuously increasing (Swanepoel, 2014). This chapter will present the findings that were obtained from the data collection that was done and also that analysis of the data. The results were obtained from participants who were currently undergoing treatment or who had received treatment before from Westview clinic. The findings of the study are presented in terms of the objectives of the study.

4.2. PATICIPANTS PROFILES

Tables 4.1 and 4.2 will represent the demographics of the individuals that participated in the study. Table 4.1 represents the age, gender, race and the number of times that the participants have relapsed. Table 4.2 represents the type of substance that the participants used in the beginning of their engagement with substances and the substance that they are currently using.

Table 4.1: Demographics (N=14)

Category	Sub-category	Number of Participants
Age	20 and below	5
	21-25	5
	26-30	0
	31-35	2

	36-40	0
	41-45	0
	46-50	1
	51-55	0
	56-60	0
	61-65	0
	65-70	1
Gender	Male	12
	Female	2
Race	Black	11
	White	2
	Coloured	1
Relapsed	1 time	9
	2 times	2
	3 and more times	3

Table 4.1 shows that the age ranges of the participants that were used in the study were between the ages of 18 and 67. Most of the participants that were interviewed were males and only two females participated in the study. Furthermore, the study consisted of 11 black, 2 white and 1 coloured participant, the interviews were conducted in three 4 areas whereby three of those places are in Soweto which are Bekkersdal, Kagiso and Munsieville and the other interviews were conducted in Florida which is where the main office of Westview Clinic is situated. Lastly most of the participants (Nine) had relapsed once and two participants had relapsed twice, whiles the other three participants had relapsed three and more times.

Table 4.2: Type of Substance Used (N=14)

Type of Substance	Before Relapsing	Current Usage
Alcohol	2	2
Dagga	4	
Nyaope	2	9
Marijuana	5	
CAT	5	1

Crystal Myth	3	
Cocaine	1	2
Other	8	1

There are many different substances that individuals can be addicted to. There are individuals who also use more than one substance at a time. Table 4.1 represents the type of substances that the participants used when they started substance abuse and also the substances that they used after that and also the substance that they are using currently. Some of the participants used more than one substance and that means that they fall under more than one category which is reported in the table. The substances that were mostly used by the participants were Alcohol, Dagga, Nyaope, Marijuana, Cat, Crystal Myth and Cocaine. When it comes to the substance that the participants were currently using, most of them (nine participants) mentioned that they were using nyaope.

4.3. PARTICIPANTS INITIATED TO GET TREATMENT

There are individuals who are taken into treatment without them initiating it, whereby it is suggested by a loved one or a professional. 6 of the participants stated that they were forced into going to get treatment whereby it is followed by consequences that could occur if they do not agree on getting the needed help that they need. 7 of the participants on the other hand stated that they are the ones who initiated the idea of going into treatment, however once they get there most of them either do not survive the treatment or they completed it and relapse after the treatment.

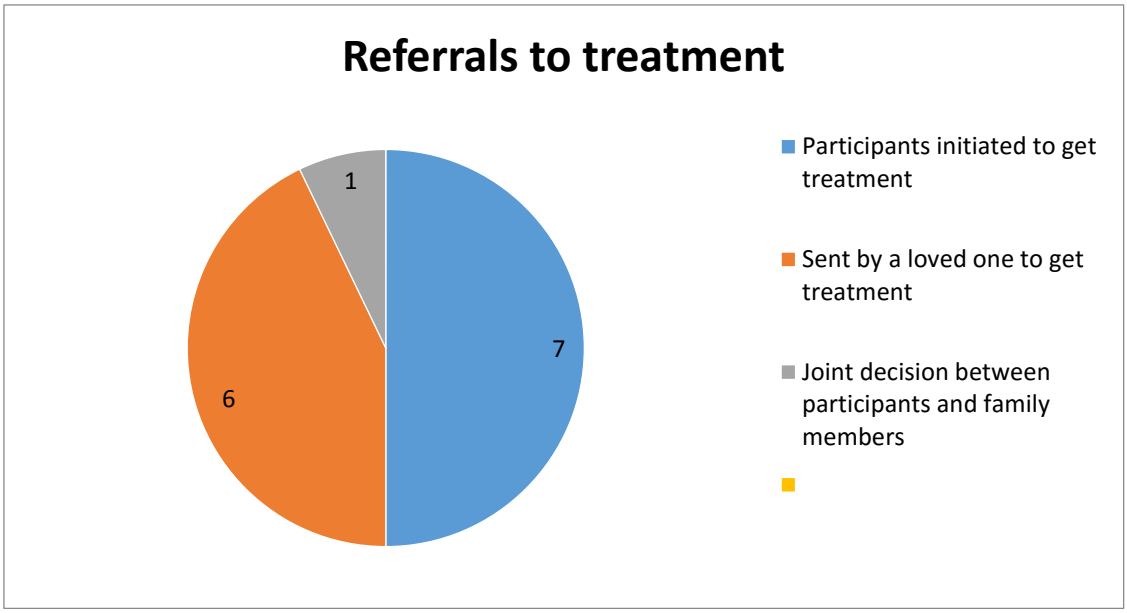


Figure 4.3 Referrals to Treatment (N=14)

Figure 4.3 shows that 7 out of 14 participants stated that they had initiated to get treatment before they relapsed, while 6 out of the 14 stated that they never initiated treatment and that it was done by a loved one and only one of the 14 participants stated that it was a joint decision that was made between them and their loved one to get treatment. Treatment cannot be successful if the individual's mental state, physical and emotional state is not ready for the treatment. Three of the participants felt that they were forced by their loved ones to get treatment while two of the felt that they were given ultimatums to getting treatment. Individuals may always be taken to treatment however with some treatment is not successful because of the position that they are in currently in their lives. Some may have seen that they have a problem and that they need to get help, while some may see their addiction as not being a problem or they may not even consider themselves as being addicts in the first place.

> *"The first time I got treatment was when I got a close near overdoes on crystal myth and I landed up at Sandton clinic. I was still working so I had medical aid and I landed u in the psychiatric ward, but my mother ultimately made the decision that I should go into rehab. I went into a rehabilitation centre called Chresen clinic, in Bloomhof. So it wasn't really my decision, I was kind of forced into it." (Participant 9)*

> *"Not really, they were giving ultimatums that I do this or I do this and if I don't do this, these are the consequences. So I saw that if I keep smoking then school will be sacrificed, my car, I will lose everything and that is when I said okay let me try and change, but unfortunately it did not work out." (Participant 13)*

There are stages of change that were proposed by Prochaska and DiClemente (1983) The first stage is the pre-contemplation stage, the second stage is the contemplation stage, the third stage is the preparation stage, the fourth stage is the action stage ant the last stage is the maintenance stage. These stages were put in place to help health professionals to be able to identify the stage in which the individuals are currently at in their lives, that way they will be able to prescribe the right treatment for the individual. The stage in which the participants who state that they do not have a problem are currently on is the Pre-contemplation stage. This is the stage whereby the individual is either ignoring or unaware of the fact that they have a problem or that they are not taking the fact that they have a problem seriously or even thinking about making changes in their lives (Connors et al., 2013). The factors that can cause to be in this stage is that some people are not educated about the effects that their addiction can have on them and their loved ones, some are just

not receptive to indicators that their addiction is a problem and they tend to portray behaviours of denial and resistance (Connors et al, 2013).

4.4. DENIAL OF ADDICTION PROBLEM

It is one thing to be told that one has an addiction problem and it is another thing to recognise that one has an addiction problem. Figure 4.4 presents the findings of the participants who stated that they did not consider themselves as having an addiction problem when they first started receiving treatment.

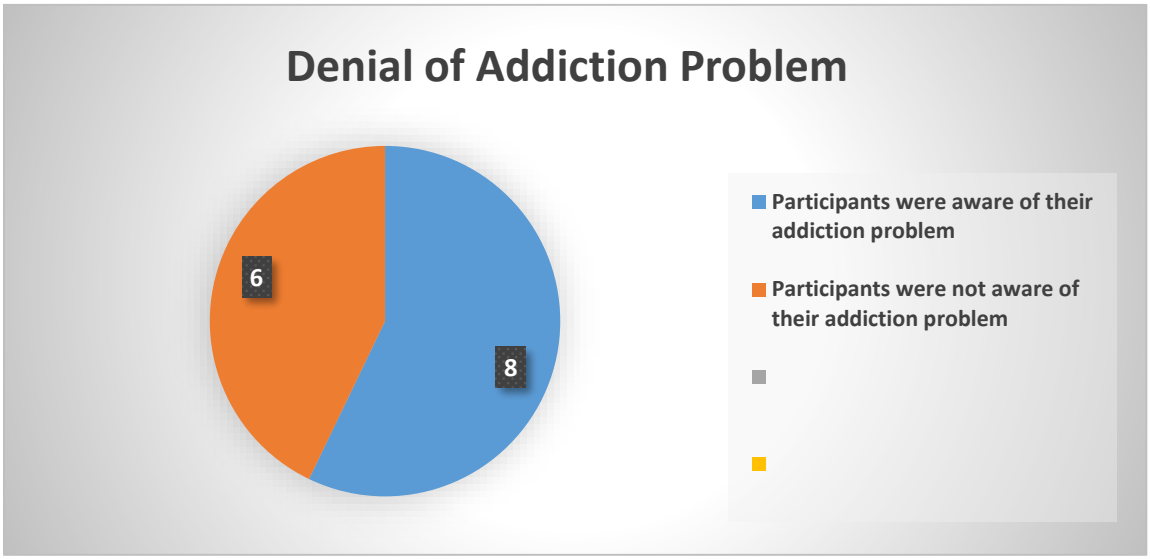


Figure 4.4: Denial of Addiction Problem (N=14)

Figure 4.4 shows that quite a few participants (six out of 14), did not acknowledge that they have an addiction problem. With that some of them felt like the treatment were not working whiles others thought that they were being forced into getting treatment. Other participants agreed that as long as they have not accepted or had that self-awareness of the fact that they have a problem, treatment will never work and which results in relapsing.

> *"For long time I didn't but then when I saw the physical effect and my emotional effects and I went into psychosis. Like in and out of psychosis. So uhm… I realised that I had a problem when I tried to commit suicide, December of 2014 and when I came out of my coma I pretty much took the next step and I realised that I had a problem, I really had a problem. (Participant 2)"*

> *"No. you know what, it wasn't about that. I was still naïve, I was still naughty. I knew when I came out of the clinic, I think I was there for 29 days or nearly a month but I knew that I was not going to stay clean. When I left the clinic my addiction actually got worse. You learn so*

much in rehab about new drugs, sometimes you not serious and I really wasn't serious and I still had money, I had a job, I had a car. So no, I knew when I came out I was just going to carry on." (Participant 9)

Denial is based on the fact that the addictive problem is not acknowledged or that for the individual it is non-existent and it could be because addict ion can be surrounded by painful thoughts, emotional conflicts and also anxiety (Simmons, 2008). Denial is one of the defence mechanisms that is elicited by the individual's ego. These individuals doubt or have the disbelieve that they have an addiction problem and that leads to them justifying their continued substance use and abuse (Rasmussen, 2000). Through this defence mechanism of denial the individual is able to maintain their self-esteem and denial also reduces the individual's acceptance of addiction and increases resistance to treatment (Rasmussen, 2000).

4.5 PSYCHOLOGICAL FACTORS OF RELAPSE

Relapsing is not just a mental or biological aspect but it also involves psychological aspects that can cause an individual to relapse. During the interviews some participants mentioned some psychological aspects which caused them to relapse. The well-being of an individual of an individual is also determined by their psychological stance. Some use substances as a way of trying to handle those psychological factors. Figure 3 represents some of the psychological facts which contributed towards the individuals relapsing.

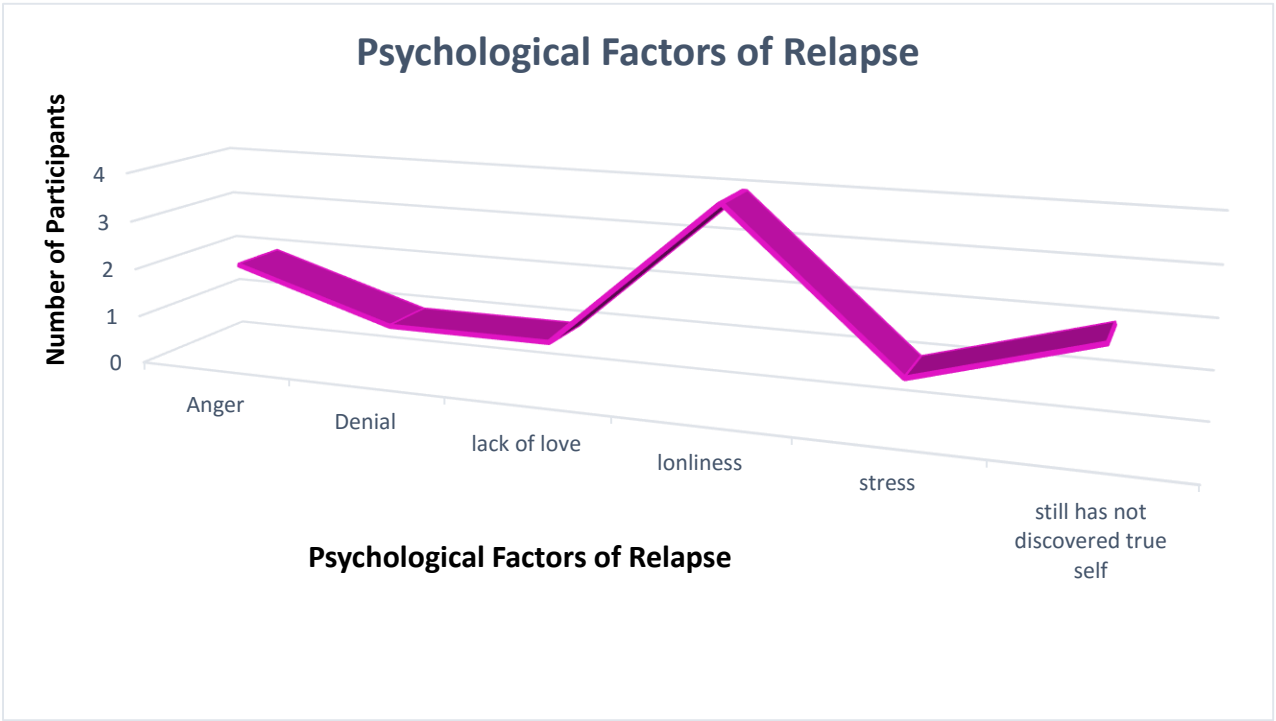


Figure 4.5: Psychological Factors (N=14)

From Figure 4.5 what was found is that the psychological factors that were identified by the participants as being factors that were causing them to relapse was anger, denial, lack of love, loneliness, and stress. There are other individuals who have no self-awareness and have not discovered their true self and as a result it can lead to relapsing. From what the participants had mentioned as psychological factors that cause them to relapse was that eight mentioned emotional factors which were anger, denial, lack of love and also loneliness and four mentioned other factors which were stress, and true self. These are also known as intrapersonal risk factors which involves emotions like loneliness, lack of effective coping mechanisms and stress management, lack of assertiveness, cravings, losing motivation, lack of commitment towards maintaining abstinence and not having control over the substance use (Swanepoel, 2014).

> *"...I would break but now I am failing to take a long break, because once I am angry, or feeling lonely or once I am… I am easily triggered back into relapsing. The trigger is very easy for me. Once I am angry, feeling lonely, rejected, that us when I go back…" (Participant 3).*

> *"It was a thing of smoking without anyone being aware of it because I missed that feeling that I was used to but then this thing of smoking without anyone being aware became a habit and an everyday thing." (Participant 5)*

4.6 SOCIAL FACTORS OF RELAPSE

People do not live alone, isolated and secluded from others. They are part of many systems, involved in many things which have an influence on them. Figure 4.6 will be presenting the social factors that they identified as being influencing factors towards them relapsing.

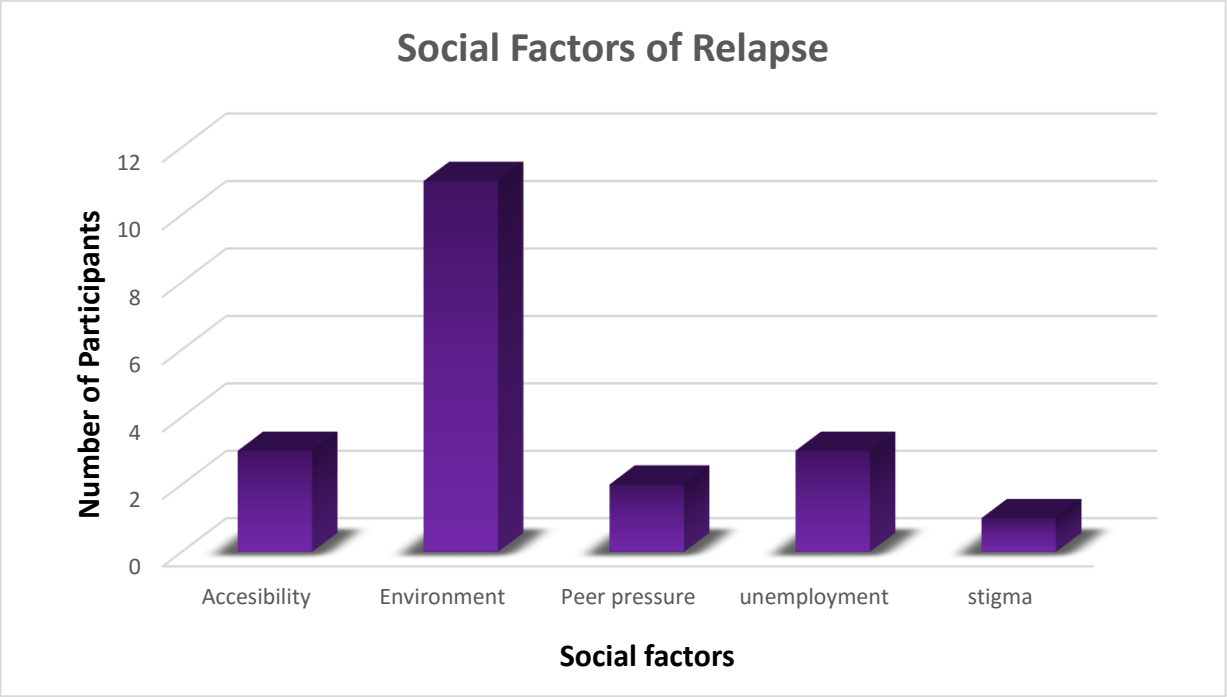


Figure 4.6: Social Factors of Relapse (N=14)

The social factors that were identified by the participants in Figure 4.6 were accessibility, environment, peer pressure and unemployment. Accessibility was a factor because it came up that where the participants live it is everywhere and sold at places that are easy to access. That links with the issues of the environment, majority of the participants agreed that the environment is a factor on its own because it has influence on the regarding accessibility, and the type of environment it is. Peer pressure has always been a problem in many situations especially amongst young people. With peer pressure it is easy for people to be lured into substance abuse, however there are people who believe that peer pressure has nothing to do with the fact that a person will relapse or not and that it is all a personal decision and a choice that one makes. Unemployment on the other hand has been seen as a motivating factor for relapsing because individuals say that, substances become an escape route for the individuals. They state that because they sit at home and have nothing valuable to do with their time it is easy for them to think of the substances.

> *"Firstly it is unemployment, peer pressure and also family problems… it was just being at home and doing nothing. I completed my matric last year and I have been sitting at home since then doing nothing and I am not the kind of person who can just sit at home and do nothing, I like being busy" (Participant 11)*

> *"At the rehab that I was at they do not want alcohol and drugs. The only thing that was allowed was cigarettes. So what happened is that we ran out of cigarette and when I thought of it, I live close to the rehab, so I decided to escape and jump the gates. I remember it was on a Sunday, I left and nobody saw that I had escaped and when I got to my community, I got here and smoked marijuana because I would not be able to entre with it at the rehab so I made sure that I finish it. When I got back they asked me why my eyes were like that, that they are not used to them being like that. Sunday everything was okay when I went back and on Tuesday I was surprised when they called me. They asked me if I went out on Sunday and I denied it and then they informed me that somebody saw me and then they went to test me and I refused to be tested. They then stated that if I refuse they will have to dismiss me, they then called at home and told them that I had escaped and that they were dismissing me. But since they dismissed me I have not been smoking nyaope, I have just been smoking marijuana." (Participant 7)*

Social factors also known as interpersonal factors can also lead an individual to relapse. These factors include peer pressure or influence, limited access to services in the community, lack of recreational activities, stigmatisation and lack of support, conflict management and difficulty in finding employment (Swanepoel, 2014). Individuals tend to abuse substances in order to cope with tension that is in connection with life stressors and to relieve symptoms of anxiety and depression resulting from things like traumatic events and all these events are also potent to provoking relapse (Goerders, 2004). Furthermore, incidences like exposing the individual to environmental stimuli or cues that is associated with substances can produce intense cravings which can also lead to relapsing (Goerders, 2004).

Substances have become so prone in communities that it is available and easily accessible everywhere. Nowadays one can access substances at street corners, bus depots, taverns, taxi ranks, in the work place and even at schools. The availability and prevalence of substance use is increasing together with the increased range of substances that are available and also there is an increment in the behaviours and attitudes that are cause by substance abuse (Swanepoel, 2014). Peer pressure on the other hand is a result of the influence that peers have over one. If a recovering client does not change friends or social groups after treatment they stand a high chance of being peer-pressured back into using those substances. Peer pressure can be a result of relapse and that is because substance using peer groups can discourage sobriety and encourage continued use of substances (Swanepoel, 2014).

4.7. FAMILY DYNAMICS CONTRIBUTION TO RELAPSE

Family plays an important role in individuals lives.it is a two-way street, the individual is affected by the family and the family can affect the individual. Substance use and abuse does not only involve the individual who is engaging in it but it also involves the individual's family. As much as the family can be affected, they too can affect and also be the cause of an individual to relapse while in the recovery process, due to various reasons.

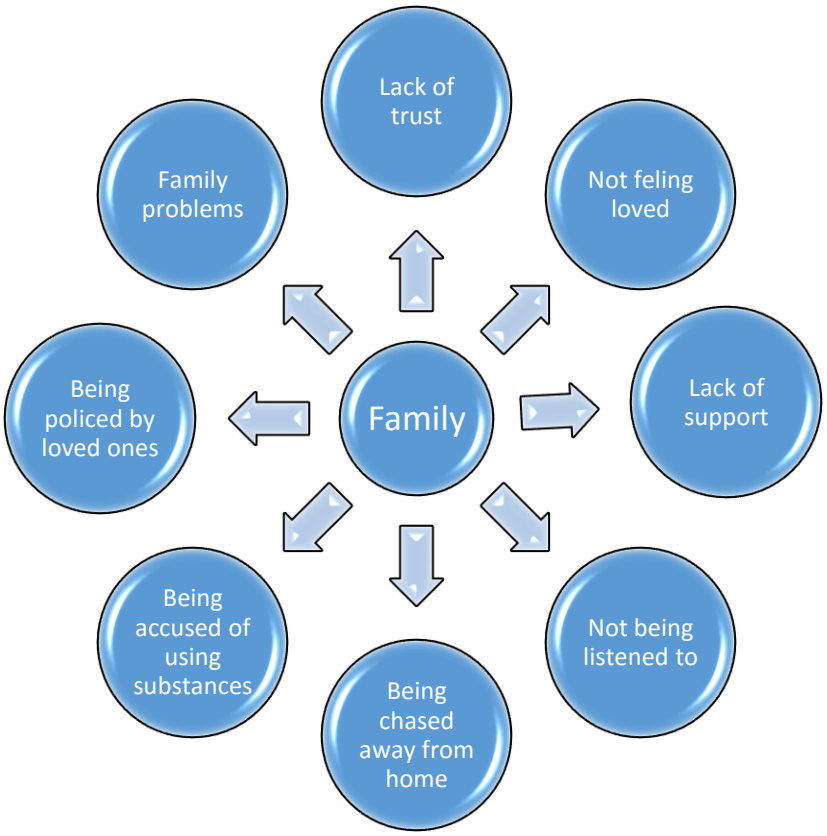


Figure 4.7: Family Dynamics Contribution to Relapse

Figure 4.7 shows the reasons why the participants relapsed. Majority of them mentioned that lack of support from the families is the reason why many people relapse. The family distances themselves from them and they are classified as the black sheep of the family. Some of them mentioned that they thought it is better if they go back and use those substances because even when they are working hard and really trying to recover their families do not believe them and for them they still believe that they are using even when they are not.

> *"I was living with my aunt and they are the people who supported me the time that I went to rehab and when I came back I went back to my aunts place and I had stopped smoking and I told myself that with the support, they would also help me to find a job and things like those. So I got there and I stayed with them, but I didn't sit at home for a long time because I found a job and after I got a job there were agreements that after I get money I would by my own shack and build it out side in my aunts yard and all those things did not happen. They took my money and used it and what I needed I did not get anymore and then I got angry and then one of the days the woman who was renting in the yard gave my cousin money and I took that money from my cousin and told him that I will go and buy what that woman wanted but I used that money to go to my grandmother in the east rand, when I go there me and my grandmother did not get along and I had to come back again and then when I came back things were not good at my aunts place and that is when I decided to move out and give them space and that is when I relapsed. Because I had stress of where am I going to live, because they have kicked me out." (Participant 14)*

The family system is an important system in the recovery of the recovering addicts, as much as they are affected by the addiction of their loved one, they also affect the recovering individual and they too can be a factor that causes individuals t relapse. Families are meant to play a specific role in the recovering process of their loved ones. However, if they fail to play that role meaningfully, it can lead the individual to relapse.

Substance users and abusers are usually perceived as individuals who are loners or people who are cut off from primary relationships, however most people who live are addicted to substances live with their parents or another close relative. There are so many factors that are related to the family that can influence or be the reason behind an individual relapsing. relapse can be due to family destructions, stresses, losses and also isolating the recovering addict can have a big negative impact on their recovery process (Baharuddin, Zakaria, Hussin, Mohamed, Sumari, Sawai, & Ahmad, 2012).

4.8 PARTICIPANTS PERCEPTIONS ABOUT RELAPSE

Relapsing is an issue that is not raised by many, but many people who it are in recovery experience as some point during their recovery process. There are different views about it whereby some view it as being normal and as something that is part of the recovery process and on the other hand some view it as being a problem and something that should not occur when one is undergoing recovery. Figure 4.8 presents the results of the number of participants who thought that relapsing is normal and also those who thought that it should not happen.

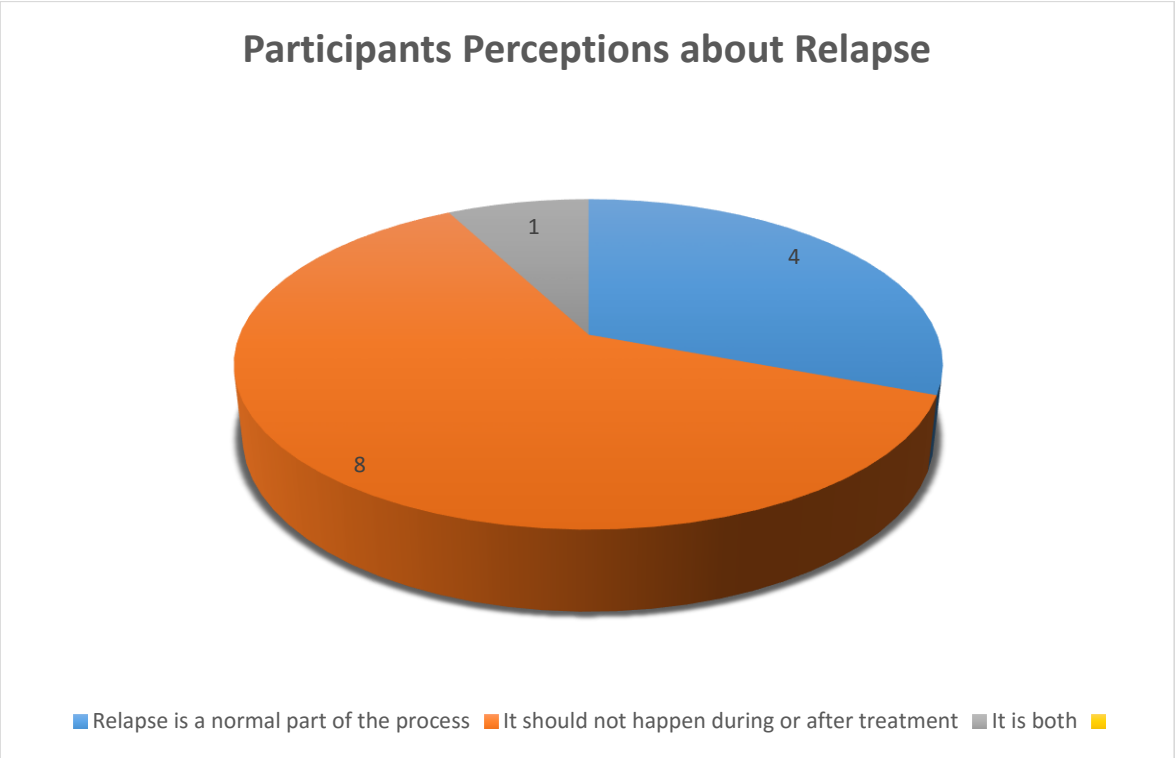


Figure 4.8: Participants Perceptions about Relapse (N=14)

Figure 1 shows that majority of the participants (9) do not consider relapse as being part of the recovery process and for them relapsing should not occur once a person has received or is in the process of receiving treatment. The participants did not find it to be part of the recovery process because one can be sober for 5 years but they are still at risk of relapsing and also the fact that substances are not good for one's health and the effects that the substance abuse come with.

Some of the things that the participants had to say about relapsing:

> *"Relapsing is not normal, first of all. You can be 10 years sober. You start lying to yourself, saying that if you have this one glass it will not do you anything because I haven't drank it for 10 years. That is the thing that causes problems. That one glass of beer will wake up 10 years that you haven't been drinking. It like a psychologist once explained to me in cape town, that you can be sober for 25 years, if you take that first drink, that drink is like a parasite, it's never ever going to be enough, it's like a parasite and it calls its friends, that is how this guy put it, he said not its inviting its friends to the party. That is when you relapse and you drink for the 25 years that you have not been drinking." (Participant 1)*

> *"Relapse is a horrible, horrible, horrible thing because I had everything now 6 months ago and I relapsed and I have lost everything again. so if people can avoid relapse then it is wonderful." (Participant 9)*

However, there are participants who thought that relapsing was a normal process of recovery and this is what they had to say:

> "*It's normal and the reason I am saying that is because…some doctor talks about relapsing as being a choice, it is not a disease and when you go to rehab you are told that it is not a choice it is a disease. So I combine them both and make it normal, at the end of the day whatever you do is your choice. It's quiet contradicting. At the end of the day it is your choice. I went to rehab, I want to smoke again or I want to quit. It is also a disease because it is inside your body and it has already damaged your brain and you can live with it for the rest of your life. that is why they call it an addiction and why they call you an addiction and why they call us addicts. 20 years or 30 years after if you smoke again you are going to go back full force. So it is a disease and again it is a choice. It's a contradiction on its own. It balances the two that is why I say that it is normal. It is a choice and the situations that we face in life are not the same" (Participant 13)*

Relapsing is a problem for many individuals and that is because of the perception that they have about relapse and recovery. Many recovering addicts, including their family members believe that once a person has been for treatment they are expected to stay clean and not go back to the substance at all and maintain complete sobriety. That is the kind of mentally one has when they think of treatment, but is that always the case? As mentioned above, there are many factors that can cause individuals to relapse and go back to their addiction, however because of the lack of understanding behind relapse for many individuals, once a person relapses it is believed to be the end of everything and the adopt feelings of hopelessness.

Relapse is a normal part of the recovery process and most of the time addicts are embarrassed and ashamed of thinking about their recent relapse, that is because they associate relapse with failure and it also come with shame and guilt (Brownell, 2012). Learning from one's experience is important, that way they can become thinking individuals who can work through relapse (Brownell, 2012). Completely abstaining from substance use is always stressed by professionals in treatment programmes and also in private practices and it is seen as a measuring tool for the success of recovery; however, Portman (2010) states that it is very rare for a person never to drink again after their first attempt to quit and that some of these slips are a normal part of recovery.

4.9. EFFECTS OF RELAPSING ON INDIVIDUALS

Issues behind relapse do not only end when it occurs, there are always effects that follow once one has relapsed. The participants used in the research study raised some for the effects that relapsing had on them and the challenges and obstacles that they experienced once they had relapsed which are represented in Figure 4.9.

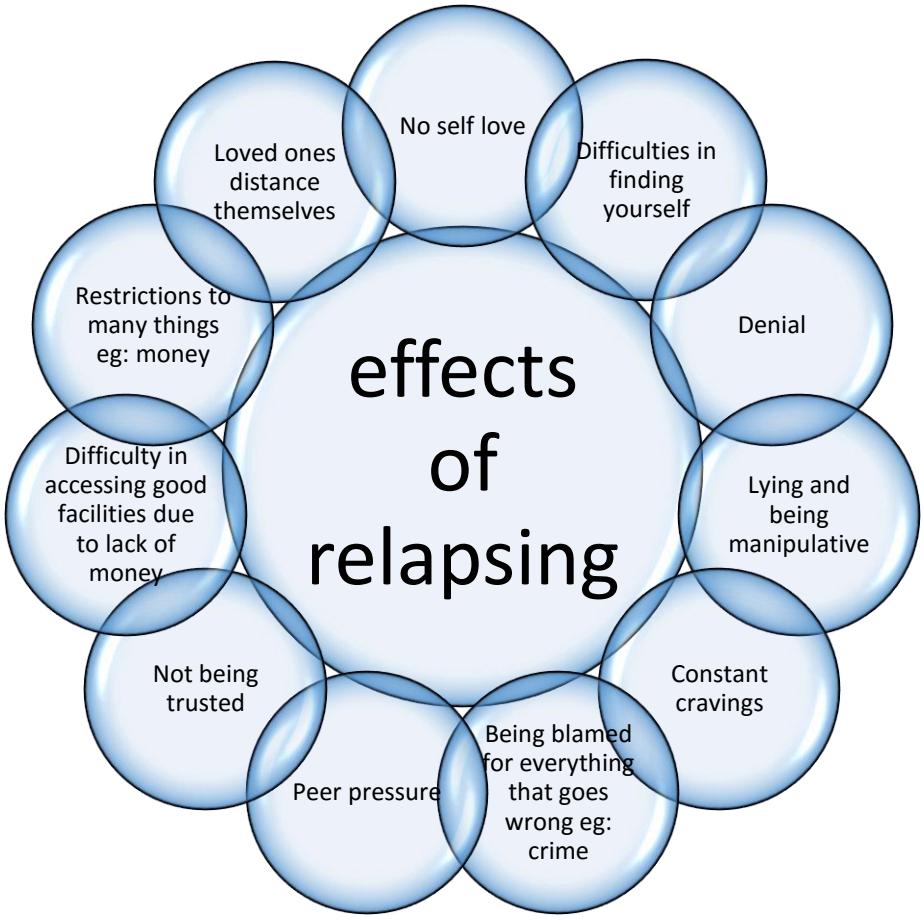


Figure 4.9: Effects of relapsing on individuals

There are many outcomes, challenges or effects of relapsing. The effects of relapsing that were mentioned by the participants were no self-love and this could be because of how relapse is viewed by other people as a point of failure and that contributes to the other effect of finding it difficult in finding themselves. Other effects of relapse that were mentioned by the participants were denial, lying and being manipulative. This can be a point whereby the individuals deny the fact that they have relapsed and have returned to the state of dependency, they end up lying about their current situation so that the way that their loved ones view them does not change, because some end up being blamed for everything that goes wrong in the community or households, like committing crime. The trust that they were also starting to earn and build is destroyed once again and it is difficult to get it back. Due to the lack of trust the individuals are restricted to many things and loved ones distance themselves. The participants also raised the point that once they go back it is hard for them to control their substance intake and they end up going back full time and satisfying their cravings.

At times one would find that the recovering individual is serious about maintaining their state of sobriety, however due to peer-pressure and peer influence it can be quiet

challenging. Another challenging aspect that was raised by the participants was that it is hard for them to be re-admitted into a treatment facility once they have relapsed. That on its own is a challenge because it lowers the chances of individuals going back on track with their recovery process and that also demotivates the individuals to try again and learn from their experience.

4.10. WAYS IN WHICH RECOVERING CLIENTS CAN BE SUPPORTED

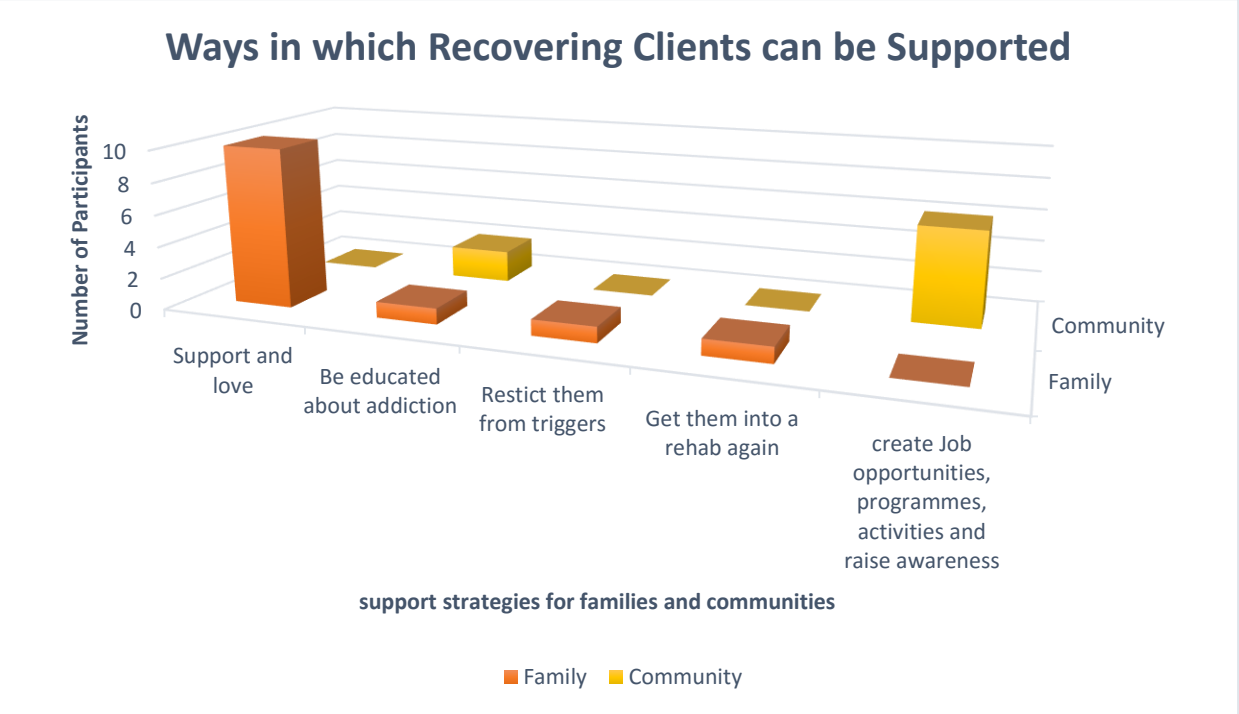


Figure 4.10. Ways in which Recovering Clients can be supported (N=14)

The family and community play a part in the lives of addicts. Many communities and families complain about the number of addicts within the families and within the communities. Figure 4.6 states ways in which the participants would love to have support from either their family members or the community. Most of the participants (10) mentioned that what they need from their family members that could help them from relapsing is by offering them support. What also came up was that in order for the families and communities to be support systems, the need to be educated about addiction, this was mentioned by three participants. Another form of support that was raised was that the community should create job opportunities, programmes and activities for recovering addicts in that way they will be kept busy and that way they will not have to think about substances. There were also a few participants who thought that there is nothing that the community can do to help them in order not to relapse.

Families can play an important role of being a supportive structure for addicts who are undergoing treatment and managing the recovery process. Weak support from family members and the community can lead to relapsing of the individual can lead to high levels of relapse (Baharuddin et al., 2012). Each individual will have their own perception of recovery and relapse, and that may be a reason behind whether or not their loved ones will relapse or not. To have a successful recovery process, the availability of support from loved ones, family's knowledge about the relapse process and the involvement in personal programmes are more likely to help decrease the chances of relapse (Daley, 1985). Jay (2015) stated that the duty of the family is to be supportive, however they can also contribute to the prolonging of addiction and when families are provided with good direction and learn to work together, they can be transformed into a great source of energy because the process of working together rebuilds families.

Ways in which relapse can be avoided is by gaining acceptance from both the family members and the community. Some of the participants stated that when they leave rehab they are judged by their family members and loved ones and that the trust is completely gone and because of that they are always blamed for everything that goes wrong or they are watched in every move they take.

> *I think the main thing is not criticism but support. And mainly when the person speaks… let's say I go out you find people that are say ah this guy can afford to go every three months and sit and pay thousands of rands, so automatically its moral breaking that they don't trust you. they…. In their minds "Ah give him another two weeks he's back to square one". You know that type of thing. The criticism. They don't give you the chance to prove yourself, even though you whole heartedly want to make that change. I mean you wouldn't come here if you did want to change. (Participant 1).*

On the side of the addicted individuals there needs to be an acceptance of advice and guidance that comes from both the family members and also the community members and in turn the family members need to show commitment towards their loved ones and help them in leading a better life and that means taking responsibility for helping and motivating their loved ones into treatment and creating a supportive environment while they are undergoing recovery (Baharuddin et al., 2012).

4.11. WESTVIEW CLINIC

4.11.1. Role of the organisation in helping recovering clients from relapse

Treatment centres play a major role in the process of recovery. That is where addicted individuals go when they need help to start their recovery process. Figure 4.11.1 will be showing the roles that the participants thought that the organisation should play in helping not to relapse while undergoing recovery.

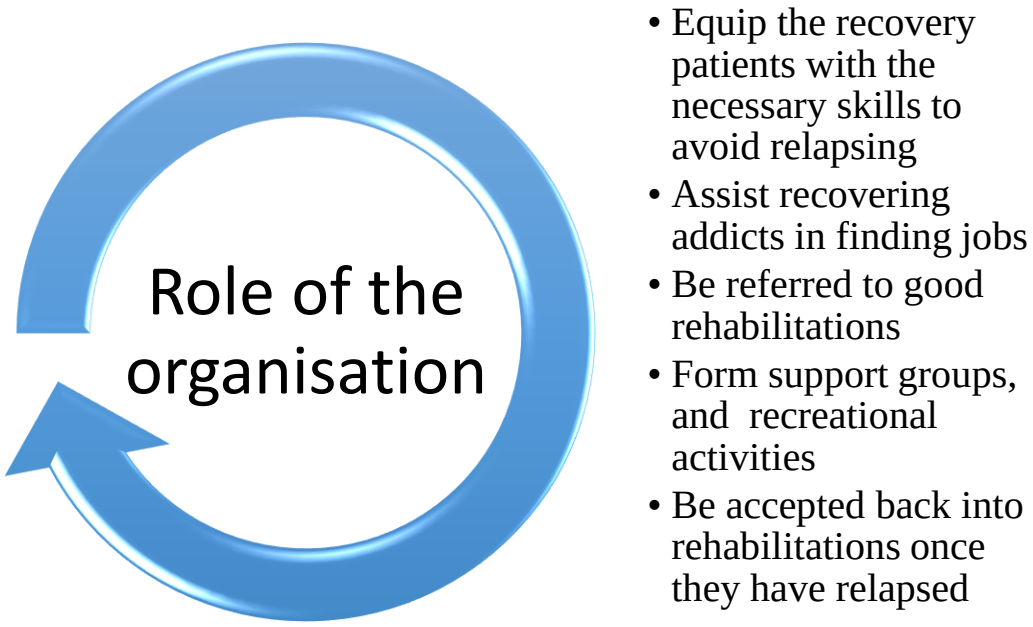


Figure 4.11.1: Role of the Organisation in Helping Recovering Clients from Relapse

The participants mentioned quiet various roles that they think that the organisation should play that can help them to avoid relapsing. Four participants stated that the only way that the organisation can help them is by helping them to find jobs, while two of the participants mentioned that the organisation should equip them with skills that they can use after rehabilitation. Another two mentioned that they would like the organisation to have continuous support groups and form recreational activities that they can do after treatment and only one of the participants stated that they would like to be accepted back into rehabilitation centres since they have relapsed. There were few participants (Three) who stated that there is nothing that the organisation can do to help them in avoiding relapse, but rather that the success of recovery is entirely up to the individual.

The responsibility of the organisation to its patients should not end when the individuals are discharged from the treatment centre. The individuals need to be assisted by the

organisation to adapt into their communities and still at the same time be able to maintain their sobriety.

4.11.2. Form of treatment received

Westview clinic works with both inpatient and outpatient treatment, whereby in patient treatment offers treatment that is private whereby the patients there pay for themselves using medical aids or cash if they can afford it. The out-patient treatment is whereby service users are sent to one of the rehabilitation centres that the organisation works with to receive inpatient treatment that is sponsored by the government.

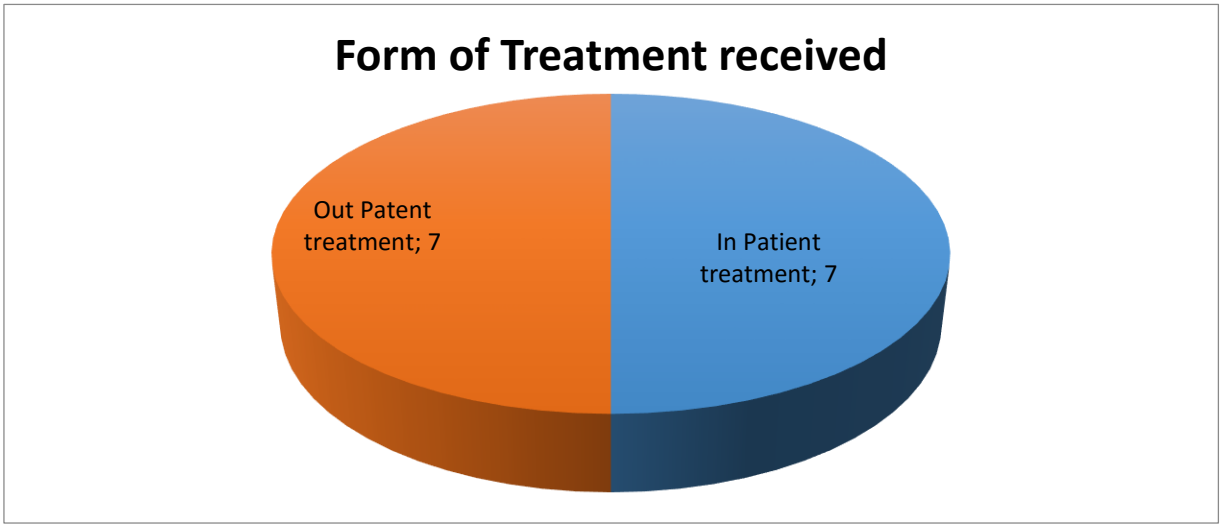


Figure 4.11.2: Form of Treatment Received (N=14)

As presented in Figure 4.11.2 half of the participants (seven) received in-patient treatment, while the other half (seven) received treatment from out-patient. Three of the participants mentioned that they were not satisfied with the kind of treatment that they received before they relapsed, while one of the participants mentioned that they relapsed within the facility and it was a result of the way the rehabilitation operates. The participants also stated that facilities offered by government are not good because its either addicts take advantage of the fact that they are in rehab for free or that the quality of services provided at government sponsored facilities are not good as services provided at a private facility like the in-patient treatment.

> *"I was the one who decided that I need to get treatment. But the rehab that I was taken to was useless because I could access the substance from there and I saw that I should just continue smoking because it was also there and the smell of the substance will tempt you to go back and smoke." (Participant 6)*

Participants who stated that it is difficult for them to get re-admitted into rehab facilities once they have relapsed and also stated that the help that they need from the organisation is to be given a chance to be readmitted into the facilities. When it comes to government funding facilities it is difficult for re-admissions to always be conducted and that is because there are so many individuals who are referred to rehabs on a daily basis that they end up working on a system of the availability of beds and also first time treatment receivers are considered first. When it comes to private institutions one can only access them if they are on medical aid or have the money to pay and that means those who have the money cab go back for treatment and receive the treatment that they need while others cannot afford and as a result must rely on government funded facilities. Voskuil (2015) stated that substance users who relapse after undergoing treatment and their possible re-admissions to the facilities affect the funds that have been allocated for treatment in a negative way and it also places a greater burden on treatment facilities when it comes to the capacity of individuals that can be accommodated for those who are first time admissions.

4.12 ROLE OF SOCIAL WORKERS IN HELPING SERVICE USERS TO AVOID RELAPSING WHILE IN THE RECOVERY PROCESS

As much as the organisation as a whole has the responsibility of helping recovering addicts, social workers in the field of substance abuse also have a responsibility towards recovering addicts. Figure 4.8 represents the roles that the participants think that the social workers should play in helping them from relapsing.

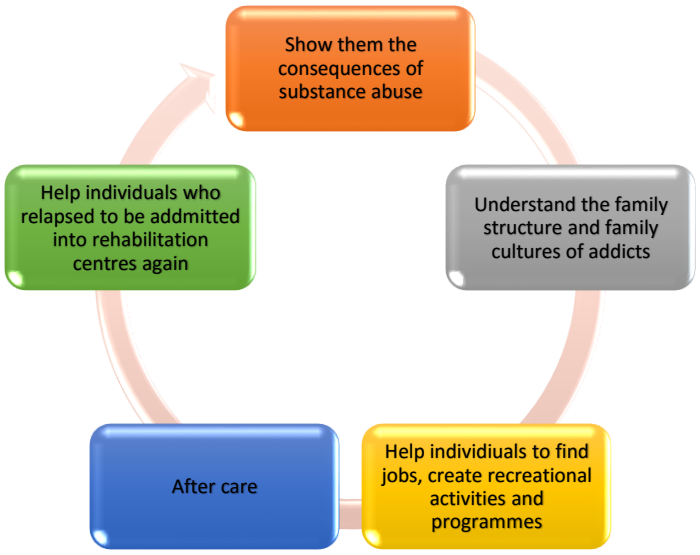


Figure 4.12: Role of Social Workers in Helping Service Users to Avoid Relapsing while in the Recovery Process

Social workers are not there just to offer counselling services for the addicted individuals but they are there to offer support and also work together with the individuals in their recovery process. Social workers are meant to be enablers and as a result they must enable the service users to find their strengths, be aware of their weaknesses and also work with them in using those strengths maintain a successful recovery process. Social workers can assist the individuals into adapting back into their communities and families and also working with the families and the individuals in the transmission that is taking place. Social workers are also educators and it is their responsibilities to educate individuals, families and communities about substance abuse and its impacts on individuals, families and communities and also equip individuals with needed skills to be able to adopt and live better lifestyles.

Social workers play an important role in helping individuals, family members, schools, workplaces and communities to address the issues of addiction. Social workers' role is to more than just stopping the substance use and abuse, they need to provide marital and family counselling or to assist service users to obtain legal aid and to find jobs and put focus on child care and to help service users to rebuild their lives (DiNitto & McNeece, 2001). Social worker's responsibility is also to monitor the progress of the addicted individuals and also monitor the attendance of the counselling sessions (DiNitto & McNeece, 2001).

4.13. CONCLUSION

The whole of the research and the findings of the research have been based on the theoretical model of the biopsychosocial model. The model states that "addictive behaviour are complex disorders which are determined through biological, cognitive, psychological and socio-cultural processes," (Donavan, 2005, p. 2). The findings showed that there are many factors that can influence individuals to relapse and that it is not always due to the failure of treatment. Individuals are part of systems and they cannot live apart from those systems and as a result in order for them to rebuild their lives they need the support, whether it is from families, the workplace or the community. The organisation is not only a platform that should look at the individuals from a biological lens but they also need to consider the fact that individuals may stay in the treatment centre for six months but after that six months they need to be assisted to adopt and go back into their environments are at the same time maintain the sobriety. Social workers are important part of the recovery process of individuals and that is because most of the time they work directly with the

addicted individuals and hence support and the role of enabling is Important in the working relationship between the social worker and the service users.

CHAPTER 5

DISCUSSION

5.1 INTRODUCTION

Addiction is the continuous use of substances which causes mood-alteration, despite the consequences that it may have on the individual; it is influenced by the genetic, psychosocial and environmental factors (Bettinardi-Angres & Angres, n.d.). The previous chapter was based on the findings of the study. It comprises of the themes that emerged from the study, such as the factors that contribute to the participants relapsing, the effects that relapse has on the individuals and the role that the family, community, organisation and social workers should play in helping individuals to avoid relapse and maintain their sobriety. This chapter will be summarising the study and also presenting the main findings of the study and lastly it will discuss the recommendations for participants, Westview clinic and also social workers.

5.2 SUMMARY OF THE STUDY

The study was based on the patient's perceptions of why they relapsed during or after treatment. This research was conducted at Westview clinic which is an organisation that works with both in-patients and Out-patients. The research method that was used was the qualitative method and the approach that was used was case study and the reason for using this approach was because the research was not only based on literature but it was also included information from individuals who had experienced relapsing.

The sampling technique that was used was availability sampling. The sample consisted of both male and female patients who were 18 years and above and has experienced relapsing whether it was during treatment or after treatment and a total number of 14 participants were used in the study. All the interviews were voluntary and the participants were contacted on behalf of the researcher by the social worker at the agency, furthermore the participants received participant information sheets that

explained the study and also signed consent forms for both the interviewing and the recordings before they were interviewed.

Face to Face interviews was used for data collection and a structured interview schedule was used as the research tool of the study and also probing was used when necessary. To test the research method, approach and tool a pre-test was conduct with two participants from Westview Clinic, whose data was not included in the findings. To analyse the data Clarke and Braun's thematic analysis, which consists of six phases was used.

5.3 MAIN FINDINGS

5.3.1 To identify subjective factors that are inclined to make patients vulnerable to relapsing.

Relapse is an issue that cannot and should not be separated from the recovery process and an element that should considered in the recovery process. There are many factors that contribute towards relapse. That emerged in the findings were that treatment can be a factor of relapse and the reason for that is because at times treatment is not initiated by individual but their loved ones, doctors or employers. However, in the study most of the participants mentioned that they are the ones who initiated treatment. Steven (2013) also stated that an individual's lack of readiness and determination to turn down temptations after recovery is the reason behind relapsed and that is the reason why rehabilitation of substance abuse is a problem for government institutions and also for private institutions.

Denial of addiction also contributes to relapse, whereby its either the individual does not perceive themselves as being addicted and dependent on the substance, some individuals believe that they can stop the addiction at any time and claim that they can control their substance intake. Being denial affects the treatment because that means that there will be lack of dedication in the recovery process and without self-awareness and admitting that one has a problem will cause resilience towards treatment. One of the things that cause denial is the stigmatisation behind substance abuse. A person who is addicted can easily feel ashamed and that they are stigmatised and that is due to a large part by negative societal attitudes towards addiction (Freimuth, 2008). At times I could be that the problem is not acknowledged or even recognised or for others that the problem does not exist (Simmons, 2008).

Relapse does not only consist of biological aspects but also consists of psychological and social factors. From the study what was found was that participants stated that psychological factors that caused them to relapse were anger, denial, lack of love, loneliness, stress and no self-awareness. The social factors that were identified were the accessibility of substances in communities and some within the treatment centres. The environment in which one is part of can be a factor of relapse, whether it is the environment in which they live or work in. furthermore peer pressure and peer influence and also the stigma towards individuals who are addicts in the way that they are labelled by others and also how they are perceived by others. Unemployment has been a big problem in the country and many are affected by it. Participants stated that the reason behind their relapse was due to unemployment whereby they just sit and have nothing productive that they can do or nothing that is available to keep them busy.

5.3.2 To explore the challenges faced by patients after relapsing.

The recovery process is not a once off occurrence; rather it is a life time process that needs to be maintained. Maintaining sobriety is not easy and can be challenging for individuals. Relapsing for the participants is like going back to the drawing board. The participants mentioned that there are many challenges that they face once they have relapsed. Some mentioned that they ended up lying and being manipulative just so that they would be able to use the substance without the knowledge of their loved ones. However once their families find out they lose the trust that they have been trying to earn. One becomes an addict because they end up having to depend on the substance, whereby even when they try to stop again it becomes difficult because they have to constantly satisfy the cravings. These effects of relapse do not only affect the individual but they also affect the family because they end up distancing themselves from their loved one.

5.3.3 To obtain participants recommendations of how the problem of relapse could be addressed by the Westview clinic in the treatment programme.

Treatment centres play a direct role in working with the patients through their recovery process, however the support of the patients should not only be biological but the psychological aspect of the issue should be addressed. Giving the patients medication does not guarantee that sobriety will be maintained, instead also the possibility of

relapse should be addressed. The participants used in the study stated that they would like support from the organisation even after treatment is finished. Things that came up were being equipped with the necessary skills to avoid relapse, getting the necessary help in finding jobs and also being part of after care services like attending support groups.

The participants that were interviewed were both from in-patient treatment and out-patient treatment. Some of the participants raised the issue that they were unable to get treatment after their relapse and that is because government institutions work on a process of availability of beds, while some mentioned that they are able to come back because they can afford the private treatment.

The difference between in-patient treatment programmes and out-patient treatment programmes is that in-patient treatment programmes are almost abstinence based and do not always offer options of harm reduction and abstinence is always the bench mark of in-patient programmes. It provides high levels of medical supervision and can help patients to increase awareness of the triggers that place them at the risk of relapse (Mignon, 2015). On the other hand, Out-patient is one of the most known and used kind of treatment, it is the treatment that is offered while the individual remains in their community and can still go about their daily activities like going to work. This kind of treatment is mostly recommended if there is support in the family and no negative elements (Mignon, 2015).

5.3.4 To obtain participants recommendations of how they could avoid the possibility of relapse as individuals through the help of the community and families.

Those living with substance addiction do not live alone in a secluded place instead they are part of systems such as their family and also the community. Support was raised as being the most important element that the participants needed in order not to relapse. Under the umbrella of support many other elements were raised by the participants like getting employment, receiving education about the dangers of substance abuse, being given a chance to get treatment again and also be given the opportunity to be part of activities, and programmes.

As much the families and communities are also affected by the addiction of substances, they need to take the responsibility of working together with those who are addicted to maintain their sobriety and also to encourage and motivate their loved ones.

5.4 CONCLUSIONS

Substance abuse and use is a big problem in South Africa and addiction has affected many individuals. It starts off as being a once off occurrence or an occasional occurrence which is elicited by different factors. eventually the substance use turns to substance dependence and leads one to being addicted to the substance. As soon as the addiction takes its toll on the individual or the family many seek treatment, however it is not 100% guaranteed that the treatment will be lead to complete sobriety. Many think that addiction can be cured; however, it is a life time recovery process that needs to be maintained.

Many patients relapse while undergoing treatment or even after treatment due to various factors, which at times could be similar factors that caused them to start using substances in the first place. From the study the factors that rose which caused the participants to relapse were issues related to treatment whereby they either did not initiate getting treatment or were denial of the fact that they had a problem. There were also psychosocial factors, social factors and family related factors that caused the individuals to relapse.

The study also explored the support systems that play a role in the participants lives, like the family, community, the organisation and social workers. All these systems have an important responsibility towards the patients. As mentioned by the participants many of them state that in order for one not to relapse support is needed. This support can be offered through various aspects like job creation, skills development, love, patients, encouragement and also motivation.

5.5 RECOMMENDATIONS

5.5.1 Participants

- Participants need to be aware of the fact that relapse is a possibility when they are undergoing recovery and that there are many triggers and factors that can cause one to relapse. As a result, they are supposed to go into treatment with some self-awareness of what could cause them to relapse and work on avoiding or overcoming those factors.

- Many of the patients go into treatment with the misconception that they will be cured from their addiction. The participants need to realise that addiction cannot be cured; it is a recovery process whereby the sobriety needs to be maintained.

5.5.2 Westview

- The organisation can change their focus of being on the addiction only but also focusing on the substitution of the addiction. This is whereby the patients can work towards substituting their addiction to a healthier lifestyle, like discovering their strengths and also skills and talents that they can focus on rather than the substances or their addiction.
- The organisation works with in patients and outpatient treatment, the outpatient works with the clients for 6 weeks and then they are sent to one of the rehabilitations that the organisations works hand in hand with. Some of the participants had complains that they relapsed during treatment due to the kind of rehabilitation that they were sent to. In cases like these there should be an after care for those who have relapsed during treatment or even after to explore the reasons why they relapsed and also with regards to those who relapsed during treatment the organisation needs to look into the problems that caused the patients to relapse and work together with the rehabilitation centres and try and solve the problem.
- The organisation should not only focus on rehabilitating individuals or referring them to a rehab centre but they must also focus on the readiness of the individual to get treatment and their current stand points in their lives.

5.5.3 Social workers

- When working with the clients with addiction, social workers should also have counselling sessions that are dedicated to relapse, whereby they show and explore with the patients that relapse can occur at any time during the recovery process.
- The social workers should educate the families and also the communities about relapse, that way it will bring more understanding to others and also in that way addicts can gain that support that they need and the stigma behind addiction can be reduced.

- In working with the patients to recover and maintain that recovery, social workers should explore those factors that could cause the individual to relapse and also work together with them in how they can avoid relapse.
- Social workers should not approach the relapsed clients in an authoritative manner but rather be a support structure that can work together with the patients to work through the relapse.
- During counselling sessions, the social workers should also focus on aspects of denial, and the readiness for individuals to be referred to rehabilitation.

5.5.4 Future research

- In order for relapse to be understood in depth, one needs to look at it from all lenses. Future research can look at relapsing within ethnic groups and see if it contributes or has an influence on relapsing.
- Another aspect of study that can be looked at to get the perceptions to relapsing is to look at the economic class and the access to treatment once one has relapsed. One can look at the possibility and chances of being readmitted to get treatment once an individual has relapsed.
- The study consisted of more males than females and hence future research could look at both males and females equally to determine which gender is more prone to relapsing. or see if gender can be a reason for relapse in the males or females.

5.6 CONCLUDING COMMENT

Relapse should not be seen as failure but rather as a step back that one needs to take in order to re-evaluate themselves and their lives. In order for treatment to be successful and recovery to be maintained Addicted individuals need to acknowledge that they have a problem and take the personal decision that they need help. Relapse should be viewed as a learning curve and not only in a negative way.

"You are not alone and you are not a failure. Be proud that you've tried. Just because you slipped, doesn't mean you cannot recover. Keep trying, and don't give up. Find out how to learn from your relapse to succeed the next time." - Unknown

"I am not defined by my Relapses but my decision to remain in recovery despite them."- Unknown

REFERENCES

Appiah, R., Danquah, S.A., Nyarko, K., Ofor-Atta, A.L. & Aziato, L. (2016). Precipitants of substance abuse relapse in Ghana: A qualitative exploration. *Journal of drug issues.* 1-12.

Babbie, E. (2007). The basics of social research. United States of America: Thomson Wadsworth.

Baharuddin, D., Zakaria, Z., Hussin, A.H., Mohamed, S., Sumari, M., Sawai, R.P, et al. (2012). *The experiences of family support by people in recovery from drug addiction.* Paper presented at the Asian conference on social sciences official conference proceedings, University Sains Islam Malaysia.

Barbar, J. (1995). *Social Work with Addicts.* London: The Macmillan Press LTD.

Bettinardi-Angres, K. & Angres, D.H. (n.d.). Understanding the disease of addiction. *Journal of nursing regulation, 1,* (2), 31-37.

Blanche, T.M., Durrheim, K., & Painter. D. (2006). *Research in Practice: Applied Methods of the Social Services.* South Africa: University of Cape Town Press.

Boekel, L.C., Brouwers, E.P.M., Van Weeghel, J.V., & Garretsen, H.F.L. (2013). Stigma among health professionals towards patients with substance use disorders and its consequences for health care delivery. *Drug and Alcohol Dependence. 131* (1), 23-35.

Book, F & McHenry, B. (2015). *A contemporary approach to substance use disorders and addiction counselling* (2nd ed.). United States of America: Wiley

Brownell, P. (2012). *Gestalt therapy: For addictive and self-medicating behaviours.* New York: Springer Publishing Company

Brownell, K., Marlatt, G.A., Lichtenstein, E., & Wilson, G.T. (1986). Understanding and preventing relapse. *American Psychologist. 41*(7). 765-782.

Can, G., & Tannverdi, D. (2015). Social functioning and internalized stigma in individuals diagnosed with substance use disorder. *Archives of Psychiatric Nursing, 29,* 441-446.

Chung, T., & Maisto, S.P. (2006). Relapse to alcohol and other drug use treated adolescents: Review and reconsiderations of relapse as a change point in clinical course. *Clinical Psychology Review, 26,*(2), 149-161.

Clack, H. W. (2002). Bridging the gap between substance abuse practice and research: The national treatment plan initiative. *Journal of drug issues, 32,* (3), 757-767.

Clarke, V. & Braun, V. (2013). Teaching thematic analysis: Overcoming challenges and developing strategies for effective learning. *The Psychologist, 26,* (2), 120-123.

Compton, B.R., Galaway, B & Cournoyer, B.R. (2005). *Social Work Processes.* Australia: Thomson Brooks/Cole.

Connors, G.M., DiClemente, C.C., Velasquez, M.M. & Donovan, D.M. (2013). *Substance abuse treatment and stages of change: Selecting and planning interventions (2nd ed.).* New York: The Guilford Press.

Creswell, J.W. (2009). *Research Design: Qualitative, Quantitative and Mixed Method Approaches:* Los Angeles: SAGE.

Daley, D.C. (1988). Five perspectives on relapse in chemical dependency. In D.C. Daley (Ed.), *Relapse: Conceptual research and clinical perspectives.* New York: The Haworth Press.

DiNitto, D.M. & McNeece, C.A. (2001). *Addictions and social work practice.* Retrieved from www.lyceumbooks.com/pdf/socialworkissuesopps_chapter_08.pdf

Durrant, R. & Thakker, J. (2003). *Substance Use and Abuse: Cultural and Historical Perspectives.* California: SAGE Publications.

Fouche, C.B. & Schurink, W. (2011). Qualitative research designs. In A.S. De Vos, H. Strydom, C.B, Fouche, & C.S.L. Delport (Ed.), *Research at Grassroot.* Pretoria: Van Schaik.

Freimuth, M. (2008). *Addicted? Recognising distructive behaviour before it's too late.* United States of America: Rowman & Littlefield Publishers.

Goeders, N.E. (2004). Stress, motivation and drug addiction. *Current Directions in Psychological Science, 13,* (1), 33-35.

Guest, G., Namey, E.E. & Mitchell, M.L. (2013). *Collecting qualitative data: A field manual for applied research.* Los Angeles: SAGE.

Gruber, K.J. & Taylor, M.F. (2006). A family perspective for substance abuse implications from the literature. *Journal of Social Work Practice in the Addictions, 6,* (1), 1-29.

Heerden, M.S., Grimsrud, A.T., Seedat, S., Myer, L., Williams, D.R. & Stein, D.J. (2009). Patterns of substance abuse in south Africa: Results from the south African stress and health study. *Original articles. 99,* (5), 358-366.

Jackson, B.R. (2014). An overview of the relapse prevention (RP) model. *Journal od Addictive Disorders.* 1-24.

Jackson, K.M. & Sartor, C.E. (2016). The natural course of substance use and dependence. In K.J. Sher (Ed.), The oxford handbook of substance use and substance use disorder (pp. 67-134). New York: Oxford University Press.

Jay, D. (2014). *It takes a family: A cooperative approach to lasting sobriety.* United States of America: Hazelden.

Jordan, P. (2013). *Drug abuse in Damaging South Africa's Youth.* Retrieved from www.fanews.co.za/article/healthcare/6/general.../druga-abuse-is...south-africa.../13795

Kuria, M.W. (2013). Factors associated with relapse and remission of alcohol dependent persons after community based treatment. *Open Journal of Psychiatry, 3,* (2), 264-272.

Kvamme B, O., Asplund, K., & Bjerke, T.N. (2015). Drinking Resumption: Problematic alcohol use relapse after rehabilitation. A phenomenological hermeneutical perspective. *Scandinavian Journal of Caring Sciences, 29,* (4), 716-723.

Larimer, M.E., Palmer, R.S., & Marlatt, G.A. (1999). Relapse prevention: an overview of Marlatt's cognitive-behavioural model. *National Institution on Alcohol and Alcoholism grants. 23,* (2), 151-159.

Lian. T.C., & Chu, F.Y. (2013). A qualitative study on drug abuse relapse in Malaysia: Contributory factors and treatment effective. *International Journal of Collaborative Research on Internal Medicine & Public Health.5,* (4). 217- 232.

McWhirter, J.J., McWhirter, B.T., McWhirter, E.H. & McWhirter, R.J. (2013). *At risk youth: A Comprehensive Response for Counselors, Teachers, Psychologists, and Human Service Professionals.* Australia: Brooks/Cole.

Mignon, S.I. (2015). *Substance abuse treatment: Options, challenges and effectiveness.* New York: Springer Publishing Company.

Miller, G. (2015). *Learning the language of addiction counselling* (4th ed.). Canada: John Wiley & sons.

Miller, R.L. & Brewer, J.D. (Ed.). (2003). *The A-Z of social research: A dictionary of key social science research concepts.* London: SAGE Publications.

Moore, T.M., Seavey, A., Ritter, K., Gordon, K.C. & Stuart, G.L. (2014). Ecological momentary assessment of the effects of craving and affect risk for relapse during substance abuse treatment. *Psychology of Addictive Behaviours.28,* (2), 619-624.

National Institute on drug abuse (2007). *Drugs, Brains and Behaviour: The Science of Addiction.* U.S: Department of Health and Human Services.

Niaura, R.S., Roshenow, D.J., Binkoff, J.A., Monti, P.M., Pedraza, M. & Abrams, D.B. (1988). Relevance of cue reactivity to understanding alcohol and

smoking relapse. *Journal of Abnormal Psychology. 97,* (2), 133-152.

Orb, A., Eisenhauer, L. & Wynaden. D. (2001). Ethics in qualitative research. *Journal of Nursing Scholarship, 33,* (1), 93-96.

Padgett, D.K. (1999). *Qualitative Methods in Social Work Research*. Thousand Oaks, C.A: SAGE.

Panebianco,D., Gallupe, O., Carrington, P.J. & Colozzi, I. (2016). Personal supportnetworks, social capital and risk of relapse among individuals treated for substance abuse issues. *International Journal of Drug Policy.27,* 146-153.

Portman, T.C. (2010). *The new template for recovery: How to quit drinking and build a better life.* United States of America: Dogear Publishing.

Ramlangan, S., Peltzer, K., & Matseke, G. (2010). Epidemiology of drug abuse treatment in South Africa. *SAJP, 16,* (2), 40-49

Rasmussen, S. (2000). *Addiction treatment: Theory and Practice.* Thousand Oaks: Sage Publications.

Rassool, G.H. (2011). *Understanding Addiction Behaviours: Theoratical and Clinical Practice in Health care and Social Care.* United Kingdom: Palgrave Macmillan.

Reagon, T. (2016). *Latest drug statistics South Africa 2016.* Retrieved from https://christiandrugsupport.wordpress.com/2016/.../latest-drug-statistics-south-africa...

Rebublic of South Africa (2009). Prevention od and Treatment of Substance Abuse Act, 2008. Pretoria, South Africa: Government Print. Retrieved in Government Gazette, Vol. 526, No 32150, 21 April.

Republic of South Africa, Department of Social Development (2013). National Drug Master Plan 2013-2017. Pretoria, South. Africa: Government Print

Rickwood, D., Magor-Blatch, L., Mattick, R., Gruenert, S., Zavrou, N. & Akers, A. (2008). Substance Use: A Position Statement Prepared for The Australian Psychological Society. Retrieved from www.psychology.org.au.

Rong, C., Jiang, H., Zhang, R., Zhang, L., Zhang, J., Zhang, J & Feng, X. (2016). Factors associated with relapse among heroin addicts: Evidence from a two-year community-based follow up study in China. *International Journal of environmental research and public health, 13,* (177), 1-11.

Rubin, A. & Babbie, E. (2010). *Essential research methods for social work*. Australia: Brooks/ Cole Cengage Learning.

Sharma, K.S., Upadhyaya, S.K., Bansal, P., Nijhawan, M. & Sharma, D.K. (2012). A stdy of factors affecting relapse in substance abuse. *Indian journal Life Sciences, 2,* (1). 31-35.

Shenton, A.K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information, 22,* 63-75.

Sihna, R. (2001). How does stress increase risk of drug abuse and relapse. *Psychopharmacology. 158.* 343-359.

Simmons, L.L. (2008). *The everything health guide to addiction and recovery: Control your behaviour and build a better life.* Canada: Adams Media

Sobell, M.B., Wilkinson, D.A. & Sobell, L.C. (2012). Alcohol and drug problerms. In A.S Bellack, M. Hersen. & A.E. Kazdin (Eds.), *International handbook of behaviour modification and therapy* (2nd ed., pp. 415-436). New York: Plenum Press.

Steven. (2013). *Overview of the Drug Abuse Problem in South Africa.* Retrieved from www.harmonygroup.co.za/drugs/overview-of-the-drug-problem-in-south-africa

Sutker, P.B & Adams, H.E (Ed.). (2013). *Comprehensive handbook of psychopathology* (2nd ed.). New York: Plenum Press.

Swadi, H. (1999). Individual risk factors for adolescent substance use. *Drug and Alcohol Dependence, 55,* 209-224.

Swanepoel, I. (2014). *The causes of relapse amongst young adults following in-patient treatment for drug abuse in Gauteng province* (Masters dissertation). University of Pretoria, South Africa.

Tappen, R.M. (2011). *Advanced Nursing Research: From theory to practice.* Canada: Jones & Barlett Learning.

The National Institute of Druge Abuse (2008). *Drugs, Brains and Behaviour: The Science of Addiction.* National Institute of Health: United States Department of Health and Human Sciences.

Tims, F.M. & Leukefeld, C.G. (1986). *Relapse and recovery in drug abuse*. Maryland: Department of health and human services.

Vaillant G.E. (1998). What can long-term follow up teach us about relapse and prevention of relapse in addition. *Brithish Journal of Addiction, 83,* 1147-1157.

West, R. & Hardy. A. (2005). *Theory of Addiction.* UK: Blackwell Publishing Press.

Witkiewitz, K., Marlatt, G.A. & Walker, D. (2005). Mindfullness-based relapse prevention for alcohol and substance use disorder. *Journal of Cognitive Psychotherapy: An International Quarterly, 19,* (3), 211-228.

World Drug Report (2015). World Drug Report. New York: United Nations Publication.

APPENDIX A

Interview Schedule

I am not my addiction: Patients' perceptions of why they relapsed during or after treatment at Westview clinic.

Demographics

1. How old are you?
2. When did you start engaging in substance use?
3. What kind of substance do you or did you use?
4. What kind of community do the patients come from?

Background of substance use and treatment

5. When you first started treatment, who decided that you should get treatment?
6. Did you agree to get treatment or was it something that you were forced to do?
7. Did you consider yourself as having a problem? Why?
8. What are the factors that led to you taking the substance?
9. What kind of treatment did you receive previously?

Relapsing during or after treatment

10. When you relapsed, was it the first time receiving treatment or have you received other forms of treatment before?
11. What influences relapsing in patients while undergoing treatment in a rehabilitation centre?
12. Do you think that the environment that you grew up in determines if you will relapse after treatment or not?
13. Depending on whether you relapsed during treatment or after treatment, what are the issues or obstacles that you came across that led you to using the substance again?

Roles that family members, community and professionals can play in assistance with reducing the number of relapses

14. What role can the family and the community play in assisting recovering patients?

15. What can the organisation do to help patients who have completed the programme or those who are still part of the programme from relapsing?
16. What role can the health professionals like social workers play in assisting patients not to relapse?
17. Do you consider relapse as a normal part of the recovery process or do you think that relapse is wrong and should not happen at all?

APPENDIX B

Participant Information Sheet

I am not my addiction: Patients' perceptions of why they relapsed during or after treatment at Westview clinic.

Good day,

My name is Magaret Nkosha Ngoepe and I am a fourth (Final) year student registered for the degree Bachelor of Social Work at the University of the Witwatersrand. As part of the requirements for the degree, I am conducting research about the patient's perceptions of why they relapse during or after treatment. It is hoped that this information may enhance social workers understanding of why people relapse and also help to improve the treatment strategies that can be used to help reduce the rates of relapsing within the organisation. The aim of the study is to explore the patient's perceptions of why they think they relapsed during or after treatment.

I therefore wish to invite you to participate in my study, your participation is entirely voluntary, and refusal to participate will not be held against you in anyway. If you agree to take part, I shall arrange to interview you at a time and place that is suitable for you. The interview will last approximately an hour. You may withdraw from the study at any time and you may also refuse to answer any questions that you may feel uncomfortable with answering.

With your permission, the interview will be tape recorded. No one other than my supervisor will have access to the tapes. The interview tapes will be kept for two years following any publications or for six years if no publication originates from the study. Please be assured that your name and personal details will be kept confidential and no identifying information will be included in the final research report.

As the interview will include sensitive issues there is a possibility that you may experience some feelings of emotional distress. Should you therefore feel the need for supportive counselling following the interview, I will arrange for this service to be provided free of charge by the Westview clinic organisation. The following social workers may be contacted at: Kagiso- 079 869 6023/ California- 072 874 0600.

Please feel free to ask any questions regarding the study and I shall answer them to the best of my ability. I may be contacted on tel. 0768021292, or my supervisor, Ms Francine Masson on tel no. 011 717 4480. Should you wish to get a summary of the results an abstract will be made available on request.

Thank you for taking the time to consider participating in my study.

Yours sincerely

Magaret Nkosha Ngoepe

APPENDIX C

Consent Form

I am not my addiction: Patients perceptions of why they relapsed during or after treatment at Westview clinic.

CONSENT FORM FOR THE PATICIPATION IN THE STUDY

I hereby consent to participate in the research project. The purpose and the procedures of the study have been explained to me by the researcher. I understand that my participation is voluntary and that I may refuse to answer any particular questions or withdraw from the study at any time without any negative consequences. I also understand that my responses will be kept confidential.

Name of participant:

Date:

Signature:

CONSENT FORM FOR AUDIO-TAPING AND USE OF VERBATIM QUOTES OF THE INTERVIEW

I hereby consent to tape-recording of the interview. I understand that my confidentiality will be maintained at all times and that tapes will be destroyed two years after any publication arising from the study or after six years after completion of the study if there are no publications. I also understand that no one will have access to the tape recordings other than the researcher's supervisor.

Name of participant:

Date:

Signature:

APENDIX D

Clearance Certificate

SOCIAL WORK
THE SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT (SHCD)

DEPARTMENTAL HUMAN RESEARCH ETHICS COMMITTEE (SOCIAL WORK) CLEARANCE CERTIFICATE

PROTOCOL NUMBER: SW1/16/04/02

PROJECT TITLE: I am not my addiction: Patients' perceptions of why they relapsed during or after treatment at Westview Clinic

RESEARCHER/S: Ngoepe Margaret (709188)

SCHOOL/DEPARTMENT: Social Work

DATE CONSIDERED: 15/04/2016

DECISION OF THE COMMITTEE: APPROVED

EXPIRY DATE: 15/04/2018

DATE: 22 July 2016

CHAIRPERSON: Dr Francine Masson

Cc: Supervisor: Dr Francine Masson

DECLARATION OF RESEARCHER(S)

To be completed in **DUPLICATE** and **ONE COPY** returned to the Administrative Assistant, Room 8, Department of Social Work, Umthombo Building Basement.

I/We fully understand the conditions under which I am/we are authorised to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the committee. **For Masters and PhD an annual progress report is required.**

SIGNATURE

12/12/2016
DATE

PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES