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CHAPTER ONE

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LIST OF ACRONYMS

AA	Alcoholics Anonymous
AIDS	Acquired Immune Deficiency Syndrome
AOD	Alcohol and Other Drugs
BCT	Behaviour Couples Therapy
CAD	Christian Action for Dependence
CDA	Central Drug Authority
CSO	Concerned Significant Other
CSOs	Concerned Significant Others
DAC	Drug Action Committee
DSM-5	Diagnostic and Statistical Manual of Mental Health Disorders – Edition 5
EAP	Employee Assistance Programme
HEAL	Healing Educating Addicted Lives
HIV	Human Immuno-deficiency Virus
MWLC	Mighty Wings Life Centre
NA	Narcotics Anonymous
NGO	Non-government organisation
SACENDU	South African Community Epidemiology Network on Drug Use
SANCA	South African National Council on Alcoholism & Drug Dependence
SANDMP	South African National Drug Master Plan
STD	Sexually transmitted Disease
SSCS	Stress-Strain-Coping-Support Model
SUD	Substance Use Disorder
SUDs	Substance Use Disorders

CHAPTER ONE

GENERAL INTRODUCTION AND ORIENTATION TO THE STUDY

“I was always there for you ... to the extent that I was never there for me ...”

(Concerned significant other of a partner with a substance use disorder, Session 4)

1.1 INTRODUCTION, BACKGROUND AND HISTORICAL OVERVIEW, PROBLEM FORMULATION AND RATIONALE FOR THE STUDY

Under the introduction, or the first chapter of a scholarly writing, as is the case with this thesis, the scene or stage is set for what is to follow (Thomas, 2017:2; Punch, 2016:96; Creswell, 2014:107). The reader is orientated by way of introducing the topic selected for the research and background information on it is provided. The research problem is demarcated, the rationale for embarking on this research endeavour is supported and a theoretical framework underpinning the research is offered. The research questions, goals and objectives to address the identified research concern, are thoughtfully formulated. The approach the research adopted, its design and research methods are explained and the ethical considerations undertaken are detailed. The concepts central to this study are introduced and clarified before a chapter outline of the full report is presented. The chapter ends with a summary.

On how to approach the introduction to the study, Thomas (2017:4) suggests that researchers apply the *BIS-principle* that follows this procedure:

- providing *background* information on the topic or the context in which the research problem is situated and from which the proposed project emanates;
- highlighting the *issue*, pointing to some missing evidence or dilemma in the existing literature; and
- stating the *solution* by presenting the researcher's motivation and intention to address this identified issue through the research undertaking.

This suggested principle will be followed in presenting the ensuing outline of this work.

1.1.1 Background to and historical overview of the topic and the current state of the knowledge of this subject

My involvement in rendering social work services to clients involved with and affected by a substance use disorder (*hereafter abbreviated as SUD*), spans more than 30 years. I rendered such services in the following practice settings:

- in and out patients treatment facilities (private and faith-based),
- in state departments and industries in a consulting capacity as part of Employee Assistance Programmes (EAP); and
- in private practice in a network of psychiatrists and medical doctors as well as at treatment facilities and aftercare and support groups.

In my practice experience, I became acutely aware of the intense hardships endured, and numerous challenges experienced by concerned significant others (*hereafter abbreviated as CSOs*) who represent spouses, partners, parents and children living with a partner or family member with a SUD. Since this observation aroused my interest in the topic I proposed the topic for investigation. I particularly noticed that these CSOs take on most, if not all, of the social and economic responsibilities in an attempt to salvage and sustain relationships, and to survive physically, materially, emotionally, mentally and socially (Nagesh, 2015:373; Hudson, Kirby, Clements, Benishek, Nick, 2014:106). Research (see the ensuing discussion) into the impact of SUDs on the family is well documented, both in the in the South African context and the international arena.

In the foreword to the South African National Drug Master Plan (SANDMP) (South Africa, 2013-2017:1), Dlamini, the then Minister for Social Development, points out that: “The impact of alcohol and substance abuse continues to ravage families, communities and society”, impacting negatively on the users, their families and communities in which they live. In costing the emotional and psychological impact of alcohol and drug abuse on the users, their families; also considering the high levels of crime and other social ills associated with this pandemic, alcohol and drug abuse have placed many households, even communities, under siege. With the focus still on the South African context, Matsimbi (2012:5) and Hitzeroth and Kramer (2010:76)

point to the fact that families of persons with SUDs are left with feelings of helplessness, disappointment, frustration and doubts contributing to increasing anger and hostility. Adding to this list of negative consequences, Marinus, Van der Westhuizen and Alpaslan (2017:19), citing Fisher and Harrison, mention that the CSOs of persons with SUDs experience anxiety, low self-esteem, feelings of loneliness and rejection due to a situation in which they perceive themselves as worthless and responsible for their own family member's condition of substance abuse.

The emotional and psychological consequences alluded to by the South African authors quoted above corroborates with the international scenario. Both McCann, Lubman, Boardman and Flood (2017:1) writing from Australia, and Toner and Velleman (2014:147) from the United Kingdom, indicate that SUDs do not only have severe detrimental implications for the substance abuser, but also for the family, specifically on their social, psychological, physical, financial and legal life dimensions. These indications support Ripley, Cunion and Noble (2006:172), in Virginia in the United States, referring to substance abuse contributing to increased couple arguments, inadequate communication strategies and decreased cooperation with relationship issues. In addition, Rowe, (2012:59), Medical Practitioner and Associate Professor, Department of Epidemiology and Public Health, Center for Treatment Research on Adolescent Drug Abuse, University of Miami Miller School of Medicine in the United States of America, in her review on the history of family therapy for drug abuse, contends that the psycho-social functioning of children whose parents abuse drugs is seriously impaired. In the same study, she points out that partners and children are at risk of family violence. Citing Fals-Stewart, Rowe (2012:59) states that there is an additional likelihood for contracting HIV and AIDS as well as STD-infections through unsafe sexual practices and intravenous drug use. Other scholars also drew attention to interpersonal complications for the CSOs, including relationship dissatisfaction, negative interactions and relational violence (Hudson et al., 2014:107; Cox, Ketner & Blow, 2013:161-162; Amato & Previti, 2013:161; O'Farrell & Clements, 2012:123; Dethier, Couterotte and Blairy, 2011:152; Benishek, Kirby & Dugosh, 2011:81).

Barnard (2005:1), based on a study conducted with family members of relatives with SUDs in the United Kingdom, concluded that "...the costs of the chemical substance addiction of a CSO to the family were too great ... [they] express feelings of loss, anger, shame and disappointment in how drugs had destroyed their family." In their research on the impact of a parent's substance abuse on children in the United Kingdom, Copello, Velleman and Templeton (2005:370) cite Kroll who identified six themes commonly found amongst the children living with a parent with a SUD; issues of distortion and secrecy; separation; family dysfunction; living with fear; abuse and role reversal; and role confusion. Kirst-Ashman (2013:447, 448) identifies eight similar themes that characterise the effect of a SUD on the family, indicating that the family's behaviour has to adapt to substance abusing behaviour, trying to keep the family together in adverse circumstances whilst dealing with their own feelings and trying to cope.

The American psychologist and an addictions specialist, Perkinson (2008:242), stated that people "...who live in addicted homes live in a whirlwind." He alludes to the fact that these environments are out of control and unpredictable, with the non-using spouses becoming pre-occupied with the substance abuser with no time for themselves and their own needs. At the same time, they acquire a number of maladaptive skills to cope. McCann et al. (2017:210) state that families are "frequently fractured" because of the continuing damaging effects of a relative's problematic substance use-related behaviour. A family caught up in a substance use disorder, according to Gudzinskiene and Gedminiene (2010:163), is perceived as a "damaged family" displaying the following characteristics:

- a restraint on and a lack of expression of the needs, feelings, and wishes of family members;
- disturbed patterns of communication amongst family members, coupled with a lack of understanding amongst family members, and an observable absence of family structure;
- the family as a system seems to be physically and emotionally detaching and detached from others; and
- role reversal and role changes in children and the family with all energies and activities geared towards survival.

Against these introductory remarks, a historical overview of perceptions and approaches to deal with a SUD of a family member is provided in Table 1.1 to introduce the context of CSOs¹ living with a partner with a substance use disorder.

Table 1.1: A historical timeline on the perception of, contributing factors to, and treatment modalities to SUD

Time-line	Pre 1930	1930	1940	1950	1960-1990	2000 onwards
Perception and orientation towards substance use disorder (SUD)	Moral	Disease	Disease	Disease and behaviour	Disease Behaviour Social	Holistic
Causes and contributing factors to SUD	SUD caused by immoral behaviour	SUD caused by parental dysfunction	SUD sustained by partner	SUD sustained by partner and circumstances	SUD due to partner, circumstances and learnt behaviour. Family needs help to help SUD	SUD due to bio-psychosocial contributors. Family and partner need help
Treatment modalities. In patient and/out-patient clinical treatment	Religious input	Religious Psychiatric Medical	Religious Psychiatric Medical Support groups*	Psychiatric Medical Social work Support groups	Psychiatric Medical Social work Psychology Alternative** Support groups	Medical Social work Psychology Additional*** Support groups

* Support groups refer to voluntary group sessions for SUD or family members such as AA and AL Anon.

** Alternative includes use of sleep therapy, herbal remedies, acupuncture, spiritual healing, etc. usually replacing traditional treatment modalities.

*** Additional can include alternative, but does not replace traditional treatment modalities.

Considering Table 1.1, it becomes noticeable that SUDs were first perceived and recorded as a *moral issue*, a condition caused by immoral behaviour and the treatment was religious by nature (Hitzeroth & Kramer, 2010:15). After this viewpoint had been subjected to intense scrutiny, research and debate (to be explained further on in the ensuing discussion), the initial focus and perception of SUDs as a moral issue changed, and it became embraced as an *addiction that resulted from a disease* (Gudzinskiene & Gedminiene, 2010:165; Loughran, 2006:35; Johnson, 1990:11). Moreover, this disease was also seen to be caused by genetics, and/or parental dysfunction and as one that was sustained by CSOs (Askian, Krauss, Baba,

¹From here, and for the context of this study CSOs will refer to spouses, partners and fiancées of partners with a SUD.

Kadir & Sharghi, 2016: 269, 270; Sherrel & Gutierrez, 2014:26; Johnson, 1990:13). This also led to the notion to view substance abuse as a family disease or as an illness of the family, with the family causing and maintaining the SUD. As a result, both the substance user and the family suffered (Fals-Stewart, Lam & Kelly, 2009:116; Peled & Sacks, 2008:391; Boylin & Anderson, 2005:4). The notion of the disease concept to substance addiction was adopted.

For treating the “disease” of addiction, a combination of religious, psychiatric and medical treatment modalities were adopted. This notion of *addiction as a disease* and its impact on family life was subsequently expanded by *adding a behavioural and social frame of reference* to the equation (Wesley, 2015:89; Cranford, Floyd, Schulenberg & Zucker, 2011:211; Loughran, 2006:38). Currently, *SUDs are seen in a more holistic manner*, with the interplay of intrapersonal, interpersonal and environmental dynamics being responsible for this disorder. The treatment of persons with SUDs has adopted a more holistic approach and outlook and includes inputs from a variety of professional and para-professionals and support-groups (Adedoyin, Beacham & Jackson, 2014:594; Daley & Feit 2013:164). The variables given in Table 1.1 refer to the concept-perception evolvement of SUDs and its causality, as well as the treatment modality required to arrest it. These should not be viewed statically within the rigid-time frames provided. It is rather fluid by nature where the variables influence each other reciprocally. Having briefly discussed the evolution of perceptions on SUDs, their causes and contributing factors together with their treatment modality-evolvement, the focus now shifts to specifically look at the CSOs evolving involvement over the time frames.

Historically, and when narrowing the discourse to focus on the role of CSOs living with a person with a SUD, the concept of this group of people can be dated back to the 1930s. Richard Peabody, a recovering alcoholic committed himself to the treatment of others with an alcohol problem, in 1936. He regarded the parents of alcoholics, specifically a domineering mother and uninvolved father, as being the contributors to and even the cause of a child’s SUD (Peabody, 1936). Even the renowned addiction researcher, Jellinek, in 1942, suggested that persons who abuse or are dependent on alcohol should remove themselves from their family during

treatment to be able to focus only on their recovery, without being affected by family matters (Jellinek, 1942: 246). About ten years later the CSOs, specifically referring to spouses, cohabiting partners, and fiancées of partners with an alcohol problem were spotlighted as being responsible for negatively affecting their partners with a SUD. This happened when Whalen (1953:632-641), a social worker, and an executive member at a Family Service Agency in Dallas, Texas, stated that spouses of persons who abuse or are dependent on alcohol, contributed to marital problems because of their own issues with dependency (Klostermann, Kelly, Mignone, Pusateri & Wills, 2011:1502, 1503). Futterman (1953:37-41), a psychiatrist working in the field of alcohol abuse, concluded that the spouses of persons with alcohol use disorder are only content when their husbands are intoxicated and in need of their so-called 'help'. This viewpoint of the CSO being the culprit received much support up to that time when the spouse would then be described as "neurotic" and complemented the addictive needs of their alcoholic husbands (McCrady, Wilson, Munoz, Fink, Fokas & Borders, 2016:444; Loughran, 2006:34).

Prior to these views held by the professionals in the field of addiction at that time, a support group, referred to as "Al-Anon meetings" for the spouses of the Alcoholics, had been established (from an Information document on Al-Anon; a brief time-line 2014). With her friend Anne, Lois, the wife of Bill Wilson, a recovering alcoholic and the co-founder of Alcoholics Anonymous (AA), had set this up as a regular meeting place for companionship. The first meeting held started as far back as 1935. These groups functioned in a similar manner to the AA-groups based on the concept of peer support.

Twenty-three years later, and probably owing to the work done by Al-Anon, Joan K Jackson (1958:90), a psychiatrist at the University of Washington, placed her research findings of the interviews with family members of persons with alcohol dependency in the Annals of the American Academy of Political and Social Science. The results opposed the popular views that spouses are either the cause or sustain substance abuse in their partners. She found, in fact, that the non-using spouses were also the "victims", and not only "instigators" of substance abuse (Hawkins and Hawkins in McNeece & DiNitto, 2012:257; Loughran, 2006:34).

Shifting the focus of the discussion to the treatment of SUDs, the notion of labelling SUDs as a “family disease” in the late sixties directed Johnson (1973), an Episcopal priest and recovering alcoholic, to develop the so-called “Minnesota Model”. This model was established in the 1950s stipulating that alcoholism deserves to be treated as a primary condition affecting the addict physically, mentally and spiritually. The model expanded during the 1960s to include persons from various disciplines working towards recovery in teams, impacting on treatment internationally. The model included “family interventions” for the treatment of SUDs in the early seventies. This model dictates the direct and instrumental involvement of family members, specifically the spouse of the addict, to primarily assist with motivating the person with a SUD to go for treatment, and supporting the person during treatment (Copello et al., 2005:369). Loughran (2006: 36) refers to this period as the “Family Systems Phase” and pointed out that it “represented an attempt to integrate emerging systemic theories into work with couples and families dealing with alcoholism”.

Over the next ten to twenty years, through the work of Black (1982) and Beattie (1992), respectively, two new concepts and ideas emerged in this field of social learning, “co-dependency” and “adult children of alcoholics”. Beattie (1992), a social worker and clinical consultant in addiction and family services, a recovering alcoholic married to a person with alcohol use disorder, being the most prominent in understanding and explaining the behaviour of families involved in addiction at the time. Even though much debate as to whether co-dependency actually exists or not, Beattie (1992) postulates that co-dependency is a learned emotional and behavioural way of coping that affects a person’s ability to have a healthy and mutually satisfying relationship. This author holds the view that co-dependants are seldom capable of living their own lives, constantly attempting to rescue others, often at the cost of self.

As pointed out by various scholars (Wilson, Rodda, Lubman, Mannin & Yap, 2017:57; Klostermann et al., 2011:1502-1503; Hudson, Kirby, Firely, Festinger & Marlowe, 2002:172), CSOs are affected by the substance abuse of their partners and their responses in turn affect the partner, indicating that both parties warrant

assistance with “adjustment problems in addition to improving the more traditional treatment of drug users” (Hudson et al., 2002:172).

Over the past two decades, various models for treating SUDs involving the family were developed (Rowe, 2012:1). The most widely recognised approaches include interventions such as The Family Disease Model (Gudzinskiene & Gedminiene, 2010); The Community Reinforcement and Family Therapy Approach (O’Farrell & Fals-Stewart, 2006; Meyers, Apodaca, Flicker & Slesnick, 2002), and The Systems Model (Sherrel & Guttierrez, 2014; Loughran, 2006), as well as the Harm Reduction Approach (Denning, 2010). These models, and variations on them, focus primarily on and address the causes and effects of addiction with specific emphasis on the relationship and well-being of the person with a SUD.

- **The Family Disease Model** (Gudzinskiene & Gedminiene, 2010) accepts SUDs as a disease affecting the family and emphasises treatment of the family as a whole. Relationships in families where a family member suffers from a SUD are characterised by emotional distance and disturbed communication. Mental survival takes precedence and undefined roles and family structures are seen as the result of the SUD. Treatment focuses on providing safety and support to the affected family members as well as help with communication skills and expressing feelings (Gudzinskiene & Gedminiene, 2010:169).
- **The Community Reinforcement and Family Therapy Approach** (Meyers et al., 2002; O’Farrell & Fals-Stewart, 2006), views SUDs as a disease but places the non-using spouse on centre stage to facilitate movement towards getting the partner with the SUD into treatment and supporting their abstinence. This approach mainly comprises behavioural marital therapy or couples behavioural therapy that concentrates directly on constructive communication to sustain sobriety (Kinney, 2012:306; Klostermann et al., 2011:1503; Meyers et al., 2002:286).
- **The Systems Model** also uses the disease concept of a SUD but concerns itself more with the factors contributing to, and consequences of the disorder,

and how these factors are managed (Lewis, Dana & Blevins, 2011:168-186). Structural family therapy is used to deal with issues of engagement and the use of power control in the relationship (Loughran, 2006:31-48). In addition to the family therapy, Sherrel and Gutierrez (2014:26-34) propose various couple-related treatment modalities such as behaviour couple therapy, congruence couple therapy, and emotion focused therapy.

- **The Harm Reduction Approach**, as is the case with the other models and approach, views SUDs as a disease in which the consequences of the disorder are emphasised placing the focus on helping family members acquire decision-making skills for self-care and empathy for the partner with a SUD. This approach resembles the “The Stress-Strain-Coping-Support Model” (SSCS Model) (Velleman, Orford, Templeton, Copello, Patel, Moore & Godfrey, 2011:147) which interprets family members’ symptoms as a result of the destructive circumstances of living with a person with a SUD. The positive or negative coping strategies employed to arrest the problem situation is addressed during treatment. The aim of the therapy is for both the person with SUD and the partner to achieve this competence and demands a high level of skill from the therapist. Yet, compared to traditional treatment interventions, it provides an alternative, personalised approach (Vakharia & Little, 2017:66; Denning, 2010:174).

Table 1.2 (on following page) provides an overview summary of the approaches and models used in the treatment of families caught up in SUDs. These approaches and models show considerable overlap in their effect and are not mutually exclusive. Although they are primarily based on the disease concept of SUDs, the difference their application would make would depend on understanding how their intervention would help the family’s problem. Behaviour Couples Therapy (BCT) intertwined with these models has gained greater importance recently (Sherrell & Gutierrez, 2014:27; Klostermann et al., 2011; Orford, Templeton, Copello, Velleman, Ibanga & Binnie, 2009:34, 36). However, it is for use in intervention practice for someone with a SUD, while less attention is paid to the CSO as a person in their own right.

Table 1.2: Approaches/models identified in working with families with a SUD

Model/ Approach	Family Disease Model (Gudzinskiene and Gedminiene 2010:163-172)	Community Reinforcement and Family Therapy Approach (Copello et al., 2005:371-375)	Systems Model (Rowe 2011:59-81 Loughran 2006:36-39 and Sherrel and Gutierrez 2014:26-34)	Harm Reduction Approach (Vakharia & Little, 2017:65-76; Denning 2010:164-174)
Premise of understanding of the family effected by SUD	Not only the person with a SUD but the whole family is (has become) ill	The person with a SUD is the primary focus of attention and intervention. This person needs help and the family is involved in getting the person into treatment and assisting with recovery	Main focus is the factors contributing to the SUD by focusing on the interaction between family members and the family in the environment	Person with a SUD is ill and family is affected by illness and needs to cope in this situation
Mode and focus of intervention	Family therapy to ensure - <ul style="list-style-type: none"> Emotional and physical safety for family of person with a SUD Emotional support for family members and assist them to express their feelings Enhance communication skills 	Family therapy to - <ul style="list-style-type: none"> Enhance communication skills Assisting the person with a SUD in getting into treatment and sustaining sobriety 	Family and couples therapy assisting with - <ul style="list-style-type: none"> Setting boundaries in the relationship Open sharing of thoughts and expressing feelings Networking with treatment facilities and support groups 	Family; couple, and even individual therapy to - <ul style="list-style-type: none"> Improve decision-making skills Self-care of all family members; sustaining relationships Cater for the avoidance and prevention of problem situations

Appraising the current state of the knowledge on the topic proposed for investigation

After -

- closer scrutiny of the mentioned model and approaches;

- consulting literature on the topic regarding the treatment of persons with a SUD (Cox et al., 2013; Engelbrecht, 2012; Gam, 2010; Denning, 2010; Orford et al., 2009; Perkinson, 2008; O'Farrell & Fals-Stewart, 2006; Howells & Orford, 2006; Copello, Velleman & Templeton, 2005; Craig, 2004; Benshoff & Janikowski, 2000; Miller & Meyers, 1999), and
- my own practice experience and observations, I observed a trend confirmed by Orford et al. (2009:380) asserting that research endeavours focused on family members of persons with a SUD *is small* when comparing it to research and literature available on substance abuse, the treatment of a person with a SUD and the impact of SUDs on CSOs.

It seems as if the CSOs of partners with a SUD do not take centre stage in these treatment modalities and programmes by becoming, in their own right, the focus for treatment. Wilson et al. (2017:57) highlight this by stating that support for CSOs, specifically referring to the spouses, fiancées or cohabiting partners of a partner with a SUD has traditionally been seen as an “adjunct” to the treatment for individuals with a SUD. The partner’s involvement in the treatment of the persons with a SUD is mostly instrumental by nature and primarily geared to motivate the partner with the SUD to go for treatment (O'Farrell & Fals-Stewart, 2006). They get involved in the whole treatment regime, mainly “for the sake of the person with the SUD” by supporting the partner during treatment to regain sobriety and after treatment to remain sober (Daley & Feit, 2013:161). In most instances the involvement of partners in marital and/or family therapy, when the partner with a SUD, is focused on restoring the balance in the family system and assisting with the creation and provision of an enabling environment to facilitate the person with the SUD’s maintenance of sobriety and the prevention of relapses (Lewis et al., 2011; Denning, 2010; Copello et al., 2001). The involvement of partners has focused primarily on information about addiction and/or communication skills.

These inferences made from the consulted literature and my observations from social work practice prompted me to embark on a small scale pilot study to substantiate my observations. The lack of focus on CSOs as partners with a SUD *per se* would be the primary focus of intervention in the context of living with a fellow-

partner with a SUD. A pilot study for this purpose is admissible (Punch, 2016:96; Maxwell, 2013:66) for pinpointing the issue or formalising the research problem (Thomas, 2017:4), for supporting the case and for strengthening the motivation for the intended research project.

I approached three social workers independently of each other who come from Durban in Kwazulu-Natal, Cape Town in the Western Cape and Wellington in the Boland, Western Cape, to take part in this pilot project. They are respected as authorities and experts by their peers in the field of SUDs and its modes of treatment. The one is the director of an inpatient treatment facility; another is an assistant director of an outpatient treatment facility; and the third person is a senior university lecturer with longstanding experience of treating those and their families for their SUD condition. They were requested to share their views by answering a number of questions by e-mail (See Addendum E) on whether,

- to their knowledge, if existing treatment programmes for persons with SUD make adequate provision for addressing the needs of CSOs living with a partner with a SUD
- if a separate treatment model, catering exclusively for CSOs living with a partner with a SUD, would be of benefit.

All three experts agreed that none of the existing treatment programmes and interventions applied in practice were adequately equipped to meet the primary treatment needs of CSOs living with a partner with a SUD. (For their responses in this regard consult Addendum E). In justifying their views, they furnished the following motivations:

- Time and human resources constraints experienced by non-government organisations (NGOs) and the State Departments restrain the maintenance of existing treatment programmes and not allow for expansion of programmes that make greater provision for CSOs;
- The needs of CSOs appear to be secondary to those of the partner with the SUD;
- Very few programmes or centres make provision for treating partners and if they do it forms part of the treatment of the substance abuser;

- The partner's involvement is mainly to support the aftercare of the person with the SUD; and
- Assisting the partners for a longer time to help them understand addiction and recovery, while recovery for the whole family and helping them develop their own recovery skills is generally not part of actively supported treatment.

On the question of whether a separate programme is needed for CSOs of partners with a SUD, all three experts replied in the affirmative and substantiated their response as follows:

- CSOs experience emotional damage and trauma which need to be treated; if this is not treated the family is destabilised and becomes "functionally dysfunctional";
- Assisting the CSO must dovetail with and run parallel to the treatment of the person with a SUD;
- The treatment of both the partner with the SUD and the CSO must preferably run concurrently; if not, the CSO could sabotage the recovery of the partner with the SUD;
- The logistics (financially and practically) for simultaneous treatment might be problematic; and
- A separate but parallel programme for CSOs helps them to be more focused. The two recoveries should not be dependent on each other.

In addition to this introduced small-scale pilot study conducted with the experts, I also invited five CSOs attending Mighty Wings Life Centre (hereafter written MWLC) a community-based treatment programme² with a partner living with a SUD to share their views on treatment for and primarily focused on the CSOs of persons with SUD. They were requested to complete the questions contained in a questionnaire (see Addendum F).

² This programme is based on a similar support-basis and twelve step programme of Alcoholics Anonymous and Al-Anon, but it is run on Christian principles with additional social work and psychological sessions when more professional assistance is required. It is a structured "out-patient" programme and registered with the Department of Social Development as a community-based organisation.

From the feedback received, it became clear that that none of the CSOs had received any SUD-specific professional assistance for dealing with their experiences in living with a partner with a SUD before joining the programme they are currently attending.

On the question whether CSOs living with a partner with a SUD requires a separate treatment programme, they all answered in the affirmative. In addition, they provided the conditions for and aspects to be covered or foci for such a treatment programme:

- A safe space needs to be created where they can express themselves freely.
- They wanted to discuss the finances related to the payment for the treatment.
- They felt that the behaviour of the person with a SUD caused suffering and family upheaval needed to be addressed.
- They expressed the need for learning how to restore relationship with the substance abuser.
- They voiced the need to learn how to deal with their own pain, without diverting to self-medication to deal with their own emotional realities.
- They needed some instruction on how to deal with realities from a supporter's (partner's) point of view.

In addition to the above responses, three of the five CSOs or partners forming part of this pilot study were also of the opinion that more could be done to assist families living with persons with SUD, especially in these respects:

- providing information on where in communities' families can obtain assistance and how to go about to access such support;
- lowering the financial costs for involving CSOs or partners with a relative with a SUD at rehabilitation centres; and
- the provision of feedback from the centres when the person with the SUD completed treatment.

In redirecting his focus back to the literature; on two different occasions the UNISA librarian was approached to do a literature search regarding the professional assistance of CSOs of partners with a SUD in their own right on my behalf. I was informed that this search proved little success, but related literature has been

forwarded to me. I have consulted the literature at my disposal on subjecting a CSO living with a partner with a SUD, to treatment *per se*. I found the following. In the United States of America, Smith and Meyers (2004:200) have, in addition to involving CSOs for the sake of the person with a SUD, included an additional intervention goal to their behavioural relationship intervention programme focusing on the CSOs specifically. The aim is to assist these CSOs to “improve their own psychological functioning and the overall quality of their lives. This goal applies regardless of whether the substance abusers ever begin treatment.”

In their publication on the topic of family violence and aggression in families with problem substance use, McCann et al. (2017:10), Australian authors suggested the following: better access to professional services and support groups for CSOs and a greater understanding of and support for the plight of the CSOs. Munro and Allan (2011:179), following from their research conducted amongst Australian Aborigines focusing on family-focused social work interventions, recommended that there is a need for “culturally appropriate, sensitive and innovative community-level approaches” to assist the individual as well as the family of persons with SUDs. In addition, Lark (in Aldridge, 2014:113) makes a distinction between two subgroups of vulnerable people, namely people who are naturally vulnerable (children, women and older persons) and those persons who are vulnerable because of their circumstances (crime, war, abuse). These are important distinctions as it influences the therapeutic approach in assisting both the person with a SUD and the CSO, with the latter represented in either subgroup.

Copello et al. (2005:369), after a literature search on the subject of involving partners, and/or family members at various points in the treatment process of a relative with a SUD, found that the results were better. This was despite the fragmented interventions these CSOs had. Munro and Allan (2011:174) cite the work of Barber and Crisp where they report from the literature that they found positive outcomes involving CSOs in the treatment of a person with a SUD. They admit to the fact that the greater part of the interventions focusing on the person with the SUD, while the issues experienced by the CSOs received little attention or are ignored.

Considering the South African situation regarding the family and CSOs affected by family member's substance abuse, the opportunities for treatment are shared between the government and NGOs. Once a law is passed in the country's highest state body, it becomes an Act of Parliament which is carried out as regulations and policies as delegated to government departments and other official facilities. Three important documents of interest for this thesis include the Prevention of and Treatment for Substance Abuse Act 70 of 2008 (South Africa, 2008), the SANDMP, (South Africa, 2013 – 2017) and the "Blueprint" on the Prevention and Treatment of Harmful Alcohol and Drug Use (Provincial Government Western Cape, 2010). Although the first two documents referred to here, the (Prevention of and Treatment for Substance Abuse Act 70 of 2008 (South Africa, 2008: Definitions, section 32; SANDMP, 2013-2017:2, 19) acknowledge the impact of alcohol and substance abuse on families and recognise need for involvement of family members in the treatment and support of persons with a SUD, it is merely mentioned with little further description related to it. Both these documents primarily focus on the phenomenon of substance abuse and give detailed descriptions of the person with a SUD. Furthermore, Morojele, Parry, Brook and Kekaletswe (in Van Niekerk, Suffla & Seedat, 2012:195 - 208) point out that while adequate proof of effective "regulatory interventions" for addressing SUDs prevail, the implementation of these are unfortunately jeopardised because of a lack of sufficient finances, staff shortages and inadequately trained staff for this specialised service. The third document does not refer to the family or CSOs at all. Understandably, the focus of government departments would be on the treatment of the person with a SUD.

It is my perception that, although the involvement of the NGO and private sector in the treatment of substance abuse is strongly regulated by government legislation and policies, they seem to be more flexible in their approach. Moreover, people on medical aid or those who have financial means and can afford the treatment find access to such facilities easier. The South African Community Epidemiology Network on Drug Use³ (SACENDU)(South Africa 2017:18, 19), in their research brief on the

³ The SACENDU Project is an alcohol and other drug (AOD) sentinel surveillance system operational in nine provinces in South Africa. The system, operational since 1996, monitors trends in AOD use and associated consequences on a six-monthly basis from specialist AOD treatment programmes.

treatment of alcohol and drug abuse nationwide for 2016, stipulated ten recommendations for dealing with substance abuse and substance abuse policy. It is noteworthy that none of them referred either directly or indirectly to the CSOs. It is only under the eight suggested topics for further research that one topic referred to the CSO, and then that proposed an investigation into the financial cost implications for a relative's treatment for a SUD in the family.

What becomes evident from the information provided in the preceding discussion is that CSOs, the world over, are negatively affected by a family member's SUD. Evidence was gleaned from the literature consulted in the work of McCann et al., 2017; Askian et al., 2016; Wesley, 2016; Cox et al., 2013; Rowe, 2012; Munro & Allan, 2011; Gudzinskiene & Gedminiene, 2010; Orford et al., 2009; Perkinson, 2008 and Copello et al., 2005. Yet, in spite of acknowledging this fact, the situation of CSOs of partners with a SUD is not officially, and/or sufficiently accommodated in most policies or intervention strategies. This point will be taken up in the research problem to be introduced next under problem formulation.

1.1.2 Problem formulation

The aspect of "problem formulation" relates to the "I" in Thomas' (2017:4) *BIS-acronym* (introduced under Section 1.1.) and refers to the issue or the problem that needs to be solved through this intended investigation (Punch, 2016:64; Creswell, 2016:88). For Punch (2016:64) research problems can, amongst others, emanate from practice and observations from practice (Hennink, Hutter & Bailey, 2011:34). Creswell (2016:88) holds the view that research problems can stem from "real-life" and/or can be "literature-related" and advocates that the research problem identified should benefit the individuals being studied (Creswell, 2014:97). Literature-related problems, to quote Creswell (2016:88), point to "a need for more literature" suggesting that a particular topic is under-researched or little research on the topic prevails. For Maree (in Maree, 2016:29), literature-related problems boil down to a stillness or inconsistency in the body of knowledge on a particular topic.

In adopting the distinction made by Creswell (2016:88) between the real-life and the literature-related problems and based on the introductory remarks and the historical background provided, the *real-life* problem is as follows: *For persons living in an addictive home is like living in a whirlwind (Perkinson, 2008:242); as a family member's SUD turn homes into sporadic unpredictable and out-of-control environments. The CSOs of the partner with the SUD becomes so preoccupied with the latter, sacrificing their own time, needs, energies and resources to manage the whirlwind, even adopting maladaptive coping skill to survive (Perkinson, 2008:242; Orford et al., 2009:382, Cox et al., 2013:165). The persons with SUDs entering into treatment dominate the treatment agenda with their CSOs playing second fiddle in these treatment regimens. The CSO-partners are mainly instrumentally, or for the sake of the partner with the SUD involved in the treatment to help realise the latter's treatment outcomes (Copello et al., 2005:369). In most of the real-life treatment modalities, they are conceptualised as "an adjunct treatment" of "little helper" for partners with a problematic SUD (Wilson et al., 2017:57; Nagesh, 2015:373). The CSOs of partners with SUDs' own needs for professional treatment goes unattended and they seldom, and in own right, receive the specialised treatment to heal and recover from the many-varied scars caused by the whirlwind of a SUD (Wilson et al., 2017:57).*

In addition to the real-life problem identified, emanating also from the introduction and the background provided is a *literature-related problem*. *There seems to be a stillness or inconsistency (Maree, 2016:29) in the body of knowledge pertaining to the topic. Various scholars (McCann et al., 2017:19; Orford et al., 2009:380; Copello et al., 2005:380) confirm this when they all point out that research endeavours focused on family members of persons with a SUD is small in comparison to research and literature available on the topic of substance abuse, the person with the SUD, and his treatment and recovery journey. The topic on the CSOs are mainly focused on the impact a relative's SUD has on the family and the role the CSOs can play to get the family member with the SUD into treatment and support this person to remain sober following treatment (Copello et al., 2005:371-375).*

From the preceding information given, the **problem statement** can be formulated as follows: *There is a lacuna in terms of home-grown treatment or recovery programmes from the ambit of social work for the CSO partner, per se, living with a partner with a SUD.* Even guidelines informing social work support for partners of persons with SUD, in isolation, are sparse. With this said, I am cognisant of the fact that community support groups like Al-Anon, provide voluntary, lay support and assist partners of persons with SUD to focus on themselves and stop their enabling and so-called co-dependent behaviour (Askian et al., 2016:270; Cox et al., 2013:167; Dear & Roberts, 2005:293). However, this worthy spoke in the wheel of SUD treatment, cannot be equated to a specialised treatment and recovery service that partners of persons with SUD need and are entitled to.

1.1.3 Reasons/rationale for the study

In presenting the reasons or rationale for the study, Vinthal and Jansen (in Maree, 2016:30) advise that researchers need to explain how they developed an interest in a certain topic and why they believe that the research endeavour is significant. My practice-based observations and experiences in providing social work services in the field of SUDs enabled me to realise that persons in SUD treatment are, in many instances, the primary or sole focus of the interventions. The CSOs of these clients/patients are perceived to be an adjunct treatment or functional aids during the treatment to recovery and in after care (Wilson et al., 2017:57). My perception of their unattended needs and their “so-called co-dependency” (Askian et al., 2016:281) are going untreated. This motivated me to embark on this research journey.

The aim was to explore the experiences, challenges and coping strategies of CSOs living with a partner with a SUD and to obtain suggestions informing guidelines for social work support for servicing this somewhat marginalised group, in their own right, and within their own turmoil of SUD. This envisaged aim points to the “S” in Thomas’ (2017:4) BIS-acronym (introduced under Section 1.1 in this Chapter) as it indicates the *solution* for addressing the identified problem.

In addition, the stillness in the literature with reference to tailor-made social work interventions geared to CSOs of partners with SUD, in their own right, served as further motivation for this study. The envisioned guidelines for social work support will address this lacuna, legitimise and prioritise the treatment needs of CSOs of partners with SUDs, distinctively and add to the other (mainly informal) support endeavours for this client-system group.

1.2 THE THEORETICAL FRAMEWORKS FOR THE STUDY

Theoretical frameworks, as stated by Ambrosino, Heffernan, Shuttlesworth and Ambrosino (2012:46) and Teater (2010:1), are applied by social workers to interpret and describe the problems and adversities experienced by individuals and families in the world we live in. This concept “theoretical framework” is further explained by Fain (in Green, 2014:34), as interconnected concepts that are systematically organised in such a way that the nature of the relationship between these concepts or variables provide a clear understanding of a phenomenon. The purpose of including theoretical frameworks in research is that it ensures coherency throughout the design and application of methods (Green, 2014:34).

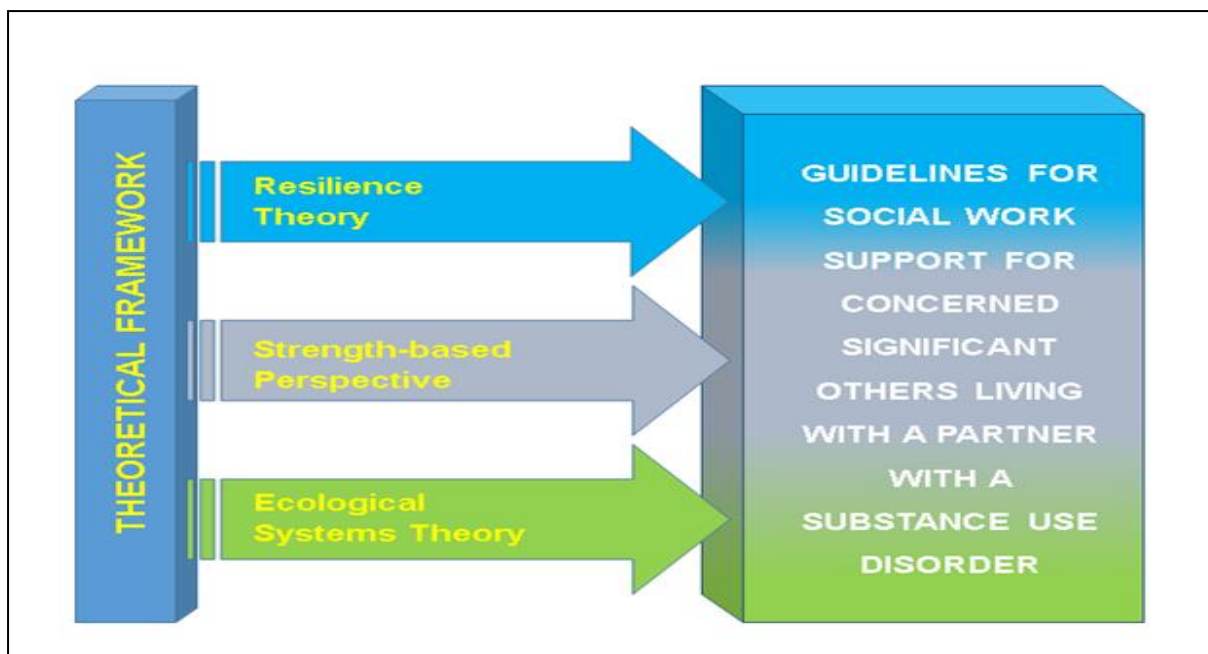
Qualitative researchers increasingly incorporate a theoretical paradigm, model, or framework which provides an overall “orientating lens” for the study, of amongst other, the pressing issues of marginalised groups (Creswell, 2014:64; Creswell, 2009:62). For Rubin and Babbie (2007:31) a theoretical framework is a frame of reference for organising observations and reasoning in a meaning making-way. Thomas (2017:99) states that “theory” in qualitative research is multi-purposed. It can be regarded as a “product” in the sense of a framework in which abstract ideas are systematically or orderly modelled. Theory can also be viewed as a model to explain something about the world, or simply be seen as a “tool” to be used for explaining the issue, such as the one currently proposed for investigation.

Given the problem formulation, the CSOs of partners with a SUD may be perceived as a marginalised group in the continuum of treatment and recovery of persons with SUDs. Tying all the viewpoints together, I understood the theoretical framework,

informing the study, to be the both a lens and a tool to be used for looking at and explaining the issue being researched and to treat it as such. In addition, and for the fact that I intended to undertake the study from a qualitative approach, I decided to adopt Maxwell's (2013:49-50) explanation for the concept theory. Maxwell refers to the theory as the "coat-closet" and the constructs of the theory as the "coat hooks" in the closet providing places to "hang" the data and to indicate the relationship between data.

In Figure 1.1 an overview is provided of the theories and perspective adopted as the theoretical framework for the proposed study.

Figure 1.1: Theoretical framework for the study



The strength-based perspective, the resilience theory, as well as the ecological systems theory were all adopted to form part of the theoretical framework for this study (as depicted in Figure 1.1 above) are introduced next.

These theories and perspective are commonly used in the field of social work as it allows for establishing a background to determine and comprehend the "interrelationship between individuals and social problems", underlining the intricate interactions that occur in the person-environment interface (Nicholas, Rautenbach &

Maistry, 2014:86). The link between these theories and perspective is clearly spelled out by Ambrosino et al. (2012:64). They point out that the *ecological systems framework* allows the social worker, together with the individual, to explore the accessibility to resources and *strengths* intrapersonal, interpersonally and environmentally. This is done by evaluating the individual's characteristics and abilities, the supporting others in their immediate surroundings and the resources in the community, uncovering which of these can be put to serve as strengths and utilise as such to deal with the issue at hand. All of this ties in with the strength-based perspective. In the process of emphasising the individual and environment strengths, provision is made for increasing opportunities which, in turn, highlight the concept of *resilience* (the ability to satisfactorily and meaningfully recover from hardship). By acquiring and applying resiliency skills, the individual becomes better equipped (strengthened) to take advantage of the opportunities in their environments (Ambrosino et al., 2012:64). Raholm (2008:70) states that linking the individuals sharing of adversities with resilience, reflects notions of hope, joy and the good life, reformulating suffering into situations of well-being.

In summary, considering the theoretical frameworks and perspective, the *ecological systems theory*, amongst others, allows for an appreciative enquiry into the systemic and relational dance between sub-systems (the CSOs and their partners with the SUD) within the bigger system. The CSOs in this systemic dance may perceive themselves as resilient, displaying a hardiness, competency and perseverance (resiliency theory). The intrapersonal, interpersonal and environmental resources and *strengths* can then be used in an effort to restore and maintain the equilibrium within the system (Beaudoin, 2005:49). This trifocal theoretical framework lens, as adopted, is probably best described by Monk, Winslade, Crocket, and Epston (1997:4). They refer to the person (the CSO of a partner with a SUD) interviewed as the "main character in the plot [*ecological-system theory*] as the courageous victor [*strength-based perspective and resilience theory*], rather than the pathological victim, as a colourful individual [*strength-based perspective and resilience theory*] who has vivid stories to recount [*resilience theory*] rather than a hopeless individual leading a pathetic life".

1.2.1 The Strength-based perspective

The strength-based based perspective, as pointed out by Chapin (cited by Lekganyane, 2017:29) can be associated with the founding work in Social Work of Richmond and Perlman in the first half of the previous century. Guo and Tsui (2010:234) postulate that this perspective was developed in reaction to the then popular intrapersonal disease-based, psychotherapeutic approaches with the strength-based perspective placing greater emphasis on the broader system and empowerment theories.

The strength-based perspective differs from the traditionally used psychotherapeutic social work model in that it does not label clients as “dysfunctional, defective or ill”. Instead it focuses on the strengths of the client with the social worker focusing on the positive attributes (Beckett & Horner, 2016:156; Mbedzi et al., 2014:103; Guo & Tsui, 2010:1). It also deviates from the empowerment approach because it does not perceive clients to be powerless at the time of requesting assistance. Saleebey (in Manthey, Knowles, Asher & Wahab, 2011:126) points out that assisting somebody from a strength-based approach is grounded on enabling or guiding clients to explore, discover and utilise their own strengths and resources to achieve their goals. When engaging with clients from a strength-based perspective vantage point, the relationship with the client is transformed from an unequal match-up to an equal shared partnership. In this position the client is then able to discover and enhance their own abilities to recover from their difficulties (Guo & Tsui, 2010:126).

The following are characteristics of the strength-based perspective derived from Manthey et al. (2010:126-152) and Saleebey (2006:16-20):

- The strength-based perspective embraces the concept of *resourcefulness* - individuals, families, and communities all have strengths, assets, and resources, so that trauma, abuse, and illness become opportunities for further growth (Paquin, 2006:128). According to Guo and Tsui (2010:234) and Powell, Batsche, Ferro, Fox and Dunlap (1997:4) resourcefulness can go beyond the family as the relationships and interactions can spread out to include extended

family members, friends and other members or groups in the community. Inviting family, spiritual advisors, and significant community members prove to be instrumental in enhancing the individual's commitment to sobriety further. This strengthens their ability to regain control over substance abuse behaviours even more (Munro & Allan 2011:177; Saleebey, 2006:17).

- The strength-based perspective is *goal orientated*. Clients are encouraged to set goals for what they would like to achieve, and their strengths are appraised and mobilised for this purpose. Working from a strength-based perspective the *environment is seen as rich in resources*. The clients are then linked up with relevant environmental strengths and resources to achieve their goals.
- In the strength-based perspective, the helping relationship is *hope-inducing*. The relationship between the social worker and client increases a sense of hopefulness as they engage in an accepting and empathetic manner with a collaborative purpose. Such a relationship also creates feelings of empowerment and self-confidence by increasing the client's perceptions of their abilities; also allow them choices and options when dealing with specific situations (Saleebey, 2006:7, 11).
- The strength-based perspective is *client-directed*. Clients are encouraged to create their own solutions and more constructive courses of action (Beckett and Horner, 2016:157).
- The strength-based perspective departs from the vantage point that clients are served best by *collaborating* with them. Social workers might provide specific skills and experiences, yet remain open to the wisdom, knowledge, insights and experiences of their clients. The inputs of the client are acknowledged and valued throughout the intervention. The relationship between the family and or individual and professional social worker is described as a "partnership". Both parties contribute to the recovery of the malady and, by implication, partner and share the responsibility to bring about change (Mbedzi et al., 2014:104; Guo & Tsui, 2010:235; Powell et al., 1997:6).

- The strength-based perspective *acknowledges* both *hurt* and *growth*, admitting that, while trauma, abuse, illness and difficulties may be painful and destructive, they can become the tools and stepping stones for dealing more constructively with adversity. This ties in with the notion of resiliency that implies that adversity, including trauma, can contribute to a greater sense of coherence and a capacity for empathy and closer bonding with others (Ungar, 2013:255; Saleebey, 2006:8).
- The strength-based perspective *focuses on the client's ability to change* and develop. For this reason, clients are not labelled; bound by labels and past experiences. They are enabled to discover and trust in their ability to obtain their goals. Realising this ability to change and putting it into fruition is in "essence" what the strength-based perspective is all about. In effect, it is actually a process that a client has to go through to overcome something difficult and to manage it constructively (Beckett & Horner, 2016:156; Mbedzi et al., 2014:103; Saleebey, 2006:77).

As Guo and Tsui (2010:233) note, the strength-based perspective, since its introduction to the ambit of Social Work, has been widely applied in a variety of social work fields like child welfare, substance abuse, family services and services for older persons (Geyer, 2010:63-86; Winek, Dome, Gardner, Sackett, Zimmerman & Davis, 2010:50; Jones, Hardiman & Carpenter, 2007:251-269). Powell et al. (1997:1) used the strength-based perspective in treatment intervention in their research in a residential treatment facility for less abled children. Lietz (2004:33) in her research in a residential treatment facility for children with emotional and behaviour problems found that the strength-based perspective is well-suited for empowering the so-called powerless people in underprivileged situations, such as new immigrants, low-income groups and patients with chronic illnesses.

Since the CSOs of partners with a SUD find themselves in relationships that are detrimental to their well-being, by implication, it can be appropriately assumed that application of the strength-based perspective, as it stands, can be adequately expanded and included in the treatment with persons with a SUD. In a South African

study that included a treatment using with a strength-based perspective for older persons with a SUD, Geyer (2010:63-86) had experienced much improvement in a number of areas. Amongst others these were their communication, conflict management, dealing with negative feelings, handling loss as well as improvement in their spiritual and religious life. Adopting a strength-based perspective, in a Canadian study on the treatment of adolescents with a SUD, Harris, Brazeau, Clarkson, Brownlee and Rawana, (2010:333-347), not only had an improved treatment outcome in all areas and overall but also found that the adolescents managed to identify, develop and use their strengths better. The network approach, an approach where all available service providers in a community cooperate to address specific problems, (Winek et al., 2012:45-69) applied in the United States of America for a family-based treatment for substance abuse followed the strength-based perspective. These authors concluded that the strength-based perspective made participants aware of and assisted them to build on positive experiences and competencies. Within a therapeutic relationship milieu built on a collaborative support structure, they did not feel judged on their SUD and criminal records. Instead, the strength-based therapeutic intervention brought about improved accountability, with an increased focus on their strengths resulting in innovative ways of dealing with the problems related to their SUDs (Winek et al., 2012:45-69).

1.2.2 The Resilience Theory

Resilience theory is closely associated with the strength-based perspective as this theory emphasises the ways in which individuals and communities *respond to, recover from, and even grow or thrive* when faced with hardships (Van Breda, 2015:1; Ungar, 2013:255; Walsh, 2006:606). All these authors point out that, instead of concentrating on the adversity, resilience focuses on the commonly held belief that people find a way to bounce back from adversity". Galea (in Green, 2014:944) also explains "resiliency" as "*bouncing back*", while Windle, Markland and Woods (2008:285) explain this concept as "*the ability to recover from or adjust to misfortune or change*".

Masten and Reed (in Munoz, Brady & Brown, 2016:102) highlight two conditions which are implicitly central to all the attempts to explain resiliency. These are: being exposed to substantial threat or severe hardship and achieving a positive response in spite of key attacks on the developmental process. This “positive response” requires a cognitive ability that can drive goal-directed efforts despite difficulties. Winkler (2014:464) makes a strong argument that resilience is not so much a personality trait but a psychological ability or competency that develops through interaction with others. Coupled with this ability, are traits such as intelligence, hardiness, sociability, grit, and optimism assisting individuals to overcome perplexing conditions (Shaw, McLean, Taylor, Swartout & Querna, 2016:34).

Resilience, referring to both individuals and communities, can be described as an outcome (Masten, Best, & Garmezy, in McCleary and Figley) and a process (Luthar, Cicchetti, & Becker in McCleary and Figley, 2017:13; Khanlou & Wray in Shaw et al., 2016:34). Van Breda (2017) advocates that the resilience theory must be viewed from an ecological perspective. This is pivotal, given the fact of social positioning and the impact of social relations on an individual’s abilities to bounce back. In addition, resilience work must be viewed against the cultural and social contexts of the situation with its political climate and governing strategies affecting individuals, families and communities and their circumstances (Bottrell, 2009:232). Winkler (2014:475) holds a similar view when postulating that resilience and its use in the field of Social Work takes place within a social context. A concerted effort should be made “to make this context itself more containing and supportive of [populations deemed] vulnerable [i.e.] children and families”. For Greene, Galambos and Lee (2003:82) the social context presents the layer of “external factors related to resilience”. In addition, they stressed the importance of family support, schools, employment opportunities as well as the viability of the community in the resilience process.

Aligning the resilience theory with the situations the CSOs living with a partner with a SUD encountered, it can be proposed that their partners are constantly exposed to adverse circumstances from which they have to “bounce back”. Greene et al. (2003:84) could claim this after their research which investigated the theoretical

assumptions of resiliency theory among 18 professionals, comprising social workers (11), psychologists and ministers of religion (4), a physio therapist, a resident counsellor and one emergency personnel trainer, in Texas (USA). Most of the professionals (72%) agreed that they need to recognise the survivors' pain and allow them time to express these feelings. Once this had been attended to they could then move on to establish what their reserves or strengths were without giving false hope.

Adopting the strength-based perspective and resilience theory as part of the theoretical framework for this study, it is hoped that, in the words of Shaw et al. (2014:40), I “can help tell the rest of the story on resilience and better equip individuals and whole communities for success”.

1.2.3 The Ecological Systems Theory

With the development and formulation of developmental psychologist, Bronfenbrenner's ecological theory of human development became increasingly studied since the mid-1970s, it has become a widely recognised and popular theoretical framework across a variety of disciplines in the social sciences for many decades (Velez-Agosto, Soto-Crespo, Vizcarrondo-Oppenhimer, Vega-Molina & Coll, 2017:903; Bronfenbrenner, 1994). Bronfenbrenner's ecological systems theory, according to Ebersohn and Bouwer (2015:2) reflects an “understanding of the complexity of the influences, interactions and interpersonal relationships” that comprise human development within broader environments and systems. These systems, as pointed out by various scholars (Wood, Kiperman, Esch, Leroux & Truscott, 2017:36; Neal & Neal, 2013:725; Darling, 2007:204) operate at multi-dimensional levels, differentiated as micro-, meso-, exo- and macro-systems illustrated in Figure 1.2. These systemic levels are in continuous interaction with each other and influence and affect the individual actions, responses and personal growth and development.

Figure 1.2: The Ecological Systems Model of Bronfenbrenner (1979) [Graphics adapted]

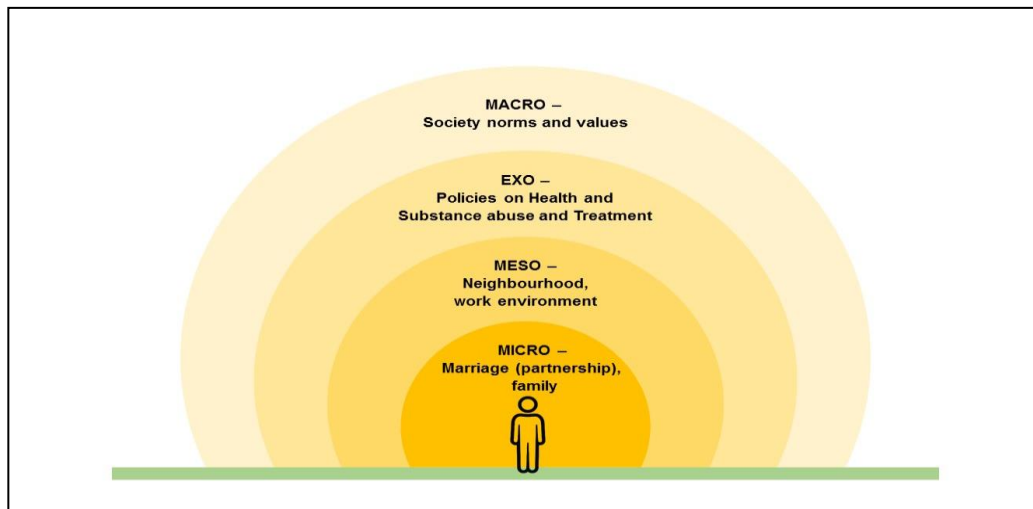


Figure 1.2 shows that Bronfenbrenner's ecological systems model places the person, and not the natural physical environment, at the centre of attention (Darling 2007:207). Elaborating further, Joly (2016:1254) emphasises that the ecological-systems theory highlights four specific elements, namely *the person*, the *processes*, *context* and *time*.

Bronfenbrenner and Morris (2006) indicate that characteristics of *the person* include personality, ability, experiences, knowledge, skills and demand. The person, according to Darling (2007:204, 207) is "active" in shaping environments, both evoking responses from them and reacting to them. *Processes*, according to Bronfenbrenner and Morris (2006) refer to the forms of interaction between the person and the environment over time. Different environments will have different influences or impacts on a person who in turn will respond to them in different ways. The ecological environment can be referred to as the *context* within which interaction takes place. The context depicts the four levels or "sub-environments" as indicated in Figure 1.2 and represents the variation that takes place over periods of time.

The microsystem includes individuals, their relationship(s) in various settings such family, friends, work or service providers; the mesosystem involves processes between two or more settings containing the individual, for example, the relationship between the home (family) and employer. In the exosystem the context refers to the

developments between two or more settings, one of which the individual is not directly involved, such legal or health networks or health. Macrosystems refer to the all-encompassing level of the previous three systems in a specific culture (Wood et al., 2016; Bronfenbrenner & Morris, 2006; Bronfenbrenner, 1994). According to Velez-Agosto et al. (2017:903), culture should not be perceived as a separate entity operating from a so-called higher outside macrosystem, but rather as the system in which every human daily activity is enacted, and becomes part of the individual's integrated self over time.

The fourth element, *time*, is an indication of how human development, relationships and interaction unfold through all four the levels, often in different dimensions. Joly (2016:1255) points out that the give-and-take interactions between the person and the elements of this environment can become increasingly complex over time. They too are determined by the individual's characteristics, the state of the socio-economic environment, specific expected outcomes and changes in the broader social context within which interactions occur.

It is against this background, that Richard, Gauvin, Ducharme, Leblanc and Trudel (2012:102) and Lewis et al. (2011:170) conclude that there is a growing recognition that the most effective interventions are those that are based on a comprehensive approach, including multiple intervention strategies focusing on both individual-level determinants and environmental level determinants of health. These determinants cut across social networks and organisations, community and even political environments.

When considering the situation of the CSOs of partners with SUDs against the background of this theory it can be concluded that they are implicated across all four the levels. Such a situation can, for example, be depicted as follows: on the microsystem level, being affected by the substance abusing partner the CSOs takes care and responsibility for their children, and eventually seeks help for the failing marriage representing the mesosystem level. Obtaining a court order at an exosystem level originated juridical procedure executed at mesosystem level to get the partner into treatment for a substance use disorder. The general perception

society at large has is that the person with a SUD requires treatment to recover and this happens at macro level.

1.3 THE RESEARCH QUESTION, PRIMARY GOAL AND OBJECTIVES OF THE RESEARCH

The research question, goals and objectives of this research are presented in this section.

1.3.1 Research Questions

In the planning of research, Locke (in Punch, 2016:18) argues for what he calls “semantic and conceptual hygiene” and recommends that a logical sequence of “problem, question and purpose” must be followed. This recommendation was adhered to. As the research problem informing this study was presented in the beginning of this chapter (see Subsection 1.1.2), the focus will now turn to the research questions. A research question is explained as “a clear statement in the form of a question about the issue the researcher wishes to study” (Thomas, 2017:324). The research question serves as a sign-post indicating the focus and direction of the study (Mantzoukas, 2008:372; Padgett, 2008:47; Jansen in Maree, 2007:1). Research questions need to be formulated in such a fashion that they answer the formulated research problem set and should also reveal new research problems and/or to resolve long-standing controversies, challenging old beliefs, norms and values (Sandberg & Alvesson, 2011:23-24). Against this background, the research questions should be formulated in an open-ended and explorative manner and should directly be related to the research topic and identified problem (Marshall & Rossman, 2016:82; Maree & Van der Westhuizen in Maree, 2016:30). Furthermore, Yin (2011:68) postulates that it is meaningful for the researcher to have a good set of research questions as it helps to inform the upcoming strategy and methodologies for conducting a study, as well as the development of instruments for data collection.

In view of my intention to employ a qualitative research approach, and the fact that in a qualitative research endeavour a research question and not a hypothesis is appropriate (Cruz & Tania, 2016:80; Hennink et al., 2011:33; Mack, Woodsong, MacQueen, Guest & Namey, 2005:2; Mahtani, 2004:59, 60), the research questions proposed are as follows:

- *What are the experiences, challenges and coping strategies of CSOs in relation to living with partner with a SUD?*
- *How and with what would CSOs living with a partner with a SUD like to be supported by social workers in view of informing the recommendation of guidelines for social work intervention?*

In keeping to Locke (in Punch's 2016:18) sequence of providing an introduction, the research questions, and then the goal, the latter will be presented next.

1.3.2 Goals for the study

When explaining the concept "goal" in the context of research, Maxwell (2013:23) mentions that in its broadest sense it refers to "motives, desires and purposes" for wanting to conduct the research and what the researcher wants to accomplish as result of it. Creswell (2009:111) holds a similar view when stating that the "goal", or, as he puts it, "the purpose statement" communicates the intent of the proposed study and further postulates that the goal should, amongst other, incorporate the central phenomenon of the study and the participants to be studied (Creswell, 2014:109). Adding on to explain the concept "goal", O'Leary (2017:373) states that a research study's goal is a restatement of the research question.

Emanating from and linked to the research questions the goals proposed for this study are:

- *To develop an in-depth understanding of the experiences, challenges and coping strategies of CSOs living with a partner with a SUD*
- *To report on the suggestions on how and with what CSOs living with a partner with a SUD would like to be supported by social workers*

- *To proffer guidelines for social work intervention assisting CSOs living with a partner with a SUD.*

To work towards realising the stated goals the following objectives are proposed.

1.3.3 Research objectives

The goal, or the purpose statement of the research, points to its objectives (Creswell, 2009:112). The latter can be seen as steps or mileposts that must be accomplished in a sequential fashion to work towards the realisation of the stated goal (Grove, Burns & Gray, 2013:708) with the purpose to signpost how the specific research questions could be answered (Farrugia, Petrisor, Farrokhyar & Bhandari, 2009:280).

The objectives are as follows:

- To obtain a sample of CSOs living with a partner with a SUD in Benoni, Pretoria, and Randburg.
- To collect data by means of a narrative writing exercise and individual in-depth interviews.
- To explore the experiences, challenges and coping strategies of CSOs living with a partner with a SUD and suggestions on how and with what they would like to be supported by social workers.
- To analyse the data thematically, implementing the eight steps of Tesch, (in Creswell, 2014:198).
- To describe the explored experiences, challenges and coping strategies of CSOs living with a partner with a SUD and suggestions on how and with what they would like to be supported by social workers.
- To interpret the data and conduct a literature control.
- To draw conclusions and make recommendations comprising of guidelines for social work intervention assisting CSOs living with a partner with a SUD.

1.4 RESEARCH METHODOLOGY

When discussing the concept “methodology” in the context of research, Carter and Little (2007:1317) after consulting various sources, provide the following definition for this concept: methodology points to “*a theory and analysis of how research should proceed*” (Harding, 1987:1) by analysing “*...the assumptions, principles, and procedures in a particular approach to inquiry*” (Schwandt, 2001:161). Wahyuni (2012:72) adds to this when elucidating that methodology specifies the model of conducting research situated in a particular paradigm. Kramer-Kile (2012:30), in an explanation of what resorts under “methodology” includes the aspects of the research approach or paradigm and the design. In writing about the aspect of design, Wahyuni (2012:72) states that the design is pivotal in connecting the methodology, the research paradigm or approach, with a fitting set of research methods to work towards goal realisation. Illustratively, methodology is a map, for example, qualitative research, while methods refer to the set of steps to travel between two places on the map. To further illustrate, the steps can be related to the ‘how’ of participant recruitment; preparation for and collection of data; data analysis and verification (Jonker & Pennink, in Wahyuni, 2010:72). From these introductory remarks and explanations provided I deduced that the methodology signposts to determine the aspects of research approach and design.

The research approach and design adopted for this study are presented next.

1.4.1 Research approach

As one of the aims of this study is to develop an in-depth understanding of experiences, challenges and coping strategies of CSOs living with a partner with a SUD, I decided to use *a qualitative research approach*. Succinctly encapsulating the nature of qualitative research, Creswell (2009:4) explains this research approach as a “means for exploring and understanding the meaning individuals or groups ascribe to a social or human problem”. Maanen (in Merriam & Tisdell, 2016:15), refers to qualitative research as an umbrella term covering numerous interpretive techniques that “explore, describe, decode, translate, and come to terms with meaning in the

naturally occurring phenomena in the social world”. Looking at a topic under investigation through qualitative tinted glasses for Hennink et al. (2011:8-9) is to use interviews, observations, life histories and biographies to explore the context and related experiences of individuals in detail with the aim of identifying issues from their perspectives, as well as the meanings and the interpretations they attach to experiences, behaviours, and events. Jansen (2010:3) refers to qualitative research as an opportunity to study diversity in populations.

Emanating from the explanations provided for the concept “qualitative research” are the characteristics of qualitative research. According to Creswell (2014:185-186), Streubert-Speziale and Carpenter (2007:21) and Mahtani (2004:55-58) these characteristics can be summed up as follows:

- Qualitative research is by its nature a holistic approach. It describes the phenomenon being studied in a holistic manner taken into consideration the fact that it is contextually situated.
- Qualitative research functions best as an emerging research design. It is inductive in nature, which allows for the unfolding of the empirical data to shape the emerging concepts and theories and research processes and steps.
- Qualitative research’s primary orientation is towards the natural world. It is applied in naturalistic settings to allow for a deeper understanding of the phenomenon being studied and develop contextually relevant findings.
- Qualitative research focuses on the lived-experiences and the meanings people attach to such experiences. It results in data that is open-ended and descriptive, focusing on the link between events, behaviours, perceptions, and actions.
- Qualitative research is a complex research approach. It accesses multiple sources of data collected from a range of sources, using various methods. These include interviewing individuals or groups, conducting content analysis of documents and audio-visual material, and observations.
- Qualitative research is a systematic research approach. It needs to be responsive to the continuous developments and changes that take place in the situations and circumstances in field settings and their locations.

- Qualitative research is an interactive approach. The researcher is required to engage with the participants and to enter into an active dialogue with them and the research material.
- Qualitative research is a fundamentally subjective approach. It allows for the inherent subjectivity of all the environmental and research processes. This requires the researcher to be actively reflexive during the research process.
- The researcher is the main instrument for the collection of data. Researchers attempt to become active participants in the experiences of the researched.

Of the characteristics salient of qualitative research, the following are particularly applicable for the proposed investigation rendering this approach well-suited for this study:

- *Qualitative research is suited for studying the meaning people attach to their lived-experiences under real-world conditions.* I intended, by way of a narrative writing exercise, followed by individual in-depth interviews, to invite the CSOs of partners with a SUD to share their experiences, challenges and coping strategies with the meaning they attach to living with a partner with a SUD.
- *Qualitative research represents the views and perspectives of the people engaged in the study.* In undertaking this study with a qualitative approach my intention was to capture, analyse and represent the reality of what it is like for CSOs to live with a partner with a SUD. This is helpful as it assists me to distance own values, preconception or meanings.
- *Qualitative research covers the contextual conditions within which people live.* It can be generally assumed that the social, organisational, and environmental circumstances within which people live may strongly influence how they function and cope within these conditions. The context, which Creswell (2016:6) refers as a “natural” context, includes, amongst other things the families, friends, work and other contexts in which people interact. The natural context was taken into consideration where the participants share their experience, challenges and coping strategies in relation to living with a partner with a SUD.

- *Contributing insights into existing or emerging concepts that may help to explain human social behaviour.* Qualitative research is based on a desire to explore and describe events of interest or concern through existing and/or emerging concepts. While the role and functioning of CSOs living with a partner with a SUD, was historically based on professional perceptions and assumptions, I intended by means of qualitative research to ensure that the voices of the CSOs are being heard as in their own right. I acknowledge that as emerging design, fieldwork realities may necessitate change yet with the end result it is aimed to offer new insights into assisting the partner as a unique person.
- Qualitative researchers strive to use *multiple sources of evidence rather than relying on a single source alone.* The purpose of qualitative research is to collect, analyse and present data. The complexity of research settings, the diversity of participants and the application of different research methods warrants a variety of sources of evidence as part of any given study (Creswell & Poth, 2018:43). Although this study intended to primarily focus on CSOs of a partner with a SUD, the research planned to employ different methods of data collection - a narrative writing exercise and in-depth interviews. These different sources allow for triangulating the data, adding to the study's credibility and trustworthiness.

Qualitative researchers, according to Green and Thorogood (2009:38), opt for a qualitative approach when the aim is to “understand the perspectives of participants, explore the meaning they give to phenomena or observe a process in depth”. In addition, Ritchie and Lewis (2005:32-33) advise that researchers opt for a qualitative approach when the following features related to the phenomenon to be studied are present.

- When it is ill-defined or not well understood.
- If the phenomenon being studied is deeply rooted within the participant personal knowledge or understanding of themselves.
- When the investigation needs to be understood from an individual or group's vantage point that hold a highly specialised role in society.

- In the case of a targeted population in which people are vulnerable, delicate and sensitive situations need to be explored.

This intended research project corresponds with three of the above stated features, making the qualitative research approach a suitable choice for investigating this topic.

First, the phenomenon under investigation is ill-defined in that the research focus on the family members of partners with SUDs is small. In comparison, literature available on substance abuse and its impact and the treatment of persons with SUDs is greater in volume and availability (McCann et al., 2017:19; Orford et al., 2009:380; Copello et al., 2005:380). That this topic appears ill-researched pointed me in the direction of the qualitative research approach as it allows adequately for the exploration of such topics. Second, the research topic of CSOs living with a partner with a SUD is of a sensitive nature, and the target population is exposed to a person's SUD vulnerability (Aldridge, 2014:113; Campbell-Page & Shaw-Ridley, 2013:489; Valtonen, Padmore, Sogren, & Rock, 2009:49, 54). Third, the topic is deeply rooted in the participants' personal experiences as it relates to their living with a partner's SUD, the challenges that emanate from it and how they cope with its consequences. They are seen as the experts able to speak authentically about this topic.

In addition to inviting the CSOs to share their experiences, challenges and coping strategies in relation to living with partners with SUDs, the qualitative research approach will allow their voices to be heard, especially to relay suggestions on how they would like social workers to support them. The outcome of this exercise will culminate in informing the guidelines to be proffered for social work interventions tailored for and specifically directed to assisting CSOs living with a partner with a SUD. The "bottom-up" approach I intend to follow in this qualitative research endeavour to produce guidelines for intervention is expected to not only benefit social workers but other professionals, groups, and facilities serving the CSOs of partners with a SUD.

1.4.2 Research design

In explaining the aspect of research designs, Creswell (2014:12) states: “Research designs are types of inquiry within [the] qualitative approach... that provide specific direction for procedures in a research design”. The research design is an attempt to describe what is being researched, how the research is undertaken, and why the research is necessary (Green & Thorogood, 2009:42). It is the logical sketch plan for the study (Yin, 2011:9). Maxwell (2013:2) holds a similar view when referring to the research design as the protocol and plan for executing the research. In the context of qualitative research, one cannot develop or borrow a logical strategy in advance and then implement it rigidly. Instead, and according to Maxwell (2013:3) the researcher is required to let the design unfold en route as the research is transpiring; to be flexible to construct and reconstruct the research design as the study proceeds and the realities in the field dictates (Thomas, 2017:14). It is for this reason that various authors (Thomas, 2017:42; Frankel & Devers, 2000:253) advise qualitative researchers to embrace the idea of an emergent design or to think of a qualitative research design as “a rough sketch”. A sketch, with guidelines and instructions to be followed flexibly that will become more detailed and be completed as the study progresses. Within the boundaries of qualitative research, it will be therefore safe to state that the research design is the outline for how the research project will proceed (Monette, Sullivan & De Jong, 2011:506).

Against the introductory remarks provided on the meaning of the concept “research design” in the context of qualitative research, the research proceeds with introducing the research design proposed for this study. I decided to employ a *collective, instrumental case study design and a phenomenological research design as well as an explorative, descriptive and contextual strategy of inquiry*.

1.4.2.1 The collective instrumental case study design

The concept “case study” is defined by Carlson, Ross and Stark (2012:49) as an in-depth enquiry and analysis of an individual’s, a couple’s or a family situation. Flyvbjerg, in Shaw and Holland (2014:88) point out that by means of a case study, a

researcher can obtain a deeper understanding of cases and situations, including its “richness and complexities”. As explained by Anderson, Leahy, DelValle, Sherman and Tansey (2014:89) citing Creswell, the case study is a strategy of inquiry in which the investigator explores a bounded system [a case] or multiple bounded systems [cases] over time. Such exploration is realised through detailed, in-depth data collection, involving multiple sources of information (e.g. observations, interviews, audio-visual material, documents) and reports, a case description and case-based themes (Baxter & Jack, 2008:543, 548; Guest, Namey & Mitchell, 2013:9, 14). Boblin, Ireland, Kirkpatrick and Robertson (2013:1268) state that the case study approach allows for a holistic understanding of a phenomenon within real-life contexts from the perspective of those involved. It is best suited to research that asks “how” and “why” questions.

In this research, I decided on a *collective case study* design with the concept “collective” implying the involvement of multiple cases (Thomas, 2016:172; Baxter & Jack, 2008:549-550; Yin, 2003). When planning to employ the case study “instrumentally”, the concept “instrumental” means the case study is applied for a specific purpose or various purposes and to help realise an aim or various goals. The aims may be

- to gain insight into the topic being investigated (Creswell & Poth, 2018:98) such as in the case of this research study - to gain insight into the experiences challenges and coping strategies of a CSO living with a partner with a SUD;
- to assist with the refinement of a theory (Thomas, 2016:121; Snow, Wolff, Hudspeth & Etheridge, 2009:234-244); and/or
- to inform policy development or professional practice (Simons in Thomas, 2016:10). This is applicable as one of the goals of this study was to proffer guidelines for social work support for CSOs living with partners with a SUD.

In addition, it needs to be pointed out that more than one session is planned with each case to allow for a deeper understanding of the phenomenon.

1.4.2.2 The phenomenological research design

With regard to phenomenology as a strategy of inquiry in qualitative research, there is general agreement among phenomenological researchers, as pointed out by Perry (2013:263) and Finlay (2012:172) that the emphasis is on the personified, experiential meanings of life circumstances. The phenomenology, as qualitative research design, focuses on how participants make sense of their lived experience; how they transform that experience into consciousness by way of the meanings they attribute it in an effort to establish connections between the scientific world and everyday life events (Bakanay & Çakır, 2016:161; Turner, Balmer & Coverdale, 2013:307). Phenomenology elicits data concerning the lived experience of an individual, for example, the “how is it for you as a CSO to live with a partner with a SUD?”, and where little is known about the topic (Smith, 1998:214). Creswell (2009:13) agrees when stating that, researchers employ phenomenology as a strategy of inquiry when aiming to discover “the essence of human experience about a phenomenon as described by participants”. Phenomenology, in essence, entails the use of subjective, first person, lived experiences as the cradle of knowledge and getting to the core of the matter being investigated (Maslow in Smith, 1998:214; Vydelingum, 2000:101). For these given reasons I decided to adopt the phenomenological research design as part of the strategy of inquiry.

1.4.2.3 The explorative design

Exploratory research is usually undertaken when the research topic is new, as well as when the topic area is very broad (Grinnell & Unrau, 2008:18). Grove et al. (2013:370) hold a similar view by stating that explorative research is conducted to increase knowledge of a particular phenomenon, and/or to gain new insights, and/or discover new ideas. In view of the lacuna in information on the topic proposed for investigation and social work interventions that are tailor-made, and focusing exclusively on the CSO living with a partner with a SUD (earlier alluded to), the explorative research design was deemed appropriate to explore this under-researched area.

1.4.2.4 The descriptive design

With descriptive research, researchers set out to collect, organise and summarise information on an issue being investigated by, *inter alia*, describing what a situation is like and what it means to the individuals experiencing it (Punch, 2016:67). Sandelowski (2000:334) postulates that qualitative descriptive studies have as their goal a comprehensive description of events and related experiences in ordinary language and require that a researcher remains close to the data. Neuman in Grinnell and Unrau (2008:21) add that this newly documented information may, as content contradict, add to, or confirm prior beliefs about a situation. A similar view is taken by Mathani (2004:57) claiming that qualitative research is primarily descriptive in that it might disclose the intricacies surrounding the phenomenon and also even explain why things happen as they do. In order to suggest guidelines for social work support, which is set out as a goal for the study, the real-life situations of CSOs of a partner with a SUD, and their suggestions for social work support would be described as shared by the participants.

1.4.2.5 The contextual research design

In view of adopting the collective instrumental case study design, I also planned to include the contextual research design as part of the strategy of inquiry. To consider the context is commonplace in qualitative research, according to Hennink et al. (2011:288). In the social sciences the meaning of words, actions and experiences can be ascertained and understood only in relation to the context in which they occur (Terreblance, Durrheim & Painter, 2006:274; Monk et al., 1997:34). According to Ritchie and Lewis (2005:27), the contextual design in qualitative research refers to the detailed description of phenomena as experienced in the sample in their own terms expressed in their own way.

1.5 RESEARCH METHOD

Although related, the concept “method” in the context of research is often confused with “methodology” (Kramer-Kile, 2012:27). This author explains that “research

methods” refers to and describes how the research is executed. Carter and Little (2007:1318) are of the same opinion when elucidating that methods are the “techniques for gathering evidence” or “procedures, tools and techniques” of research. Methods are research in action and pertains to the tasks or activities related to defining the population, the recruitment of participants and methods of recruitment, methods of data collection, analysis and verification (Kaplan in Carter & Little, 2007:1318). Cruz and Tantia (2016:79) hold a similar view when referring to the concept “method” in the context of research relating to how the study is conducted, including how the data has been collected and analysed.

The proposed research methods to be used in this research are presented under the following headings:

- Population, sampling, sampling techniques and participant recruitment
- Preparation for data collection
- Method of data collection
- Pilot-testing the research instruments and the methods of data collection
- Method of data analysis
- Plan for ensuring the trustworthiness of the study and the research findings

1.5.1 Population, sampling, sampling techniques and participant recruitment

In research, the concept “population” refers to all the individuals who have certain characteristics that qualify them for inclusion in the study (Thomas, 2017:141; Hennink et al., 2011:85-87). Dudley (2011:138) describes it as “all of the people of interest to the researcher conducting a study”, or, to quote Guest et al. (2013:42), “the entire group of elements that you would like to study”.

The population of the study decided on for this study consisted of *all CSOs, with specific reference to spouses, partners, and fiancées of partners with a SUD living in the South African province, Gauteng and within this province specific the cities of Pretoria, Randburg and the East Rand*. Time and money considerations led me to focus on these cities within the mentioned province as I work and reside in Pretoria.

As pointed out by Miles et al. (in Punch, 2016:82), “you cannot study everyone, everywhere doing everything”. Consequently, Marshall and Rossman (2016:110) and Babbie (2014:119) recommend that researchers draw a sample from the population. The concept “sample”, refers to a subset of the population, or it can be regarded as individuals chosen from the larger population for inclusion in a particular study (Guest et al., 2013:42; Yin, 2011:99; Grinnell & Unrau, 2008:137).

In qualitative research, the approach to sampling will turn to the non-probability type, as it supports the explorative design and the notion that the findings of a particular study cannot be generalised to the whole population (Dudley, 2011:148; Koerber & McMichael, 2008:467). Comparing the focus of qualitative and quantitative research, Padgett (2008:56) concluded that qualitative research is more focused on flexibility and depth rather than mathematical probability (as in quantitative research). This explains the need for smaller sample sizes characteristic of qualitative research to obtain more in-depth information (Hennink et al., 2011:84). Guest et al. (2013:47) hold a similar view about non-probabilistic sampling relating it to the point that statistical analysis is not the purpose or method of dealing with generated qualitative data nor is it planned with generalisation in mind. Qualitative samples are customarily too small to be subjected to probability theory. On the contrary, through qualitative studies rich, contextually-laden, and explanatory data are sought for the purpose of developing an emergent in-depth understanding that is being investigated from the accounts of information-rich participants providing information on a given topic (Guest et al., 2013:47; Reybold, Lammert & Stribling, 2012:700). Dudley (2011:140) describes non-probability sampling as “sampling in which we do not know if every person in the population has an equal chance of being selected”.

When it comes to participant recruitment in qualitative research, qualitative researchers generally opt for “purposive recruitment” (Hennink et al., 2011:85) with this type of sample selection being regarded as “legendary” in qualitative research (Guest et al., 2013:46; Reybold et al., 2012:700; Abrams, 2010:538). Purposive or purposeful sampling follows a well-defined rationale to fulfil a specific purpose (Yin, 2011:88; Collingridge & Gantt, 2008:391). With purposive sampling the aim is to deliberately select participants by keeping the study’s purpose in mind, who have the

necessary experience, or are “information-rich (Reybold et al., 2012:700; Suri, 2011:65) in providing the “most relevant and plentiful data” on the phenomenon of interest.

To clarify this; when the researchers use purposive sampling, they apply their own judgement and select participants with a particular purpose in mind. This implies that they will be going to the field and look for potential participants who will be in the best position to provide, an information-rich, experience-based, and first-hand perspective on the topic under investigation and invite them intentionally to bring their perspectives into the study (Patton in Reybold et al., 2012:700; Dudley, 2011:145; Abrams, 2010:538; Padgett, 2008; 53; Flick, 2007:27).

I am of the view that purposive sampling is “mind-full” sampling; following the contention of Weis and Willems (2016:227) and Reybold et al. (2012:700) stating, that *who* the participants are is more important than *how* they were chosen. This calls for inclusion criteria to be drawn up in view of assisting with recruiting participants purposively and mind-fully.

In order to select participants for inclusion in this study purposefully, I intended to use the following *inclusion criteria*: The participants had to -

- be CSOs (i.e. spouses/partners/fiancées) of partners with a SUD who had before or who were currently attending support groups or are linked to a drug action committee or treatment facility. Persons excluded from the research are parents, children and/or siblings of a person with a SUD.
- been involved with a partner with the SUD in a committed relationship for a minimum of three years and longer to allow for a time-wise detailed account of their experiences, challenges and coping strategies in relation to living with a partner with a SUD.
- possess a reasonable level of language proficiency in Afrikaans or English, being able to express their experiences in a clear manner, both in writing and conversation.
- be comfortable with the idea of narrative writing, as their involvement in this research will *inter alia* require of them to share their story in terms of their

experiences, coping mechanisms and challenges and coping strategies in relation to living with a partner with a SUD.

- participate out of their own free will.
- inform their partners about their prospective participation and obtain their consent for participating. Only CSOs who had informed their partner with the SUD about their intention to participate in the study and whose partners have not objected to their participation were included. This criterion was decided on to avoid any negative impact or harm from the partner with a SUD should he or she feels threatened or annoyed by the CSOs' participation in the study.

When shifting the focus to the aspect of how many participants should be recruited or the sample size, the qualitative researcher should be less concerned with the number of participants, but more concerned with whether a detailed understanding of a phenomenon was obtained “to indent socially constructed meanings of the phenomenon and the context in which it occurs” (Hennink et al., 2011:84). In essence is boils down to the fact if the research questions were sufficiently answered (O'Reilly & Parker, 2012:190). The emphasis should therefore be less on sample size and more on sample competence when demonstrating that “saturation” has been reached. Saturation or “data saturation” refers to the point where the data being collected start to repeat itself (Hennink et al., 2011:88; O'Reilly & Parker, 2012:192). In the final analysis this principle of data saturation will determine the sample size.

In order to *identify and select participants* I intended to reach out to treatment centres and support groups for persons with SUDs and their CSOs in Pretoria and surrounding areas as well Randburg and the East Rand. (The choice for this geographical area was indicated and motivated earlier). The persons I would be referred to after contacting these organisations would be informed about the research and can become gatekeepers⁴ through which I would be able to select

⁴ A gatekeeper refers to someone who controls access to the research field (Flick, 2007:117). A gatekeeper is seen as person who holds a prominent and recognized role in a community and who can play a facilitative role by encouraging members of a community to participate in a research project (Maxwell, 2013: 90; Hennink et al., 2012:93).

suitable participants for the research. It is pointed out by Abrams (2010:542) that researchers have to set aside time to build relationships with gatekeepers in order to obtain access to a population of interest.

The Director at Mighty Wings Life Centre (MWLC) was selected as starting point en route to participant recruitment. I intended to obtain permission from the Director of MWLC who would serve as gatekeeper, as one of the proposed sites for my research. I have a long-term relationship with the organisation MWLC in an advisory capacity about policy matters to the board as well as conducting intake assessments and consultations with new persons joining the programme. The administration for all three of their branches is centralised in Benoni. The centre takes in an average of 20 new clients on a monthly basis and supporting family members in the three branches on a monthly basis. The plan was that once permission for me to conduct the research at this centre had obtained from the Director or Board of MWLC, the intake officer would notify and update me of all new admissions at the various branches. When approximately 25 new people had registered, I would visit each branch and, during the orientation meetings with the new intakes of CSOs (the spouses, partners or fiancées) on the programme, introduce the research project, inviting the newcomers who are interested in participating in this project to meet with him at the end of the meeting.

On arrival at the group meeting, my intention was to welcome all the recruited participants. Once everyone is present, I planned to introduce myself, explain the purpose of the research, and engage in an open discussion about the need and prospects for assisting partners living with a person with substance use disorder. Following the discussion the group would be asked about how they would feel about participating in this research project, given the inclusion criteria for the research.

Once partners who met the criteria had volunteered their involvement, arrangements would be made to provide and discuss the invitation letters (Addendum A) and consent form (Addendum B). At this contact the following information would also be passed on: Information on -

- proposed methods of data collection; obtaining their biographical information; the process of writing a personal narrative focusing specifically on their lived-experiences, challenges and coping strategies in relation to being a CSO living with a person with a SUD; the in-depth interviewing process and the topics, expressed as questions, to be covered (Addendum D);
- logistics surrounding the activities of data collection in terms of the when, where, and the duration, as well as, the locations where it will take place, and
- ethical considerations to be observed during this research project, including the rights and privileges of the participants.

1.5.2 Preparation for data collection

Under the previous sub-heading, paragraph 1.5.1 of this Chapter, I explained how I intended to recruit participants for inclusion in the study. Guest, et al. (2013:67) state that recruiting methods are related to sampling strategies and note that the individuals recruited (as proposed in this study in a purposeful manner) must be screened for eligibility and according to a stated inclusion criteria. (The inclusion criteria were also included in the previous section). Similarly, they must be informed about what the study entails, what their participation will entail, how they will be protected, and what their rights and privileges are. To sum up, the activity of recruitment can be seen as the method used to obtain a desired sample, but also to inform prospective participants about the method of data collection and what it would entail. Mikėnė, Gaižauskaitė and Valavičienė (2013:52) underscore the point that, although the participants have been informed about the study and the logistics involved in participating in a research project during the pursuit of participant recruitment, the recruited participants need to be adequately prepared for the research activity of data collection.

I endeavoured to prepare the recruited participants for the processes of data collection at the MWLC support group meetings for CSOs. The CSOs of partners with SUDs meet twice per week where they usually obtain information on various SUDs as well as get an opportunity to share their experiences of living with a person with a SUD.

The individuals after expressing a willingness to participate in this study would have been informed about the process of data collection that would be followed in the study. Upon checking their eligibility for participation, and them consenting to do so, the now recruited participants would on a one-one basis be comprehensively orientated and prepared for data collection by informing them that -

- They would be requested to write the story of how it is for them to live with a partner with a SUD by sharing their experiences, coping strategies and challenges in this regard. The writing down of their experiences would be done individually in my presence, or if they preferred, at their home at an appropriate time and opportunity. When writing at home they would be requested to forward the document electronically to me for further scrutiny.
- The stories which they had written and presented to me would be read by me in view of preparing for an interview to be conducted with them individually. At this interview information shared by them in their written stories would be clarified and further explored.
- They would be requested to grant me a further interview in which they will be asked for suggestions on how they as CSOs living with a partner with a SUD would like to be supported by social workers in view of ultimately developing guidelines for social work intervention aimed at this client-system group.

Following the explanation provided above with regard to preparing the participants for involvement in this study, they would be requested to once more confirm their willingness to participate in this research project by signing and returning the consent forms (Addendum B) for both themselves and their substance abusing partners. An opportunity will be provided for them to ask questions to clear any uncertainties.

1.5.3 Method of data collection

In view of collecting data from the participants, I proposed to use *a written exercise and individual in-depth interviews*. Both these methods of data collection fit within the qualitative approach. Moen (2006:6) notes that, for the purpose of the research dialogue, interviews and interview transcripts, and letter writing can be employed. Roberts (2003:147) adds to this and refers to written narratives as “an account by an

individual of their life in written form” when the personal narratives create and describe memories that reveal both actual and collective meaning (Gaydos 2004:195).

Instead of responding verbally to open-ended questions put to them, participants would be given an instruction on a written exercise inviting them to write down any information relating to the experiences and challenges they have or have had in living with a partner with a SUD and the coping strategies they employed to navigate through the challenges they experienced. Allowing participants the opportunity to share their story experienced related to a specific phenomenon has the prospect of assisting them to chronologically ordering the meaning of those experiences (Schwandt, 2001:168; Creswell, Hanson, Clark, Plano & Morales, 2007:240). Payne (2006:79) acknowledges that such stories may be selective and partial and strongly influenced by socio-cultural norms and circumstances. It is for these stated reasons that a follow-up in-depth face-to-face interview was suggested. Each participant and I would meet on an agreed date at a prearranged venue for a follow-up in-depth interview where the information shared in their respective stories would be revisited, explored and further clarified to try and fit the missing pieces in the apparent story puzzle.

A second individual in-depth interview was planned with the aim to focus mainly on obtaining suggestions from the CSOs about how, and with what they would like social workers to support them, considering their circumstances of living with the partner with a SUD.

In explaining the meaning of the concept “in-depth interview”, Hennink et al., (2011:109) write, “an in-depth interview is a one-on-one method of data collection that involves the interviewer and interviewee discussing specific topics in depth.” Another scholar regards it as a “conversation with a purpose” and “a shared journey” (Donalek, 2005:124). Guest et al. (2013:113) encapsulate the following as distinctive features of in-depth interviews: they are conducted one-on-one; utilise open-ended questions; use inductive probing to get to the depth of the matter being explored; and make it look and feel like a conversation. An interview-guide containing semi-

structured and unstructured questions could be used to facilitate an in-depth interview. In explaining the concept “interview-guide”, King and Horrocks (2010:35) write an interview-guide “...outlines the main topics the researcher would like to cover but is flexible regarding the phrasing of the questions and the order in which they are asked, and allows the participant to lead the interaction in unanticipated directions”. The interview-guide can be seen as recall for steering the interviewing process (Wahyuni, 2012:74; Hennink et al., 2011:12).

Now that the proposed main steps of data collection have been introduced, I will focus on a discussion of how the actual process of data collection was envisaged. After all the participants had been recruited and had consented to participate in the research project, their biographical information would be obtained (Addendum D) in their first individual face-to-face contact meeting. The purpose of this information would be to assist me to place the participant’s responses, and portrayed circumstances in context. The biographical information to be obtained would include the following information: their age, gender, time in a relationship with their partner with a SUD, whether if they have children or not, their educational qualifications, whether they are employed, their religion, whether they have used/abused drugs themselves or not and if they have gone for help themselves or the partners SUD.

- *The narrative writing exercise*

After obtaining the biographical information, the participants would be requested to write the “story” about living with a partner with a SUD. The following instruction would be given: *“Write your story detailing your experiences on how it is (was) for you to live with your partner addicted to a substance. Elaborate on the feelings and challenges you experienced and what you did/you do to cope living with a partner addicted to a substance.”* No time limit or further guidelines would be given to allow them to write their reactions spontaneously. As there were no limitations venue-wise the participants were free to write at any place where they felt safe to do so. These written narratives would be analysed as described under the sub-heading “method of data analysis” presented further on in this Chapter.

Having received the written story, and whilst analysing it I would make notes on aspects that I wanted to explore further and then discuss with the participants in the next interview.

- *The in-depth interviews*

The first in-depth interview, as stated, would be dedicated to “completing” the story written by the participants. The following were the logistics and protocol I planned for this purpose:

- Once I had analysed the participants’ stories and made notes on aspects to explore further, I planned to set up an appointment for the next interview with each of them individually choosing a convenient date and time.
- Before discussing the content of the written stories, participants would be requested to reflect on their experience of writing; *“What was it like for you to sit down, think through and write your experiences as instructed?”* This request would not only serve as an introduction to the discussion by reflecting on the exercise and linking it to their stories but would also give an opportunity to debrief the participants before going into the detail of their stories shared in writing. I remained cognisant of the fact that CSOs constitute a vulnerable population. Hence guarding against not turning this interview into a therapeutic session whilst interrogating their written narratives was important. In advance I also arranged for a counselling service to be available should a need for it arise during the session.
- Following the activity of reflecting with the respective participants on their experiences around the writing exercise, I plan to proceed by focusing on the issues and themes deduced by me from the analysis of their narratives, and the notes I had made. These aspects would be presented to them and discussed by way of further exploration, clarification and elaboration. The participant and I would therefore become “co-enquirers” in the process of interrogating, and making meaning of their circumstances. Since the envisaged aim with this first interview was to explore the content of the written narratives and thematic focal areas, no interview-guide with open-ended questions would be drafted; explorative probes would rather be formulated as

the co-enquiry unfolds. However, I envisaged the following themes to be further explored: the participant's experiences; ways in which they coped and managed their lives, and the challenges encountered in living with a partner with a SUD.

In the second in-depth interview the plan was to get suggestions from the CSO-participants living with a partner with a SUD on the kind of support they would like to get from social workers and how it should be offered. To focus on this, I planned to put the following question to them: *“Against the background of the experiences and challenges shared in the previous session, how would you suggest social workers can support you, and persons in similar situations like you in relation to living with a partner with a SUD?”*

My aim was to further explore each suggestion forwarded by them. I planned to request them, where I deemed it necessary, to further elaborate on how the suggestions shared should be operationalised.

Interviewing techniques form a vital part of the research. Referring to the in-depth interview, Hennink et al. (2011:109) described the interview as a specific method used between the researcher and participant to collect data. This method enables the researcher to obtain information from individuals on a specific topic and makes up the “cornerstone of success for the vast majority of qualitative studies” (Padgett, 2008:99). The research planned on employing the following *interviewing techniques*:

- *Collaboration*: Suzuki (in Yeh & Inman, 2007:382) describes collaboration as a relationship between researcher and community that maintains the integrity and humanity of the members of that particular group. For Heppner et al. (in Yeh & Inman, 2007:382), the purpose of this collaboration is to gain a more accurate understanding of relevant and meaningful experiences. This is directly related the aim of the study, namely to develop an in-depth understanding of the participants experience, challenges and coping strategies in relation to living with a partner with a SUD.
- *Observation*: Hennink et al. (2011:170) describe observation as a method of research by which people's behaviour; actions and interactions are observed

and recorded. This includes watching, listening, and asking questions during interviews. As in-depth interviews make up part of this study to explore experiences of participants that can arouse strong emotions, observing both verbal and non-verbal information would be required to come to an in-depth understanding of their realities.

- *Paraphrasing*: Coyle and Wright (1996:435) equate paraphrasing to restating what a participant has said to verify that the researcher conducting the interview has understood correctly what the participant has conveyed.
- *Probing*: Padgett (2008:106) emphasises that probing contributes to the spontaneity and flexibility of the interview. She adds that the preparation of the interview-guide in terms of the wording, sequencing, and the phasing in of the questions and statements is vital for a successful research interview. In this study probing would be employed by way of asking clarifying questions and requesting for further elaboration and exploration on information shared by the participants.

1.5.4 Pilot-testing the research instruments and the methods of data collection

Conducting a pilot study prior to engaging in the actual process of data collection allows the researcher to do a trial run before the actual study is undertaken to refine, amongst other things, the method of data collection and data collection instruments (Grove et al., 2013:703). Kim (2010:191) and Gilham (in Sampson, 2004:385) hold a similar view and further elaborates by referring to the pilot study as a small scale “feasibility study”, preceding the actual planned research, undertaken in order to answer or refine methodological questions and to guide the development of the research plan. It allows the researcher to adjust or revise any or all activities of collecting data, recruiting participants or applying data collection instruments and to address any emerging gaps. In addition, a pilot study also allow the researchers to assess themselves to confirm their readiness and ability to undertake a qualitative research endeavour (Beebe & Lancaster in Kim, 2010:191).

Considering the above, Kim (2010:191) refers to the trial run as “a ‘small scale’ version” of the planned study. She argues that, “it is often only when the data is evaluated that any gaps in a research design begin to show up” (Kim, 2010:199). In conducting a pilot study, the researcher has to adhere to a number of ethical principles as highlighted by Yin (2011:37) and Teijlingen and Hundley (in Kim, 2010:192). They are:

- Researchers are ethically obliged to convey methodological and related issues that emerge from pilot studies in order to further develop and construct scientific knowledge.
- Participants have to be informed that they are in fact involved in a pilot test and not the actual research.
- Pilot studies, by their nature of being a test or trial run, may not be utilised to produce results and therefore, according to Watson, Atkinson and Rose (2007:619) they are “not usually suitable for publication”.

Based on the various authors’ opinions and suggestions about the pilot study in this discussion, I planned a pilot study to establish how long it would take to compile the narrative writing exercise and how long the subsequent interviews would take as well as the time to complete the data collection process.

One of the volunteers who is a CSO of a partner with a SUD would be requested to participate in the trial run at the MWLC facility in Rooihuiskraal, as prearranged. This person’s role would have been clarified as such at the outset and engage in all the activities related to data collection planned for the participants in the main study. After completing the full round of tasks, this participant would be requested to critically reflect on the data collection process and the instruments used and suggest changes to the procedure should there be another opportunity to participate.

1.5.5 Method of data analysis

In both quantitative and qualitative research, the collection of data and the specific forms of analysis allow for a variety of options. This is confirmed by Nicholls (2009:643) when he states that, “every different methodology has its own

prescriptions for how data analysis should be undertaken". Data analysis in qualitative research for Lincoln (in Reybold et al., 2012:700) is "piecing together and editing of parts into a whole with its own meaning and significance."

In qualitative research, the researcher must administer and manage all data in a systematic, objective and constructive manner (Young, 2016:336; Carcary, 2009:21; Mahtani, 2004:68). Yeh and Inman (2009:398) as well as Padgett (2008:131) advise that data obtained through the qualitative research approach be reduced and transformed through an iterative process of reading and labelled to make it meaningful. Padgett (2008:131) points out that the researcher needs to find a balance between staying close to the data and thinking abstractly as this is a defining feature of qualitative analysis. In the context of qualitative research, the aim of data analysis, according to Kim (2010:200), boils down to translating "the lived experience of participants into a researcher's language in the name of enhancing understanding, generating knowledge and advocating for the participants".

In analysing the data obtained in this research, the eight steps proposed by Tesch (as cited by Creswell, 2014:198) were decided on for this study. The steps would be applied as follows:

- The first step would involve me reading all the written narratives and transcriptions of the interviews conducted with the participants. Thoughts and ideas that emerged from reading the transcripts would be noted.
- I would select one document, a written story, and one transcribed interview and attentively engage with it to uncover underlying themes. The identified themes would be noted down.
- Tesch suggests, as a third step, the identification of topics by engaging with the whole data set.
- Step four entails allocating an abbreviation and finding descriptive words for each of the identified topics. I planned to follow this step and then return with the list of topics and their accompanying abbreviations to the data sets and include the abbreviations next to the segments of data corresponding with the respective topics.

- A final decision would be made about the wording of each topic and, where necessary, adjust them before ultimately adopting them as themes.
- Similarly, the themes with their allocated abbreviations would be arranged in alphabetical order. This is done to ease the process of recoding, should this be required.
- The data belonging under each theme would be assembled and a preliminary analysis done.
- Should no recoding be required the research findings would be documented in the third and fourth chapters of this thesis.

1.5.6 Plan for ensuring the trustworthiness of the study and the research findings

In qualitative research the primary focus of studies concern interpreting and describing the subjective meaning of experiences of participants (Popay, Rogers & Williams in Fossey, Harvey, McDermott & Davidson, 2002:723). Qualitative research methodologies therefore aim to develop understanding by marrying both rigour and subjectivity in a creative and a scientific fashion with such a union complicating certain aspects of verification of data for research purposes (Johnson in Whittemore, Chase & Mandle, 2001:522).

The concept “data verification” is explained by Morse, Barrett, Mayan, Olson and Spiers (2002:17) as “the process of checking, confirming, making sure, and being certain. In qualitative research, verification refers to the mechanisms used during the process of research to incrementally contribute to the rigour of a study. These mechanisms are woven into every step of the inquiry to construct a solid product”. Data verification refers to the trustworthiness of research. Shenton (2004:63) acknowledges that the trustworthiness of qualitative research has, historically, been a concern for many critics. O’Reilly and Parker (2012:190) hold a similar view when stating that, “Measuring quality in qualitative research is a contentious issue with diverse opinions and various frameworks available within the evidence base”. Lee (2014:316) elaborates when stating that there is little agreement on the logic of qualitative research, given the diversity of theoretical approaches and various

research methods and divides the assessors of qualitative research into three groups. There are those who believe there is nothing unique about qualitative research and that the same criteria should apply for verifying quantitative research data. However, there are those at the other extreme who believe that these criteria are inappropriate. Then the group in the middle of these two groups have the opinion that qualitative research operates according to a different epistemological paradigm claiming that a study's trustworthiness should be ensured and appraised through alternative standards (Lee, 2014:317).

Authors, Freeman, de Marrais, Preissle, Roulston and St. Pierre (2007:25) support the last group's approach when they describe qualitative research as "open and flexible" and argue that including various philosophies, theories, research designs and methods is actually one of its strengths. They point out that researchers have always discussed how to evaluate their science, the quality of their analysis and the theoretical interpretations of their data. The differences in determining the validity of a study between diverse groups of researchers, however, is in the terms used to describe it. These are many and diverse factors like validity, reliability and rigour; and so-called parallel terms such as trustworthiness, credibility and transferability. Whittemore et al. (2001:527) cite Guba and Lincoln and add to the list of validity criteria the concepts of truth value, authenticity and goodness.

For the purpose of this study, in line with other authors on the subject of validity in qualitative research (Lietz & Zayas, 2010; Padgett, 2008; Shenton, 2004) referring to the classical work of Lincoln and Guba in this regard, I planned to follow Guba's model of trustworthiness in qualitative research as described in Krefting (1991:214-222). As indicated by Krefting (1991:214), Guba describes four general criteria to assess research, namely *credibility*, *transferability*, *dependability* and *confirmability*, defining them from a qualitative research approach. I planned to only refer to the criteria that apply to qualitative research.

- **Credibility:** Qualitative research needs to meet the criteria for credibility to pass the test of trustworthiness (Lietz & Zayas, 2010:191). A study is credible or trustworthy if it reports the meanings related by the participants correctly, offering

findings that are credible and corresponding with reality (Silverman, 2013:285; Tracy, 2010:842; Freeman et al., 2007:26; Shenton, 2004:64; Sandelowski in Krefting, 1991:216). Guba (in Krefting, 1991:217-220) proposes various strategies to enhance a study's credibility. The ones I proposed to adopt for this study will be briefly introduced:

- *Prolonged and varied field experience*: This strategy, according to Lincoln and Guba (in Krefting, 1991:127) of spending time with participants exposes the researcher to various perspectives while allowing the participants to become more familiar with the researcher. During this time, the participants build a relationship with and trust in the researcher which increases the possibility of yielding more information than they would have in the beginning (Krefting, 1991:128). As pointed out by Tracy (2010:843), spending time "in the field" enables the researcher to become familiar with different peculiarities while exploring data beneath the surface enabling the presentation of "thick descriptions" [discussed later] (Lietz & Zayas, 2010:194). Prolonged engagement in the field, as suggested by Shenton (2004:64), can begin when the researcher becomes familiar with participating organisations before engaging in the data collection process. In this research I planned to approach different treatment facilities and support groups that provide assistance to persons with a SUD and include CSOs to negotiate entry for research purposes. As I aim to engage participants in a minimum of three contacts, I should be able to achieve this goal of maintaining this level of prolonged engagement.
- *Reflexivity (keeping a field journal)*: Reflexivity refers to assessing the influence a researcher's background, perceptions and interests have on a qualitative research process in progress (Freeman et al., 2007:27; Ruby in Krefting, 1991:219). Prolonged involvement with participants could result in more in-depth data, Care should also be taken that the relationship between researcher and participant does not affect the researcher's ability to interpret the findings (Krefting, 1991:219). The researcher's role in the research endeavour and relationship with participants needs to continually and critically be reflected upon. Holding a field journal in which the researcher openly

documents overt and covert influences in and on the research and actions to minimise this (Shenton, 2004:68). This relates to bracketing, a method used to decrease the potential impact of unrecognised prejudices related to the research (Tufford & Newman, 2010:81). Researchers apply bracketing when writing their notes in a journal reflecting on their impact during the processes of data collection and analysis process (Tufford & Newman, 2010:86). Tracy (2010:483) encourages researchers to be honest and transparent in their reflections. Their involvement must not affect the research nor must the research affect them in return. As pointed out by Young (2016:333), reflexivity is strongly linked to structural coherence (discussed further on) in that the way researchers are reflexive on the research must be aligned to their theoretical framework. During the research process I would be alert to various factors which might influence the study and keep a record of my feelings, interpretations, decisions and reactions on an ongoing basis.

- *Thick descriptions*: To achieve credibility, thick descriptions of the research methodology are to be employed, information-rich data and obtaining significant meaning or detail from participants regarding a specific phenomenon are extremely important. Ultimately the researcher has to account for the contextual complexity of collected data that enhances understanding phenomena (Geertz in Tracy, 2010:843). In this study thick data would be obtained from the participants through written narratives that are further explored and described via in-depth interviews. Guba and Lincoln (in Lietz & Zayas, 2010:194) point out that employing multiple data sources ensures thick descriptions.
- *Triangulation* is another strategy for enhancing a study's credibility. This strategy, according to Cruz and Tania (2016:87) and Shenton (2004:65), refers to the use of different methods of data collection, like observation, focus groups, interviews and different data sources, such as participants from other different settings (Thomas, 2017:153; Shenton, 2004:66). In both these cases, different sets of data obtained from the same group of participants, and the same data obtained from participants in different settings, contributed to

greater credibility. This researcher envisaged this study's credibility coming from both different data methods and different data sources.

- *Peer examination:* Feedback on the research in terms of questions or observations by peers, including colleagues in the field or academics can assist the researcher to refine the research methods, thereby strengthening the arguments and input into the research (Shenton, 2004:67), especially feedback from colleagues experienced in the qualitative research methodology (Lietz & Zayas, 2010:196; Krefting, 1991:219). I would be consulting regularly with my supervisor during the course of the research process.
- *Interview technique:* As indicated by Roulston (2010:200) the qualitative interview is the most commonly used data source she encountered and it is therefore imperative that the quality of such interviews are scrutinised. This confirms the statement by Krefting (1991:220) that the interviewing process can improve the credibility of a study, especially when there is consistent reasoning about the same topic in the same interview. This would, amongst others, be realised by using the same instructions for all participants about the written narrative. Similar themes and probing questions would be used in the subsequent in-depth interview. Tracey (2010:844) uses “crystallisation” as another strategy to supplement the process towards obtaining the credibility of the written narrative by adding an in-depth interview to further explore and clarify certain specific aspects mentioned in the written narratives.
- *Authority of researcher:* In qualitative research the researcher is viewed as an instrument for collecting data (Creswell, 2014:185-186; Streubert, Speziale & Carpenter, 2007:21; Mahtani 2004:55; Krefting, 1991:221). As pointed out by Freeman et al. (2007:27), data is always influenced by both the researcher and participant subjectivity as background, theory and culture as well as perceptions and prospects of the research affect the analysis differently. Also crucial is the experience, the role and sense of responsibility the researcher takes. (Thomas, 2017:148; Padgett in Lietz & Zayas, 2010:192).

As far as the authority of the research is concerned four characteristics come into play to enhance a study's trustworthiness (Miles & Huberman in Krefting, 1991:220), namely: the researcher's level of expertise with the research topic; the ability to comprehend substantial amounts of qualitative data; seeing the research question from different theoretical perspectives (something I intend to implement); and experience and skill in qualitative research methodology. My ongoing involvement in the field of SUDs in various settings over many years gives me insight into the plight of both persons with a SUD, and the CSOs to be able to contextualise their feedback against different theories and perspective adopted as theoretical frameworks for this study.

- *Structural coherence*: This refers to the fact that there are no unexplained inconsistencies and, if they do exist, being able to indicate why the discrepancies do. The researcher can enhance structural coherence once all the collected data is captured in the research report in presented in a logical and holistic manner (Krefting, 1991:220). In aiming for structural coherence, I vouched to take care in how the data is collected, transcribed, analysed and the presenting the findings in an orderly, meaningful and scientific manner.
- *Referential adequacy*: This criterion refers to the record of any additional training of the researcher that related to the study and would improve their skill and application of its applied research methodology (Krefting, 1991:220). The researcher would keep record of the different workshops attended to gain knowledge and skills in the field of qualitative research (see Addendum I).
- **Transferability** can be defined as the degree to which research findings relate to theory, practice and future research (Lincoln & Guba, in Lietz & Zayas, 2010:195; Krefting, 1991:220). Transferability can be linked to how meaningful or relevant the findings are to contexts "outside" of the study or applied to the "wider population" (Tracy, 2010:846; Shenton, 2004:69). Where the findings resonate with a wider audience that was not part of the study or in a corresponding and confirmatory fashion verified by existing literature, it can be regarded as transferable. Although, it must be noted that it is not the aim of the researcher to

conduct a transferability audit, but for the readers of the report to do so. The researcher merely needs to provide the “tools” enabling the readers to do a transferability audit (Lincoln & Guba in Krefting, 1991:221). These tools include the following:

- Raw data in the form of field notes and audio or video recordings
 - Data reduction and analysis material such as summarised notes
 - Data reconstruction and synthesis material as themes and categories
 - Process notes on the procedures and strategies followed
 - A field journal
 - Instrument development information, for example, the pilot study.
-
- **Dependability** is referred to by Elo, Kaarjainen, Kanste, Polkki, Utrianen and Kyrgas (2014:2) as “the stability of data over time and under different circumstances”, and described by Krefting citing Guba (1991:221) it relates to the consistency of the outcomes of the research. Dependability is addressed when the researcher comprehensively reports the processes of the study in detail, with reference to the context of the research, participant recruiting, collecting and analysing data, enabling future researchers to repeat the work of to conduct a dependability audit (Nicholls 2009:645; Shenton 2004:71). I planned to keep a systematic and detailed record of all the processes followed during the research procedure to provide an audit trail that would allow for this study to be repeated. In addition, I planned to employ the services of an independent coder to analyse the data set independently and afterwards to engage in a consensus discussion about the themes derived.

 - **Confirmability**, according to Lietz and Zayas (2010:197) and Nicholls (2009:645), refers to the possibility of similar results being obtained when the study is duplicated. In Shenton’s view (2004:72) confirmability is the researcher’s responsibility to be transparent. Tracy (2010:483) sees transparency as a reflection of the researcher’s honesty in the research process captured in an audit trail (Carcary, 2009:15). Assisting me in this regard would be the keeping of a reflective journal (see Addendum K). This would serve as testimony in the recognition and acknowledgement of my beliefs, assumptions and shortcomings,

as well as my determinacy to accurately report the participants' voices and realities. In addition, I intended, in line with the recommendation of Cruz and Tania (2016:88), to clarify any personal bias as hand deliver proof of reflexivity during the research process.

1.6 ETHICAL CONSIDERATIONS

Ethics are commonly associated with morality (Rubin & Babbie, 2007:37) and within the ambit of social research, it refers to establishing standards for prescribed conduct for researchers involved in a particular study (Homan in McLaughlin, 2012:47). In explaining the nature of the concept "ethics" in a research context, Schnell and Heinritz (in Flick, 2015:32) write: "Research ethics addresses the question of which ethically relevant issues caused by the intervention of researchers can be expected to impact on the people with or about whom they research. It is concerned in addition with the steps taken to protect those who participate in the research, if this is necessary". According to Hennink et al. (2011:63) the following are regarded as universal fundamental ethical principles:

- Showing respect for people, prioritising and placing their well-being first, treating them with courtesy; informing them comprehensively about what their research and their participation entails (inclusive of any foreseeable risks and/or benefits) and not coercing them to participate.
- Obtaining maximum benefit for the target population and minimising all risk to participants.
- Being just, fair, considerate and not exploitive.

For King and Horrocks (2010:104), ethics is also related to administrative aspects of the research. Included in administrative tasks is not only conducting themselves in an ethical fashion but also in how they prepare questions forming part of the interview-guide; the preparation for and conducting of the interviews; the transcription; the analysis and management of the data; the compilation of the research report; and the presentation of the findings. Jones (2009:114) adds as tenets of ethical conduct being conscientious, meeting commitments; keeping promises; holding oneself accountable for meeting objectives; and being organised.

To sum up: ethics relates to the standards of human conduct. It calls for moral consciousness, reflexivity and accountability on the part of the researcher throughout the research process concerning decisions taken and the research related activities executed (Maxwell, 2013:7; Edwards & Mauthner in King & Horrocks, 2010:104-105).

Against these introductory remarks the researcher presents the considerations adopted for this research endeavour below. It relates to obtaining informed consent from the participant; confidentiality and anonymity, minimising harm and debriefing, as well as management of information.

1.6.1 Obtaining informed consent

In introducing the aspect of obtaining informed consent from individuals to participate in any social research project, Rubin and Babbie (2007:37) highlight that such a project “...signals the beginning of an activity that the [participant] has not requested and which may require a significant portion of their time and energy.” In addition, and even more so with qualitative research, it is expected of them to reveal personal information which is disclosed to so-called strangers (Rubin & Babbie, 2007:38). As social research is dependent on the cooperation of an individual or a group of participants, their consent to participate has to be obtained.

Consent for participating in a research project is described by Thomas (2017:47) as an agreement between a researcher and a person who freely gives permission to participate. In view of such an agreement, participants have to be informed in detail about the agreement they are entering into. They have to be made fully aware of what is expected; the format; the process the research will follow, including multimedia support for example, making audio-recordings. How information will be handled, and what exactly is required of them during the research process and its likely duration. In addition, an honest and full disclosure of the identity of the researcher and sponsoring institution must be provided; the purpose of the research disclosed; and the nature of the participant involvement requirements, their rights and privileges, as well as any risks or benefits associated with participation must be

revealed (Thomas, 2017:46; Hennink et al., 2011:63; Creswell, 2009:89; Padgett 2008:65).

Once the participant understands this and is assured of anonymity, an informed consent document agreement is discussed. The participant has to be formally and specifically invited to participate and voluntarily sign consent to this effect. Giving informed consent and doing so voluntarily takes place before the actual research commences. Depending on the topic and type of research, there might also have to be affirmed agreement for a possible extension of time to complete the research process so that this informed consent agreement should be regarded as ongoing commitment (King & Horrocks, 2010:115; South Africa, 'Ethics in Health Research: Principles, Processes and Structures', 2015:17). Participants will, furthermore, be informed that they may refuse participation or withdraw at any stage and will in no way be compromised when doing so (Silverman, 2013:166; Rubin & Babbie, 2007:38).

Prospective participants would be identified by gatekeepers or the researcher visiting treatment facilities for SUDs or support groups for CSOs. Once prospective candidates volunteered their participation and meet the inclusion criteria, I will introduce myself and then inform them about the motivation for and purpose of the research as well as what would be expected of them as participants. When they had indicated their willingness to participate, they would receive a written invitation letter to participate (Addendum A) which again introduces me as researcher, explains the purpose of the research, and indicates their role, and the ethical considerations which will be adhered to. They would furthermore, be given permission to question the content of the letter if they feel it is unclear and they would also be allowed to withdraw from the study at any stage, without penalty, should they feel the need to do so. Once they are satisfied with all the above, they will be requested to sign a consent form (Addendum B).

At the point where consent from participants are requested the researcher should be clear whether he chooses to obtain "opting-in" or "implied" consent (Thomas, 2017:47). With opting-in consent the prospective participant actively chooses to

participate in the research and gives written consent, while with implied consent, the researcher assumes participation unless indicated otherwise. For this study which includes a vulnerable population, the researcher would feel obliged to follow the opting-in consent as it would provide better protection for both researcher and participant.

King and Horrocks (2010:115) remind researchers that obtaining consent is not a once-off activity but ongoing throughout the research process, leaving the participant with an option to withdraw at any stage. The action of making the choice to withdraw without any negative consequence or continue with their participation is referred to by Hennink et al. (2011:63) as “self-determination”.

It is suggested by Hennink et al. (2011:67) and Creswell (2009:90) that it is “good protocol” to reach inform organisations that the researcher aims to approach as research sites and to act as gatekeepers by providing entry to these sites and access to potential participants about the research and to obtain their goodwill. Basically, the same information would be provided as would be the case with prospective participants. This becomes necessary as the researcher should obtain cooperation from the gatekeepers whose approval and consent is necessary to carry out the study (Padgett, 2008:66). By the same measure, Hennink et al., (2011:68) draws attention to the fact that the researcher verifies that participants have not in any way been coerced by gatekeepers to participate by obtaining the informed consent from participants personally.

In this study, permission would be requested and obtained from the Board of Mighty Wings Life Centre (Addendum C).

1.6.2 Anonymity and confidentiality

Anonymity (also described as privacy) and confidentiality are directly linked to respect for participants (South Africa, ‘Ethics in Health Research: Principles, Processes and Structures’, 2015:17). It not only is a reflection of respect of the researcher for the participants, but, according to Babbie and Mouton (2001:523), it

embraces protecting the well-being and identity of participants, something which is of utmost importance in the research process. As claimed by Silverman (2013:162) it is the researcher's responsibility to ensure that both the research data and the sources from where it was obtained remain confidential. Although these two concepts are related and are generally grouped together, it is important to distinguish between them (King & Horrocks, 2010:117).

Anonymity reflects the protection of the identity of the participant and refers to the situation where the research cannot be linked to participants, nor from all documents resulting from the research (Hennink et al., 2011:71; King & Horrocks, 2010:117; Rubin & Babbie, 2007:40). However, in qualitative research full anonymity cannot be ensured as the participants will be known to the researcher because of the methods of data collection used (Hennink, et al., 2011:71; Padgett, 2008:65; Rubin & Babbie, 2007:40). However, Thomas (2017:45) suggests that the researcher can anonymise the identities of the participant by providing them with pseudonyms or codes and/or names changes of organisations/places they come from.

As far as *confidentiality* is concerned, the researcher must assure the participants that information obtained during data collection will be managed in a confidential manner as to not reveal their identity. No information emerging from the research should be able to be traced back to them to identify them as it may lead to embarrassment, harm and even endanger them while they were participating in the research (Rubin and Babbie, 2007:39). For this reason, the researcher must make an effort to ensure that the identities of participants cannot be exposed or connected to the research. Including written narratives in this research complicates both anonymity and confidentiality even further as it contains the life stories of participants which could possibly be identified by outsiders.

Anonymity and confidentiality in this research is also important as the information obtained from the partners of persons with SUDs may, by implication, reflect on the substance abusers as well, even though the information gathered provides a better understanding of the CSO. Specific care will be taken when biographical data is collected that no link can be made to participants. They would be provided with

pseudonyms. The management of information will be done in such a way that no inference can be made to identify the participants.

1.6.3 Minimising harm and debriefing

Collecting data for research purposes may bring risk of harm with it, especially when vulnerable groups are involved. It is difficult to anticipate and plan for what is harmful in the process of obtaining information (Creswell, 2009:91). However, what can be labelled as “harmful” in the context of social research is clearly spelled out in the research literature consulted. According to Hennink et al. (2011:67) and Rubin and Babbie (2007:39) harm can be experienced emotionally or psychologically resulting in feelings of shame or embarrassment. Reliving the past or evoking current painful emotions, enduring a sense of trauma or rejection are common consequences too, especially when a topic is sensitive and the population deemed vulnerable (Dempsey, Dowling, Larkin & Murphy, 2016:485). It is advisable not to include any person who is likely to face unnecessary threat of harm as a participant, even if they represent the target population well and would make a beneficial contribution to the research project being undertaken. (South Africa, ‘Ethics in Health Research: Principles, Processes and Structures’, 2015:16).

The process of data collection should never leave the participants in a worse off situation, psychologically or otherwise, than they were before, nor should the researcher fail to allow for adequate debriefing opportunities after every contact time with participants (Padgett, 2008:69; Rubin & Babbie, 2007:38). Debriefing is the activity of dealing with emotions as they came up during the interview. Hennink et al. (2011:75) indicate four options for debriefing: first, being done by the researcher; second, another professional (like a social worker); third, a lay person attached to the organisation responsible for administering the treatment; and fourth, an external professional person. The onus lies with both the participant and the researcher for the debriefing procedures. Requesting emotional assistance comes for the participant who has to be transparent about their feelings, and the researcher who has to be sensitive and alert to the feelings of the participant (Rubin & Babbie, 2007:39).

Participants in this study, being part of a vulnerable group, would be dealt with cautiously at the stage of informed consent engagement while considering anonymity and confidentiality as advised by Silverman (2013:170). They would be assured that they will be treated respectfully, and should they feel that their involvement at any stage becomes uncomfortable. They would have the choice to withdraw, with or without debriefing, or continue on condition that debriefing is to be done afterwards. A social worker would be available for this purpose.

1.6.4 Management of information

Once all the required data from the research is obtained, it needs to be managed in a safe and a secure way to ensure anonymity and confidentiality of the participants, and only be used for the purposes of the research (Thomas, 2017:46). Creswell (2009:91) points out that the data, once analysed, must be accessible for a minimum period of five years before it is destroyed. Furthermore, it is emphasised that an accurate account of the information is required and that it may at times have to be verified before being destroyed.

As indicated by McMillan and Schumacher (2010:122), the researcher is primarily responsible for the management of all information collected and has to ensure that it is safely stored in a way that provides maximum protection to not compromise any participant's identity (Hennink et al., 2011:72). For this study's purposes, the original hardcopies of all information, including the signed consent forms, will be safely stored in a file only identifiable by me, and locked in a cupboard. All electronic copies will be saved on the computer which is password protected and under their pseudonyms to ensure further safety. Back-ups will be made on memory-sticks kept in two different places.

1.7 CLARIFICATION OF KEY CONCEPTS

In this sub-section the salient key concepts central to this study is defined or clarified and their specific meaning in the context of the study indicated.

1.7.1 Experiences

The concept “experience” is defined by the Shorter English Oxford Living Dictionary (2007:899 sv “experience”) as “an event or occurrence which leaves an impression on someone”. Such events or occurrences in the case of substance abuse are referred to by Benishek, Dugosh, Faranda-Diederich and Kirby (2006:33, 34) as a number of problems caused by the partner with a SUDs, including being affected [experiencing] by increased financial difficulty, material loss and breakages, stress and relationship difficulties. It is within this context that the concept “experiences” is described by Orford et al. (2009:379) and Copello et al. (2005:369) as family members being “affected by” or “impacted on” by the behaviour of the person with a SUD. It is furthermore described by Denning (2010:164) and Gudzinskiene and Gedminiene (20120:163) as a family “suffering from ...” a partner’s substance abuse. The latter authors (2010:167) elaborate on the suffering by including experiences of stress, feelings of despair and emptiness and encountering different psycho-somatic disorders. In addition, Askian et al. (2016:269) notes increased experiences of psychiatric symptoms including depression, anxiety and sleeplessness. For the purpose of this study, “experiences” refer to the feelings and reactions to events and encounters of the CSOs while living with a partner with a SUD.

1.7.2 Challenges

“Challenge” is defined by the Collins Dictionary (2011:287 sv “challenge”) as to “*confront or defy boldly or to dispute especially as unjust invalid or out-moded*”. As pointed out by Hussaarts, Dugosh, Faranda-Diederich and Kirby (2011:38) family members living with a person with a SUD is confronted with their erratic actions, sporadic relapses and resulting family conflicts. Due to these situations, family members were afraid to defy or dispute this behaviour and to be honest and disclose what they feel, making it the “*most important challenge*”, according to Gudzinskiene and Gedminiene (2006:166) for family members to distance themselves from the partner with the SUD’s behaviour and attitudes. The decision to associate themselves from the person with a SUD is complicated, as Denning (2010:165) points out; the CSOs are confronted with difficult questions, such as in how far they

must help and be supportive, how long must they be faced with the problems caused by the partner with the SUD, and whether they will ever be able to recover and the relationship be restored. In this study challenges will include the attempts of CSOs to confront or dispute the unjust circumstances they have been subjected to as a result of the consequences living with a partner with a SUD.

1.7.3 Coping strategies

Coping, according to Gupta, Mattoo, Basu and Sarkar (2014:82) and Kirst-Ashman (2013:22) is an indication of a person's battle to deal with environmental circumstances and overcome personal problems and conflicts. It relates to how a person thinks of himself and how he behaves in relation thereto (Lindsay 2013:81). The definition mostly applied to the concept of coping is that of Lazarus and Folkman (in Frydenberg, 2014:83) who refer to it as “... *as constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person*”. Stated more simplistically, coping refers to the thoughts and actions which are applied to deal with the internal and external strains that are perceived as being stressful (Folkman & Moskowitz, 2004:745). These thoughts and actions, as pointed out by Park and Iacocca (2014:126) citing a 2013 poll by the American Psychological Association of almost 1500 adults on how they cope with stress, included “...*exercising, eating, drinking and smoking*” as the most commonly used responses. The increase of so-called “unhealthy ways” of coping increased as stress-levels increased (Park & Iacocca, 2014:126). Coping strategies, as applied in this study will refer to the ways (actions) in which CSOs choose to or are obligated to deal with the consequences of the behaviour of the partner with a SUD, irrespective whether such actions are constructive or destructive to themselves or their relationships.

1.7.4 Concerned Significant Others

The Shorter Oxford English Dictionary (2007:2860 sv “significant other”) describes a CSO as somebody with whom one has a committed relationship. It is written thus: “a person with a profound influence on your emotional well-being and security”.

According to the South African Prevention and Treatment of Substance Abuse Act 70 of 2008 (South Africa, 2008: Definitions), CSOs are described as “persons affected by substance abuse”. They are defined as being any family or community member who is not using, or dependent on substances, but who requires services related to substance abuse. This description refers to any person who is affected by or directly involved with the life of a person with a SUD (Benshoff & Janikowski, 2000:157; Perkinson, 2008:242); it can include spouses, parents or children as well as a siblings, fiancées, or friends.

Smith and Meyers (2004:200; 201) elaborate on the term when referring to a CSO as somebody who is in a “relationship with an individual who chronically abuses substances”. They elaborate by adding that a person in that position is subjected to physical violence, verbal aggression, emotionally empty relationships, financial problems, social embarrassment, and disruptive relationships with children. Such a person may be exhibiting symptoms of depression, anxiety, anger, and somatisation (Nagesh, 2015:373; Hudson et al., 2014:106). In this research, a CSO will mean any person, with specific reference to a spouse, fiancée, partner) who is in a relationship with a partner with a SUD. This CSO is severely and destructively affected by the relationship. This definition includes reference to “co-dependent” persons who are proclaimed to be persons who are “external focusing, self-sacrificing, attempting to control other people, and suppressing one’s emotions” (Calderwood & Rajesparam, 2014:1). The previously referenced scholars similarly describe CSOs living with a partner with a SUD to be “normal people placed in an abnormal situation and having to cope with the stress arising from this” (Calderwood & Rajesparam, 2014:2).

1.7.5 Substances of abuse

According to Dykes in Nicholas et al., (2014:295-300), Lewis et al. (2011:33-60) and Hitzeroth and Kramer (2010:2-9), chemical substances which can be abused are extremely diverse and difficult to classify and define. They can be classed as being *legal or illegal substances*; for example coffee, alcohol, dagga and cocaine, *according to their chemical structure*; like natural products or manufactured in a laboratory, *according to the effect they have on the central nervous system* such as

stimulants, depressants, or hallucinogens, and *how they are consumed*, for example by eating, drinking, injecting or inhaling. This is confirmed by the information provided by the Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition (DSM-5) (2013:481).

It is further indicated (DSM - 5, 2013:481) that irrespective of the substance or class of substances, when taken in excess, they all activate the reward system of the brain that include the centres for the production of memories and reinforcement of behaviours. For the purposes of this study, chemical substances include all of the above-mentioned in so far as their use or abuse has had a detrimental effect on the relationship with the CSO. It is my impression that the drugs most commonly abused with consequent detrimental effects on family life in the Gauteng region, include alcohol, cannabis, Khat, methaqualone, cocaine and heroin or a combination of these and other drugs like nyaope.

1.7.6 Substance use disorder

Over the years, various definitions of an alcoholic, addict, drug abuser, and substance abuser have been formulated, firstly along moral terms, then as weakness, and later as disease (Hitzeroth & Kramer 2010:14-21; Chan, 2003:129, 130; Johnson, 1990:11). Some definitions are based on etiological grounds while others describe chemical substance abuse in terms of behaviour or consequences, social dysfunction or personality problem, self-destruction or as a brain disease (Hitzeroth & Kramer, 2010:14-22). The South African Prevention and Treatment for Substance Abuse Act 70 of 2008 (South Africa, 2008: Definitions) refers to a “service user” and defines such a person as someone who abuses or is dependent on substances and has been assessed as such before attending a treatment centre, halfway house, or community based service.

According to the Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition (DSM-5) (2013:483), the internationally used psychiatric diagnostic reference, “substance use disorder” (substance abuse or addiction) is described as the negative impact of the use of one or more substances on a collection of cognitive,

behavioural, and physiological life dimensions and the continuous use of the substance despite significant substance-related problems. They identify 11 different criteria in their description of substance use disorder describing this phenomenon, of which the first 9 criteria directly or indirectly refer to the impact substance use disorder has on relational interactions including functioning within family life.

In the context of this study the emphasis in defining substance use disorder will be on the consequences it has on the *relationship* between the CSO and the partner with the SUD. This, by implication, includes the concern and reaction of the CSO to the effect of the substance abuse on the partner in terms of behaviour, mood, health, responsibility, intimacy, relationship with their children (where appropriate), and employment.

1.7.7 Guidelines

The term “guideline” is defined in the Collins Dictionary (2011:734 sv “guideline”) as “*general rules, policies or piece of advice*”. Within the social work context almost twenty years ago the concept seen by Howard and Jensen (1999:285) as “systematically developed statements to guide the social work practitioner and client to make decisions about actions to be taken for specific circumstances”. For this idea to materialise the social worker has to be acquainted with the latest applicable knowledge and be able to apply it in the helping relationship. The definition of Howard and Jensen will apply for the purpose of the study.

1.7.8 Social Work

Fundamentally, the purpose of Social Work, as indicated by Kirst-Ashman (2013:58) and Garrow and Hasenfeld (2015:494) citing the code of ethics of the National Association of Social Workers (2008) in America, has always been to address the “causes of oppression, exploitation, and social inequality; to eliminate conditions that lead to human suffering; and to advocate for social rights”. It is described by Dominelli, Hackett and Ioakimidis (2013:89) as a “complex and varied profession”, one which necessitates insight into humanity’s skirmishes for social justice and

human rights for marginalised groups and individuals, and careful thought in increasing empowering person focused interventions. This description aligns itself with Nash, Munford and O'Donoghue (2005:162) who refer to the practice of social work as requiring understanding into principles of human rights and social justice within indigenous and local contexts at the point where people interact with their environment. The International Federation of Social Workers (2014) defines Social Work as a "... practice-based profession and academic discipline that promotes social change and development, social cohesion and the empowerment and liberation of people" (Qalinge in Mbedzi et al., 2015:9). In extending this definition it includes aspects of growth, development and empowerment, social justice and diversity as well as various theories and approaches to intervention to address life challenges and well-being. These definitions, by implication are all linked to the theoretical frameworks of this study, namely the strength-based perspective, resilience and bio-eco systems theory.

Considering the CSOs of partners with a SUD, they are included in these descriptions of social work in that they can be perceived to be marginalised individuals, however, within the broader array of substance abuse and related problems. They need to be empowered and restored as meaningful and respected persons within their own right. The level of intervention is to take place within the context of both their family life and the environments in which they live and work.

1.7.9 Social Work support

Support, within the social work context, refers to working on problems with those who are affected (in this case by a partner's SUD) (McColgan in Lindsay, 2013:66) and providing a service to someone in need of assistance (Nicholas et al., 2014:318). Social work support, as constituted by Martin (2013:222) and Beckett and Horner, (2016:9) cover, among other things, crisis intervention, problem solving, solution-focused and cognitive behavioural work, as well as overviews of work with children and families, adults, groups and communities.

When applying the concept “support” to the field of substance abuse according to the South African Prevention of and Treatment for Substance Abuse Act 70 of 2008 (South Africa, 2008) it is referred to as “services”, focusing on prevention, early intervention, treatment, and reintegration and after care.

Recovery from chemical substance abuse is described by Gorski (1989:2) and Daley and Moss (2002:1) as a progressive process, making personal and lifestyle changes to support abstinence. Support in this context can also be referred to as “treatment” which is defined in the South African Prevention and Treatment for Substance Abuse Act 70 of 2008 (South Africa, 2008) as the provision of specialised social, psychological and medical services to service users and the persons affected by substance abuse with a view to addressing the social and health consequences associated therewith”. This is in line with what the South African National Drug Master Plan (NDMP, 2013-2017:19) describes under their definition of treatment regarded as intervention that entails the process aimed at stimulating and upholding the quality of life of the person with a SUD and their own system. This system can include a husband or wife, children and other significant persons their lives with the help of a multi-professional team.

As substance abuse impacts negatively on all life areas of both the substance abusing partners, and other people involved in their lives, support (recovery) should address all aspects of these life areas too. This relates to the aspects of social and emotional well-being, health, financial and general insight and behaviour. Although the support programmes referred to in this section acknowledges that both the persons with the SUD and their families require assistance, Sherrel and Gutierrez (2014:23) and Benishek et al. (2006:34) indicate that intervention involving the family in most inpatient and outpatient treatment facilities is under-utilised. Denning (2010:164), however, shares the assurance that there is growing international interest and several movements to encourage families affected by SUDs to support the partner with the SUD while simultaneously attempting to take care of themselves.

For this research, social work support, and by implication, recovery means addressing and restoring the lives and well-being of CSOs of partners with SUDs to become more able to have a satisfying and meaningful life.

1.8 FORMAT OF THE RESEARCH REPORT

This planned research report comprises five chapters and a brief overview of each chapter is provided below:

In Chapter One the reader was introduced and orientated to this study with an introduction and general orientation to its proposed topic that comprised a research problem, a rationale and reasons for embarking on this research journey. The theoretical frameworks with reference to the strength-based perspective and resilience theory as well as the ecological systems theory that informed the study were introduced. The research questions, goals and objectives of the study together with the proposed research approach and design and research methods were presented. The ethical considerations to be considered, key concepts were clarified and the format of the research report were also stated.

In Chapter Two attention is paid to how the research plan that was introduced in the first chapter was then applied and operationalised. The chapter starts by providing an explanation for why a chapter is allocated to describe the application of the research process. This is followed by an explanation of how the qualitative research approach, the research design, research methods, participant recruitment, data collection, data analysis, data verification and ethical principles were operationalised throughout the research process. A chapter summary concludes the chapter.

In Chapter Three, the first part of the research findings is presented, The CSO-participants' demographic particulars and a snapshot of themes to be presented in this chapter are provided. This is then followed by a detailed discussion of the various themes coming from the data analysis that are substantiated by quotes from the narrative writings, the transcribed interviews and the integration of literature as a literature control. A chapter summary will conclude this chapter.

In the fourth chapter the second part of the research findings is presented. The themes retrieved from the data analysis will be covered. A chapter summary will conclude this chapter.

Chapter Five will provide a summary to the research report as well as giving an outline of the overall conclusions and recommendations. The guidelines for Social Work support of the CSOs of a partner with a SUD will be presented.

1.9 CHAPTER SUMMARY

In this chapter the scene was set for what was to follow in this thesis. The reader was orientated by way of introducing the topic selected for the research. For this reason a historical backdrop or overview was provided while simultaneously appraising the state of the available knowledge on the topic in published literature. The research problem was demarcated, and the reason or rationale for the proposed research was presented. The theoretical framework comprising the strength-based perspective and resilience theory as well as the eco-systems theory, were introduced with a three-fold aim: to inform the study; to serve as coat hooks to organise the data in an orderly fashion, and to be employed as a tool for explaining the phenomenon being investigated.

Furthermore, the research methodology with reference to the qualitative research approach, together with the research design were introduced. The collective instrumental case study, phenomenological research designs and an explorative, descriptive and contextual strategy of enquiry were adopted as it befits the qualitative research approach. The proposed research methods inherent in the chosen approach and design, was introduced focusing specifically on these aspects of the research: population, sampling, participant recruitment, preparation for and methods of data collection, data analysis and verification. It was also indicated how the ethical principles would be upheld, followed by the clarification of the key concepts central to this study.

Finally, the format of the research report concluded the chapter. In the second chapter, details of how the qualitative research process actually unfolded are provided.

CHAPTER TWO

DESCRIPTION AND APPLICATION OF THE QUALITATIVE RESEARCH PROCESS UTILISED IN THIS STUDY

2.1 INTRODUCTION

As mentioned in the first chapter of this thesis, while being involved in the field of social work service delivery to service users affected by SUDs, I witnessed the struggles of partners living with persons with a SUD. This state of affairs stimulated my interest in launching an investigation into the topic of the experiences, challenges and coping strategies of CSOs living with a partner with a SUD, and how they would like to be supported by social workers on their own journeys of recovery, a service to which they are rightfully entitled.

The previous chapter, in part, was devoted to introducing the research plan for this research endeavour. It gave information about the research approach, design and the research methods adopted for this study. In this chapter, a description is provided of how this research plan, which in the domain of qualitative research, is referred to as a “rough sketch”, was applied. With this in mind, guidelines and instructions followed should proceed in a flexible manner according to Frankel & Devers, (2000:253). However, before embarking on this description, I deemed it necessary to why a chapter in this thesis needs to be devoted for such purpose, and why it is warranted and permissible.

2.2 JUSTIFICATION OF THE APPLIED DESCRIPTION OF THE QUALITATIVE RESEARCH PROCESS AS CENTRAL CHAPTER FOCUS

This notion of viewing the research plan in qualitative research as a rough sketch (mentioned previously) (Frankel & Devers, 2000:253), ties in with the idea of the emergent design characteristic of qualitative research (Thomas, 2017:140; Creswell, 2014:186; Maxwell, 2013:3; Mathani, 2004:56). Qualitative researchers, who are proponents of this feature of an emergent design, see their research plan as “a semi-

structured conceptual framework to initiate the search process” (Mathani, 2004:56). He adds that it takes the format of an evolutionary process in which this conceptual framework is tentatively held, continuously revisited and revised as the research takes shape (Mathani, 2004:56). This happens especially when the researcher enters the field and engages with the fieldwork-related research activities (Creswell, 2014:186; Maxwell, 2013:3; LaBanca, 2011:1160; Mathani, 2004:56). The aim with and reason for this chapter, amongst others, is to inform the reader how the “rough sketch” was filled in and/or adjusted and completed by describing how the initial plan was operationalised.

Another reason for this chapter is to serve as a research audit trail. An audit trail is a systematic account of the researcher’s choices; decision pathways taken, and interpretations made during the research process. It describes the theoretical, methodological and analytical strategies adopted and applied and/or changed or relinquished in the research activity in an effort to enable the reader of a research report to audit the events, influences and actions of the researcher (Koch in Carcary, 2009:15; Bowen, 2009:307; Sandelowski & Barosso, 2007:229; Johnson & Waterfield, 2004:127; Wolf, 2003:175). Providing an audit trail in terms of describing the decisions made and the rationale behind the researcher’s methodological and interpretative judgements is one criterion for allowing for a peer-review; in order to establish a study’s trustworthiness and assuring the quality or rigour of a particular research endeavour (Houghton, Casey, Shaw & Murphy, 2013:14; Koch in Carcary, 2009:15; Akkerman, Admiraal, Brekelmans & Oost, 2006:261; Wolf, 2003:176).

Two types of audits are distinguished by Halpern (in Guba as cited by Akkerman et al., 2008:261-262), namely: the confirmability, objectivity audit trail and the dependability and reliability audit trail. For an extensive confirmability audit type, documentation needs to be available for the auditor, endorsing the trustworthiness of the study, claiming that every interpretation is founded in the existing data and is consistent with the available data (Halpern in Guba as cited by Akkerman et al., 2006:261-262; Johnson & Waterfield, 2004:127). To assist the auditors to conduct a confirmability audit, I made every effort to see that the research findings were presented under themes, Subthemes and even categories (see Chapters Three and

Four of this thesis). Together with them were the interpretations and the conclusions drawn (see Chapter Five) which were founded in and consistent with the data.

A reliability audit primarily scrutinises the enquiry processes of a research project by looking at “how” the data collection and analysis procedures employed were accounted for and fell within “generally acceptable” practice procedures (Halpern in Guba as cited by Akkerman et al., 2006:261-262). Enabling an auditor to conduct a reliability audit, Carcary (2009:16) advises researchers to provide “a physical audit trail” by documenting the stages of a research study and the key research methodology decisions taken. This suggestion was acted upon by devoting this chapter to an applied description of the research methodology adopted for this study to serve as the ingredients for a physical audit trail.

The ensuing part of this chapter will focus on how the research plan adopted was applied. Where I divert from this plan, it will be indicated and the diversions too will be motivated.

2.3 THE NATURE OF AND THE CHARACTERISTICS OF THE QUALITATIVE APPROACH: AN APPLIED DESCRIPTION

As previously indicated (see Chapter One: Subsection 1.4.1), I adopted the qualitative research approach as a lens for investigating the topic under close scrutiny. To recapitulate the nature of qualitative research, also introduced by definition in the previous chapter, I give the following description Yilmaz (2013:312) puts forward: “I define [qualitative research] ... as an emergent, inductive, interpretive and naturalistic approach to the study of people, cases, phenomena, social situations and processes in their natural settings in order to reveal in descriptive terms the meanings that people attach to their experiences of the world”. Qualitative research, according to Rubin and Babbie (2013:40), is concerned with exploring the deeper significance of specific human experiences to generate more comprehensive observations.

As pointed out in Chapter 1 (Subsection 1.1.1), the CSOs of partners with a SUD are generally perceived to be instrumental in the treatment to recovery, and in aftercare of the partner with the SUD. Their own needs and treatment needs related to their experiences of living with a person with a SUD go largely unattended. Since an aim of this study corroborates with the principles of qualitative research, which amongst other characteristics is to explore and describe (Morrow, 2007:211; Mathani, 2004:54, 57), I remained with the qualitative approach as initially adopted for the study as a chosen method. This approach would be instrumentally suited for exploring and describing the experiences, challenges and coping strategies of CSOs living with a partner with a SUD, and obtaining suggestions from them as to how and in what way they would like to be supported by social workers in their life experience. Their suggestions would be valuable for the compilation of guidelines for social work support.

Reinforcing the decision to remain with the qualitative research approach were the pointers provided by Ritchie and Lewis (2005:32-33) and introduced in Chapter One (Subsection 1.4.1). This approach is well-suited for investigating an identified problem that is -

- *ill-defined or not well understood.* The phenomenon under investigation in this study is ill-defined. The academic literature on the topic of CSOs or family members of persons with SUDs, and their treatment, *per se*, is small, compared to the literature available on substance abuse; its impact, as well as the treatment of persons with SUDs (McCann et al., 2017:19; Wilson et al., 2017:57; Orford et al., 2009:380; Copello et al., 2005:380; Orford et al., 2009:380). This state of affairs directed me to the qualitative research approach as it allows for the exploration of under-researched topics (Morrow, 2007:211). The qualitative research paradigm also proposes a “bottom-up” approach be adopted that would encourage an insiders’ points of view, perceptions, beliefs and meaning system to be expressed (Hennink et al., 2011:18; Morrow, 2007:215). In applying this emic perspective, the researcher gave preference to the participant’s voice, especially for forwarding suggestions on how they would like to be supported by social workers, thus contributing to informing guidelines for social work intervention. The aim of

these guidelines was not only to benefit social workers but also other professionals, groups and facilities providing assistance to CSOs of partners with a SUD.

- *deeply rooted within the participants' personal knowledge or understanding of themselves*, the qualitative approach seems to be a good fit. The topic being investigated is *deeply rooted in the participants' personal experiences* as it relates to their living with a partner's SUD, the challenges emanated from this and how they cope in this regard. They are seen as the "experts" (Guest et al., 2013:153) able to speak authentically about this topic.
- *of a delicate and sensitive nature* (see Creswell, 2016:8; Dempsey, Dowling, Larkin & Murphy, 2016:480) *and when target populations are vulnerable*. Creswell (2016:7) adds to this aspect of populations who are vulnerable by stating that qualitative research "lift up the silenced voices of marginalised groups", or people who have not be studied. The research topic of CSOs living with a partner with a SUD is of *a sensitive nature*, and the target populations exposed to a person's SUD too are vulnerable (Aldridge, 2014:113; Campbell-Page & Shaw-Ridley, 2013:489; Valtonen, Padmore, Sogren & Rock, 2009:49, 54).

In Chapter One the work of several scholars (Creswell, 2014:185-186, Lichtman, 2014:12-13, Sarantakos, 2013:45, Streubert, Speziale & Carpenter, 2007:21, Mahtani, 2004:55-58) was used to introduce the prominent features of qualitative research (see Chapter One: Subsection 1.4.1). In Table 2.1 an account is provided of how these characteristics were manifested and applied in this study.

Table 2.1 Characteristics of qualitative research as applied

CHARACTERISTIC	APPLICATION
<i>Qualitative research is based on the need for a complex detailed understanding and description of an issue founded in an in-depth exploration through the use of multiple sources of data collection</i>	Qualitative research is primarily directed towards the goal of exploration (Morrow, 2007:211; Mathani, 2004:53). It was with this objective in mind that I embarked on a journey to explore the experiences, intricacies, facets, challenges and coping strategies as described by CSOs living with partners with SUDs. In addition, I explored suggestions on how and with what they would like to be supported by social workers with the aim of obtaining a detailed understanding of the issues at hand. I employed narrative writing and in-depth interviews to avoid what La Rossa (2012:682) refers to as the less prominent “one-time only interview” and to allow for an in-depth exploration of the topic based on the need for a complex and detailed understanding of the issue being researched. This exploration provided me with data that were open-ended and descriptive (Mathani, 20034:57) enabling me to describe the features and the extent of the issue (D’Cruz & Jones, 2014:21).
<i>Qualitative research wishes to empower individuals</i>	The benefits of participating in qualitative interviews focusing on sensitive issues as mentioned by Dyregrov, Dieserud, Hjelmeland, Straiton, Rasmussen, Knizek and Leenars (2011:687), include gaining insight into the issues being discussed resulting in increased self-awareness; experiencing feelings of empowerment, and a sense of purpose. Rizq (2008:42) refers to Gale who in 1992 found that research interviews can be more ‘therapeutic’ than therapy itself. For this reason, Kvale (in Rizq, 2008:43) labelled the relationship between the researcher and the participants as a “quasi therapeutic relationship”. This interview-approach allowed the CSOs as participants, to share their experiences, challenges and coping strategies comfortably. The strategic use of research-related interviewing skills facilitated this process especially by showing interest, listening attentively and

	<p>responding empathetically. In my view, this contributed to the participants gaining more insight into their life experiences of living with a partner with a SUD. For some, it had therapeutic significance in that it was the very first time they could, in a one-on-one situation, take centre stage by talking about themselves, their experiences, challenges and coping strategies about their relationship with a partner with a SUD. In addition, and by requesting them to contribute suggestions to inform guidelines for Social Work support for CSOs living with a partner with a SUD while regarding them as being “information rich” and possessing the “experiential expertise” (Dempsey, et al., 2016:482), empowered them. Hence, involving them in the research in this way, to my mind, an empowering experience. They felt being listened to and heard, of value, and experienced a sense of being importance and that the interview was purposeful.</p>
<p><i>Qualitative research allows for a factual and flexible style of writing and reporting</i></p>	<p>In qualitative research an informal and less technical writing style is accommodated with some researchers opting to write in the first person or the active voice (Creswell, 2014:205; Lichtman, 2014:45). Given these pointers from the scholarly literature, I adopted an informal writing style and decided to use first-person pronouns, in “that it leads to greater trust and accountability and is more forceful” (Lichtman, 2014:45) in reporting evidence and the research findings.</p>
<p><i>Qualitative research requires acknowledgement of the context</i></p>	<p>Qualitative research is contextually situated with the concept “context” being viewed as “layered influences, which shaped the phenomenon of interest” (Mathani, 2004:55). In-depth interviews, as classical method of qualitative data collection is put to use to gain insight into the context in which people live, also referred to as the “life-style context” (Hennink et al., 2011:110); such as how it is for CSOs to live with a partner with a SUD. The contexts from where the data was gathered and the particulars about the participants’ should be reported in an ethical and responsible fashion, by not</p>

	<p>comprising participants' anonymity. In support of this contextual aspect, Fontana and Prokos (in White and Drew, 2011:9), caution that "we cannot lift the results of the interviews out of the contexts in which they were gathered and claim them as objective data with no strings attached". It is for this very reason that I decided to compile a biographical profile on the participants with reference to their age, whether they were employed, duration of the relationship with the partner with a SUD, having children or not and whether they, as CSOs, had previously gone for help, to provide context for the research findings to be presented. In addition, I also placed on record the context where the interviews were conducted (Table 2.3 Locations for narrative writing and follow-up interviews). In the thematic presentation of the findings I also reported on the participants' experiences, challenges and coping strategies in context of their living with a partner with a SUD.</p>
<p><i>Qualitative research aims to address gaps in knowledge</i></p>	<p>Qualitative research aims to explore and describe matters of interest or concern (gaps) by focusing on existing, unsearched issues and/or emerging issues such as new developments in the field of SUDs (Neale, Allen & Coombes, 2005:1590). However, the role and functioning of CSOs in the context of living with a partner with a SUD was historically based on professional perceptions and assumptions, such as the spouse causing and or/sustaining the SUD (Rodriguez, et al., 2014:294; Toner & Velleman, 2014:148; Hawkins & Hawkins in McNeece & DiNitto, 2012: 257-259). I wanted to ensure that the voice of the CSO, as a person in their own right was being heard.</p>
<p><i>Qualitative research focuses on words, themes and narrative stories</i></p>	<p>Data in qualitative research is "actively constructed and evolved from an exploration of people's internal constructions" (Yeh & Inman, 2007:73). Hence, the data comprises words and not numbers (Lichtman, 2014:45; Frey et al. in Chesebro & Borisoff, 2007:6). In a qualitative research report, especially the section where the research findings are presented, direct quotations or storylines from</p>

	<p>the participants narratives and transcribed interviews have to be used. These are to serve as amplifiers for the participants' voices and to substantiate the identified themes and Subthemes as well as the literature used for setting the scene for a particular theme and/or Subtheme. In Chapters Three and Four of this thesis, amongst other purposes, I have endeavoured to present excerpts of the participants' narratives and the transcriptions from the transcribed interviews to amplify and make their voices heard.</p>
<p><i>Qualitative research is in-depth on small scale</i></p>	<p>One of the many purposes of qualitative research is to acquire a detailed or in-depth understanding of the phenomenon being investigated and identify the socially constructed meanings about it. With this in mind the recruitment of a small number of information-rich participants from whom large volumes of data can be generated (Wu, Thompson, Aroian, McQuaid & Deatricks, 2016:499; Hennink et al., 2011:84; Suri, 2011:65). In confirming this characteristic, Creswell (2016:7) writes: "In qualitative research we study a small number of people but go deep to develop the detail they provide to us". As my aim was to delve deeply into the experiences and challenges of CSOs in their living conditions with a partner with a SUD; their ways of coping and their need for social work support. I was not only limited to a small-scale study, but I also had to handpick my participants purposively as they had to be information-rich about the topic (Wu et al., 2016:498; Hennink et al., 2011:85).</p>
<p><i>The researcher is the primary instrument for data collection and analysis</i></p>	<p>Referring to the role of the researcher in qualitative research, Borland (2011:7) asserts that they are the primary instruments in designing the research, data collection (Creswell, 2014:185; Yilmaz, 2013:317) and management, data analysis, and the interpretation and reporting processes. As a result, I made all the decisions regarding the research design and I was primarily responsible for the</p>

	<p>recruitment and selection of participants and the collection and analysis of the data. I do need to acknowledge the fact that I enlisted the services of an independent coder and a retired social worker, who is well-versed in qualitative data analysis, to thematically analyse the data independently from me. Afterwards the study's supervisor, the independent coder and I engaged in a consensus discussion to compare the themes deduced from the datasets to support the trustworthiness of the study. This relates to the aspect of a confirmability audit as described in Subsection 2.1 in this Chapter and supported in the literature, for example, Halpern in Guba as cited by Akkerman et al. (2006:261-262) and Johnson and Waterfield (2004:127).</p>
<p><i>Qualitative research occurs in natural settings</i></p>	<p>In underscoring this characteristic, Chesebro and Borisoff, (2007:8) write “the researcher seeks to make the research experience as much a part of the subject’ everyday environment as possible”. Qualitative research, therefore takes place in realistic and natural environments (see Creswell, 2014:185). Participants are not invited to a laboratory type of environment that is exclusively used for experimentation. They are interviewed and/or observed in an environment already known to them and where they feel at ease (Keyton in Chesebro & Borisoff, 2007:6). With this in mind, I decided to allow the participants to be interviewed at a location of their choice. Some preferred to be interviewed at home, others at their respective places of employment, while others preferred to be interviewed at the organisations where they attended support group meetings. This aspect of the setting created for holding the interview also connected with concept of the context, in that the context shapes what the participants will share and their eagerness to do so (Creswell, 2016:6). The interview-setting can either boost or inhibit the sharing. As my aim was to explore the CSOs’ experiences, challenges and coping strategies in the context of living with a partner with a SUD, I allow for the participant to select</p>

	the place where the interview would be held to allow for free uninterrupted conversation and optimal sharing. This aspect of a setting for the interview will be elaborated on further in this report (Subsection 2.6.3).
<i>Qualitative research deals with the whole</i>	With qualitative research the aim is to study a situation, such as living with a partner with a SUD, in its entirety (Mathani, 2004:55). The focus is on how it is for the participant in the situation and for the researcher to come to an understanding and to describe and interpret the situation that was explored. (Lichtman, 2014:42). As I was not interested in cause or effect, or the how one variable relates to another, I looked at the situation of CSOs living with a partner with a SUD holistically by exploring their experiences, challenges and coping strategies and the suggestions the participants gave in view of formulating guidelines for social work support.
<i>Qualitative research is inductive</i>	In qualitative research the objective in inductive reasoning is to proceed from a small point of departure, such as an idea or a notion, to eventually arrive at a theoretical understanding of a phenomenon (Nicholls, 2009:531). According to Pistrang and Barker (2012:6), inductive research is required in “under-researched and under-theorised” areas to generate theory, building it up from the “bottom” into increasingly more abstract units of data, working forward and backward between themes to establish a comprehensive data-base (Creswell & Poth, 2018:63). Eliciting suggestions from the participants to inform the development of social work guidelines for assisting CSOs of partners with a SUD resonates with the idea of a “bottom-up” or an inductive approach.
<i>Qualitative research embraces the idea of an emergent design</i>	This notion of the emergent design, as one of the salient characteristics of qualitative research (introduced in Chapter One and further expounded in Section 2.2. in this Chapter) stems from acknowledging the fact that all research contexts and the individuals within the contexts to be studied

are unique. When engaging in naturalistic research, the research methods and procedures employed must stem from and reflect the idiosyncratic nature of the field (Lincoln & Guba, 1985:209). As qualitative research is inherently open and flexible, it allows the researcher to modify the research design by pursuing new discoveries and relationships during the course of the research (Maxwell, 2103:30). Brown (in Lichtman, 2014:40) expounds on this characteristic of the emergent design when writing: “we [referring to qualitative researchers] don’t always know until we’re well into the project where we are placing our emphasis. Often we change directions and take new tacks in the midst of the work, due to our own realisation about the material, and in part from the ongoing interaction with people”. It was my interaction with Mandy during the pilot study that brought me to the conclusion of including the partners with the SUD. In our second in-depth interview, the discussion centred on the topic of suggestions on how social workers could support CSOs with partners with a SUD. Mandy, remarked that although she and others like her might benefit from social work support, she pointed out that, her husband is so pre-occupied and entangled in his substance use that he had neither insight nor interest in her needs. This made me curious about partners with SUDs. Whether they felt if their partners, the CSOs, were in need of recovery and social work support at all or not. Based on this insight borne from Mandy’s account, I decided to expand the population for this study by also including the partners with the SUD of the CSOs.

This decision to add another sample group to the study was done in consultation with the study’s supervisor, hence another **research question** was formulated in addition to the research questions formulated at the outset of the study to guide this project (See Chapter One: Subsection 1.3.1). This

	<p>question reads as follows: from your perspectives as the partner with the SUD, how and with what would CSOs living with a partner with a SUD like to be supported by social workers?</p> <p>Owing to answering this research question, the following goals were formulated:</p> <ul style="list-style-type: none"> • As seen from the perspectives of the person with a SUD, to report on the suggestions on how and with what CSOs living with a partner with a SUD would like to be supported by social workers • To offer guidelines for social work intervention assisting CSOs living with a partner with a SUD. <p>The fieldwork activities of participant recruitment, methods of data collection and analysis for this interest group of persons with SUDs, subsequently added, will be discussed further on in this chapter where the application of these activities are presented.</p>
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Having revisited the nature and characteristics of the qualitative approach and specifically a description of its application in this study, I proceed to address the research design.

2.4 THE RESEARCH DESIGN APPLIED

In the previous Chapter (see Subsection 1.5), the meaning of the concept “research design” was explained. It was further elaborated upon in this Chapter where the notion of an emergent design, as a distinctive quality of qualitative research (Thomas, 2017:140; Creswell, 2014:186; Maxwell, 2013:3; Mathani, 2004:56) was highlighted (see Subsection 2.1 and Table 2.1). To recapitulate, the concept “research design” in the context of qualitative research must be treated as a rough sketch plan outlining the protocol and procedures or the what and the how of the execution of the research (Maxwell, 2013:2; Creswell, 2009:3; Green & Thorogood, 2009:42; Frankel & Devers, 2000:253).

In planning the research, I decided to employ a collective, instrumental case study design and a phenomenological research design, as well as an explorative, descriptive and contextual strategy of inquiry for this research (see Chapter One: Subsection 1.5). I stayed with decision, and in the discussion to follow, a description is provided on how the mentioned designs and strategy of inquiry were applied.

2.4.1 The collective instrumental case study design

The “collective instrumental case study design” was introduced and expanded on in the previous Chapter (see Chapter One: Subsection 1.5). I remained with the collective case study, also known as the “multiple case study”, as it allows for an in-depth investigative exploration of a real-life phenomenon (such as the case of living with a partner with a SUD) in its natural context from the perspectives of those involved, by using multiple cases and data collection methods (Boblin et al., 2013:1268; Wahyuni, 2012:72; Creswell et al., 2007:245, 246). I employed narrative writing and semi-structured interviews, instrumentally, with a sample of CSOs (multiple cases) of partners with SUDs, to gain insight into their experiences and

challenges in relation to living with a partner with a SUD. In addition, I also tapped into the coping strategies employed in this context to address the challenges experienced. Furthermore, I requested them to, against the background of the experiences and challenges shared in the previous session, to put forward suggestions on how social workers can support them, and persons in similar situations like them, in relation to the reality of living with a partner with a SUD.

Subsequently, I also engaged with a collective or sample of the partners with a SUD in exploring their perceptions on if their partners are in need of social work assistance and how they could be supported by social workers.

In both instances the collective case study was instrumentally employed for the purpose of firstly, gaining insight into the phenomenon, and secondly to gather information to inform professional practice by formulating guidelines for social work support to CSOs of partners with a SUD. The use of the collective case study for these purposes stated, match with the nature and goals of the instrumental case study design as set out in the literature consulted (Creswell & Poth, 2018:98; Thomas, 2016:121; Snow et al., 2009:234-244).

2.4.2 A phenomenological research design

The phenomenological research design, in addition to the collective instrumental case study design, was initially decided upon and included as part of the strategy of inquiry for this study (See Chapter One: Subsection 1.5), as my intention was to explore and subsequently describe the life experiences (Lichtman, 2014:114) of CSOs living with a partner with a SUD. This ties in with the essence of phenomenological research which is to explore lived-experiences and transform them into consciousness of meaning and the formation of connotations they attach to a particular life experience (Bakanay & Çakır, 2016:163; Hood, 2016:165; Yates & Leggett, 2016:229; Hudson, Duncan, Pattison & Shaw, 2015:362; Turner et al., 2013:307; Finlay, 2012:172; Nicholls, 2009:587).

Incorporating phenomenology as strategy of inquiry, according to Finlay (2012:172-191), requires the researcher to keep the following pointers in mind which I have taken to heart in applying this design:

- *Ascribe to the philosophical assumptions underpinning phenomenology and embracing a phenomenological attitude.*

In highlighting the prominent assumptions upon which phenomenology as a strategy of inquiry is founded, Grosshoeme (2014:116-117) mentions the following:

- The meanings attached to a lived experience and the coming of knowledge are socially constructed yet remains incomplete and developing.
- The investigator, as the primary instrument of data collection, becomes part of the experience being studied whose values play a role in the investigation.
- Being biased is present both on the side of the participants and the researcher engaged in the research dyad.

A phenomenological attitude is typified by “non-interference and wonder to facilitate the ability of “seeing with renewed eyes” and, in so doing brings deeper insight and helping for us to be in greater contact with the world (Usher & Jackson, 2014:182; Finlay, 2012:175). For this to materialise, Finlay (2012:176) quotes Merleau-Ponty, a French phenomenological philosopher who affirms that “In order to see the world we must break with our familiar acceptance of it”. This conjures up Husserl’s’ (in Finlay, 2012:175) idea of bracketing, where the researcher puts habitual natural taken-for-granted understandings in abeyance; past knowledge; thoughts about the topic, as well as any judgements for the purpose of embracing a phenomenological attitude (see Lichtman, 2014:115). Lichtman (2014:116) claims this to be somewhat farfetched, especially, given the fact that the researcher is the interpreter of the data. Instead, this author advocates for what Heidegger has labelled “authentic reflection”⁵ or declaring one’s own assumptions about a phenomenon (Lichtman, 2016:116), and managing intrusions of pre-understandings throughout the research endeavour (Finlay, 2012:176).

⁵ How I have excersiced authentic reflection is discussed later in this Chapter (Subsection 2.8.5).

According to Asworth (in Finlay, 2016:176), three particular areas of presuppositions should be left out to get closer to a participant's life world in an investigation. They are: scientific theories, knowledge, and explanations about the phenomenon; truth or falsity claims the participants make; and the researcher's personal views and experiences. Acting in this fashion allowed for phenomenological reduction or a search for all possible meanings of the phenomenon.

- *Entering the life world (through descriptions of experiences)*

Recognising that the researcher-participant relationship is an equal partnership of sharing for knowledge creation (Grosshoeme, 2014:117), and exercising the skill of authentic reflection in a conscious fashion, allowed me to recognise the information with a fresh perspective as Finlay (2012:175) recommended. I allowed the participants to paint word pictures, describing their experiences through the use of narrative writing, the semi-structured in-depth interviews, and the strategic use of the research interviewing skills and by remaining empathically attuned. In all of this I operated from the stance where I viewed the participants as the "experts" with me being an apprentice enquiring student (Guest et al., 2013:153; Milena, Dainora & Alin, 2008:1279). Through the questions I asked I could develop in-depth insights and understand the life of a CSO living with a partner with a SUD.

- *Dwelling with horizons of implicit meanings*

I used the interviewing skills of active listening, probing and made requests for clarification of some of the aspects the participants shared to trace and uncover the implicit meanings embedded in the information disclosed. Following Finlay's (2012:186) advice, I set time aside to engage with the raw data as collected, dwelling on it until the implicated and layered meanings evolved. I interrogated the written narratives, looking for what was left out and what was shared, and in the first follow-up interviews with the CSO-participants I requested further elaboration to fill the gaps in the information shared.

- *Explicating the phenomenon holistically*

In arriving at a holistic and comprehensive understanding of the phenomenon under scrutiny, Finlay (2012:187-188, 190) suggests dissecting the layers of data to uncover both the shared and the hidden meaning in the data. This requires immersing oneself in the data and examining it closely. I went along with this suggestion in that I scrutinised both the written narratives and the transcriptions of the recorded in-depth interviews conducted. This enabled me to report the research findings in a systematic and logical fashion (see Chapters Three and Four) so as to allow for a judgement call to be made that a holistic and comprehensive understanding of the phenomenon had been captured.

- *Integrating frames of reference*

Integrating frames of reference requires the researcher to interpret the integrated lived experiences the participants share to provide an in-depth understanding of the phenomenon being investigated (Finlay, 2012:191). With integrating the frames of reference, outside theory and references, as a means of literature control, might legitimately be brought in to enrich the analysis. However, Finlay (2016:195) cautions that “interpretively importing theory in a questionable attempt to find the ‘real’ meanings”, should be avoided to remain on focused the lived-experiences.

To sum up: I have employed the phenomenological research design as it allowed me to gather descriptions on the lived experiences (Grosshoeme, 2014:117) of CSOs in relation to living with a partner with a SUD. Such descriptions gathered through exploration may, in turn, inform policies and practice (Yates & Leggett, 2016:229), which in the case of this research assist in the formulation of guidelines for social work support for the CSO of a partner with a SUD.

2.4.3 Explorative research design

The collective instrumental case study and the phenomenology as qualitative research designs (Creswell, 2014:13-14; Lichtman, 2014:97), together with other

qualitative strategies of inquiry, like narrative, ethnographical and grounded theory research, are all forms of inquiry intended to explore and seek understanding of the meanings individuals or groups ascribe to in an experience (Creswell, 2014:4; Glazer & Stein, 2010:56). Since one of my research objectives was to explore the essence of the experiences and challenges of CSOs who live with a partner with a SUD, and the coping strategies they employ to address the experienced challenges, I found the explorative research design a fitting match, and incorporated it as part of the strategy as originally planned. Another motivation for accommodating the explorative strategy of inquiry was based on the assertion that, through the use of qualitative methods exploratory research, can be used for investigating topics for which there is little or no research, or when the research topic is new or very broad and increased knowledge and insights are required (Grove et al., 2013:370; Sarantakos, 2013:150; Grinnell & Unrau, 2008:18; Morrow, 2007:211).

Given the scarcity in the scholarly literature on the topic and the lack of social work support, specifically, focusing on the CSOs living with a partner with a SUD, have identified that this research endeavour (see Chapter One: Subsection 1.1.3) found the explorative research design was applicable. Exploring the experiences, challenges and coping strategies of the CSOs and their suggestions for social work support that formed the foundation informing the guidelines for social work support were developed to serve this client system.

2.4.4 Descriptive research design

Apart from the fact that qualitative research is undertaken to explore ill-researched problems, issues or life related experiences (Creswell & Poth, 2018:45), it is pointed out by Polkinghorne (2005:138) that qualitative research has a descriptive commitment as another of its primary purposes. This obligation led me to include the descriptive research design as part of the strategy of inquiry. Language is put to use as an investigative tool for exploring and by inviting participants “to describe and clarify [the] experience as it is lived and constituted in awareness” (Polkinghorne, 2005:138). Following such exploration facilitated by the researcher and the description provided by the participants, means the research has a duty to provide a

comprehensive descriptive account of the explored and shared events and their related experiences (Sandelowsky, 2000:334). According to Mathani (2004:57) the aim of such description is three-fold in nature, namely: to disclose the concepts and complex pattern of relationships between the concepts observed; to disclose the intricacies surrounding the phenomenon; and to explain why things happen as they do.

Incorporating and employing the descriptive design as part of the strategy of inquiry allowed for a comprehensive description (see Chapters Three and Four of this report) of the experiences, challenges and coping strategies of CSOs living with a partner with a SUD, their suggestions for social work support, as well as for a descriptive account on the partners with the SUDs' perception on how and the social work support can benefit their partners.

2.4.5 Contextual research design

The contextual research design included as part of the strategy of inquiry was subsequently employed, purely for the fact that, in qualitative research the context surrounding the issues being investigated needs to be considered or explored and described, as meanings ascribed to actions and experiences are contextually bound and situated (Lichtman, 2014:127; Hennink et al., 2011:288; Terreblance et al., 2006:274; Ritchie & Lewis, 2005:27; Monk et al., 1997:34). Creswell and Poth (2018:322) specifically advise that if a case study design is used, as is the case of my research; the researcher needs to situate the case within its setting, when analysing and describing it. The case context can either be "broadly" or "narrowly" delineated. When the case context is broadly conceptualised, the broader political, economic and historical contexts that shape the issue being research are indicated. A narrow conceptualisation of the case context refers to aspects such as the personal and community contexts and relationships in which participants live, and their socio-cultural contexts of the study's sample (Creswell & Poth, 2018:322; Hennink et al., 2011:322).

In this study I focused on the participants' personal and relationship contexts in the interest of exploring and describing the experiences, challenges and coping strategies of CSOs living or in relationship with a partner with a SUD (see Chapter Three). In this Chapter, I introduce the participants and in Chapter Four I expand on the introduction by presenting the biographical particulars of the participants. In doing so I address aspects related to the socio-cultural context.

I also provided what Hennink et al. (2011:288) refer to as the “methodological context” in that I, in this chapter, described the setting where the data was collected together with the logistics and challenges related to this method. In Chapter One where I introduced and presented the strength-based perspective; the ecological-systems theory and the resiliency theory as theoretical frameworks for the study, I provided the “theoretical context” too in that it became the framework or the coat hooks to hook the research findings (Wu et al., 2016:498; Maxwell, 2013:49; Hennink et al., 2011:288).

In the final chapter of this report where, the recommendations, informed by the participants' suggestions will be offered, the aspect of “context of implications” (Hennink et al., 2011:289) comes into play as it will speak to the contexts and role players to whom the recommendations will be addressed.

2.5 THE RESEARCH METHODS AS APPLIED

The concept “research methods”, as introduced in Chapter One (see Subsection 1.6), refers, broadly speaking, to the specific procedures, tools and techniques employed for the activities of recruiting and selecting of participants (sampling) and data collection (as aspects of fieldwork), data analysis and the reporting of the findings (Cruz & Tandia, 2016:79; Mills in Mills & Birks, 2014:32; Wahyuni, 2012:72). In essence, the research methods relate to the practicalities of doing the research (Kramer-Kile, 2012:27).

In the discussion below, I am going to give an exposition of how the research methods adopted for the study, as introduced in Chapter One, were applied. Where I

deviated from the chosen research methods or made any additions with reference to the research methods, this will be indicated and justified.

2.5.1 Population, sample and process of participant recruitment

While the term *population* was introduced in Chapter One (see Subsection 1.6.1) expanding on it is deemed necessary to set the scene for its application. A study's population, from which a sample of participants will be recruited, is informed by the guiding questions and research objectives formulated at the outset of a study (Guest et al., 2013:42; Hennink et al., 2011:85). These will have a direct bearing on whom to recruit and how they will be recruited. Recapping on the meaning of the concept "population" as introduced in Chapter One, underlines that it signifies the total number of all possible individuals, within a geographically demarcated area relating to a particular topic from whom information is gathered on and from (Thomas, 2017:141; Punch, 2016:175).

As far as the population for this study initially was concerned, I remained with the population, as first formulated, in respect of the CSOs (see Chapter One; Subsection 1.6.1). Given my decision to also invite their partners and their SUDs to share their thoughts and suggestions on how their CSOs (spouse, partners and fiancées) could be supported by social workers meant I had expanded the boundaries of the population. Thus, in this context the partners living with the SUD were also participants. This decision to broaden the study's population, by adding other affiliates, according to Hennink et al. (2011:85) is permissible. An especially useful benefit was that the researcher became more informed about the research issues and realities from the beginning of the data collection activity and the need for a multi-perspective account would contribute to reaching the goal set for the research.

I therefore expanded the population boundaries by adding another population, which is defined as follows: all persons with a SUD in a relationship with a CSO (i.e. a spouse, partner, finance) living in the South African province, Gauteng and within this province specific the cities of Pretoria, Randburg and the East Rand.

Various scholars refer to the fact that it is practically impossible to study the whole population, given money, time and resource constraints. Hence, all empirical research requires sampling (Thomas, 2017:141; Punch, 2016:175; Babbie, 2014:119). Hennink et al. (2011:84) explain sampling in simple terms as “the process of selecting individuals from your study population to participate in the research study”. In qualitative research the purposive sampling method is used to select participants from the population, as mentioned in Chapter One (see Subsection 1.6.1). This manner of participant recruitment is informed by the study’s purpose and based on the researcher’s judgement about who will be in the best position to provide information-rich answers and insights to the research questions. therefore the researcher looks for people who have first-hand experience of the topic being investigated (Wu et al., 2016:498; Hennink et al., 2011:85; Streubert & Carpenter, 2011:28; Devers & Frankel, 2000:265).

Referring to qualitative sampling, as a cautionary measure, Mathani (2004:61) points out that, without specifying criteria to be used for the selection of participants for interviewing, is a mistaken view to them. Responding to this advice I revisited the criteria of inclusion, initially formulated for the CSOs of partners with a SUD (Chapter One; Subsection 1.6.1), and an additional criterion was included namely, that their partners with a SUD would also be willing to participate.

Since I had added another interest group, namely persons with a SUD who were partnered with a CSO, I developed the following criteria of inclusion to scrutinise their eligibility for participation. The partner with a SUD would be eligible for inclusion in the sample if they

- are in a close relationship, such as being a spouse, partner or fiancée to a CSO-partner who participated in this research.
- had been involved in such a close relationship for a minimum of three years and longer that would allow for an adequately long enough time-wise account to develop of their partner’s needs.
- possessed a reasonable level of language proficiency in Afrikaans or English, being able to express their perceptions and suggestions in conversation.
- expressed willingness to participate voluntarily.

With the criteria of inclusion for the respective interest groups revisited, the focus of my attention diverted back to the research plan, and specifically to the aspect of where I would go to recruit participants for inclusion in the study. The process for participant recruitment will be described next in the way it unfolded in the field.

As the demarcated geographical boundaries⁶ initially set for the study were conveniently close to my place of employment and residence, I decided to keep within these borders in my search for participants to reach treatment centres and support groups for persons with SUDs and their CSOs. Focusing on the existing treatment centres and support groups as social settings where likeminded people congregate, allowed for what Trotter (2012:400) refers to as the “geographical sampling” approach used in qualitative research. His explanation is along these lines: “the approach is to identify a set of known locations where the target behaviours occur [such as the treatment centres for and support groups for persons with SUDs and their CSOs] and to recruit participants from these locations using purposive recruitment” (Trotter, 2012:399).

In executing what was originally planned in respect of participant recruitment I contacted the director at Mighty Wings Life Centre (MWLC), a community-based, out-patient treatment centre in Benoni on the East Rand as a starting point en route to participant recruitment. My intention was to obtain her permission to conduct the research at the respective branches of their organisation situated in Benoni, Randburg and Rooihuiskraal in Gauteng. Apart from MWLC forming part of the geographical sampling approach, this centre was part of my suite of formal networks and services. Hennink et al. (2011:96) recommends such a strategy. As part of my community engagement, one of the key performance areas in my position as social work lecturer is to offer clients of MWLC assessment for suitability to the programme and individual social work sessions when required. In addition to MWLC as a research site, I also expanded my search for participants to other formal and informal networks within the geographical boundaries identified for this study.

⁶ Pretoria and surrounding areas as well Randburg, Rooihuiskraal and the East Rand were identified as the geographical areas for the study.

For this reason, time was spent on compiling a list of all centres/organisations rendering counselling treatment and support services to persons with SUDs and their CSOs. I listed the names of the contact persons with whom I was familiar and requested them to act as gatekeepers noting their telephone numbers and email addresses. I spent a significant amount of time reflecting on who I should approach as gatekeepers at these organisations choosing persons in authority who would be in a position to grant or deny me access to potential participants. Several scholars documented in the literature suggest this (Kawulich in Dempsey et al., 2016:483; King & Horrocks, 2010:31).

In total 16 organisations⁷ and individuals were contacted in my search for suitable participants who would meet the requirements for the study. I established contact with those I had identified to act as possible gatekeepers (as indicated in Figure 2.1 on the following page) either telephonically and/or via email. During these contacts I introduced myself and briefly informed them about my research endeavour and its importance. I also enquired from them about their willingness to act as gatekeepers in this project, either by granting me permission to conduct the research at their centre/organisation, and/or directing me to potential participants whom I could

⁷The organisations and support groups contacted provide the following services:

Christian Action for Dependence (CAD): Aftercare service (in the form of group or personal meetings) is available to recovering substance dependants, their relatives and to co-dependants, based on Christian principles.

Alcoholics Anonymous (AA): AA is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism.

Al-Anon: In Al-Anon, a support group modelled after Alcoholics Anonymous (AA), friends and relatives of alcoholics learn to detach themselves from the drinker and concentrate on their own healing.

Nar-Anon: Nar-Anon Family Groups are filled with people that are experiencing and know or have known a feeling of desperation about the addiction problem of someone very near to them.

Stabilis is an accredited and registered treatment centre, which provides treatment programme alcohol, medication and drug dependence (abuse).

Castle Carey (SANCA): Provide services to all communities, groups and individuals with respect to prevention and treatment of substance/chemical dependence.

HEAL: HEAL is a non-profit Public Benefit Organisation that focuses on family unity by reconciling family relationships, training and equipping families to interact and to fight addiction together through a support structure for both the recovering addict and the supporter.

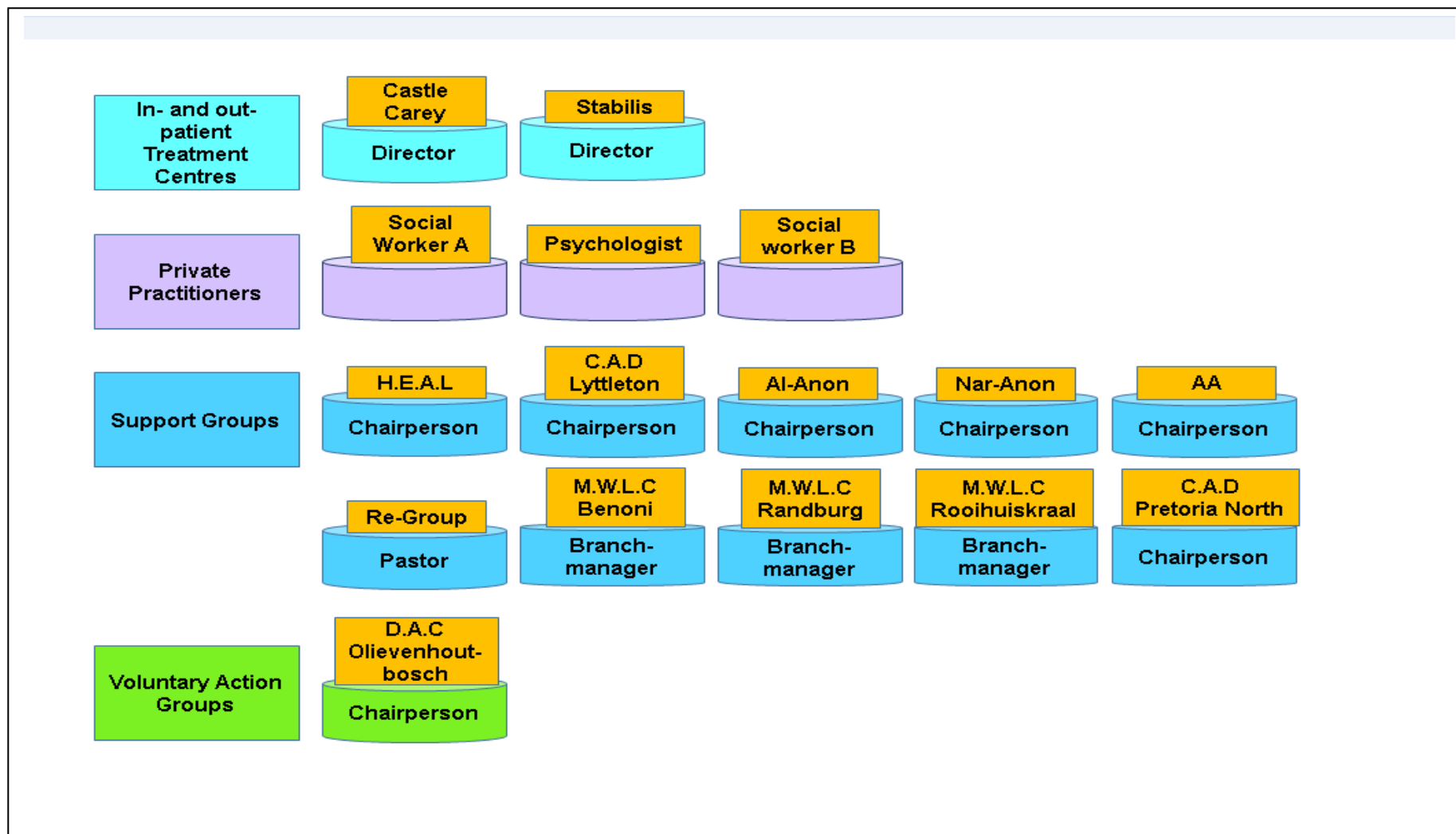
Re-Group Family Support group based on Christian philosophy for persons addicted to substances and their family.

Drug Action Committee (Oliewenhoutbosch): This Committee coordinates a group of volunteers initiating substance abuse prevention and intervention activities in the area.

approach to participate in my study. In essence, the gatekeepers would, what King and Horrocks (2010:31) say would provide “insider assistance”. This implies that they would be able to identify possible participants who meet the criteria of inclusion, pass information on to them about the research project and send any particulars of anyone wanting to participate in the project on to me, the researcher.

The responses in relation to the requests extended to the respective contact persons (as depicted in Figure 2.1 on the next page) to act as gatekeepers by assisting me in providing access to research sites and potential participants varied. Of the 16 contacts made, 12 of the contact persons and individuals initially showed considerable interest in participating but eight were faced with practical and/or ethical issues. Four of the sixteen contacts, namely, the AA, Al-Anon, Nar-Anon and Castle Carey declined or did not respond to the emails, denying me access to their respective research sites and potential participants. This left me with four sites, namely the three MWLC branches and one CAD group who were prepared to accommodate me and assist with identifying possible participants and participant recruitment.

Figure 2.1: Overview of the organisations, treatment centres, support groups and persons contacted to act as possible gatekeepers)



Having received permission from MWLC through their Director, Chanene van Zyl⁸, to conduct research at their branches I contacted the Branch Managers of the three MWLC-branches. I also approached two social workers in private practice (Jacques Botes and Mandy Stokes), working with clients with SUDs, to help locate more participants. As CSOs do not make up a large part of the private social workers' caseload and they were concerned about ethical matters, both of them referred me to other facilities in a better position to assist me in finding participants. I then contacted the Stabilis Treatment Centre located in the northern Pretoria as it primarily focuses on the person with a SUD, but also includes add-on sessions with CSOs. I telephoned the Director, Dr van der Merwe who, in principle was keen to assist, but foresaw ethical and practical difficulties and referred me to the Christian Action for Dependence (CAD) that meets weekly on their premises. The Chairperson of CAD, Jansie Nel, was very excited about the proposed research project, willing to assist and even set up an appointment for me to attend a meeting where I could explain the purpose and needs for the research and requested the voluntary participation from those who were interested.

I furthermore managed to establish contact and meet with the manager from Healing Educating Addicted Lives (HEAL), a support group for persons with a SUD and their CSOs in the eastern part of Pretoria. She was keen to assist but, as the majority of the CSOs are parents of children with a SUD, they would not meet the requirements of participants for the research. I encountered the same situation with the Pastor of the church who heads up Re-Group in Kempton Park where they indicated a willingness to participate, but their weekly meetings were primarily for children and youth with a SUD with parents as CSOs. Parents of children with SUDs fall outside the criteria for inclusion for the research.

The Chairperson from CAD in Lyttleton, after a number of calls and emails and a visit to their premise to introduce the study during a meeting, as I had done with CAD at Stabilis. He never came back to me. A clinical psychologist in private practice in

⁸ Only the names of persons who provided written permission (Addendum L) to use their name in my report are mentioned.

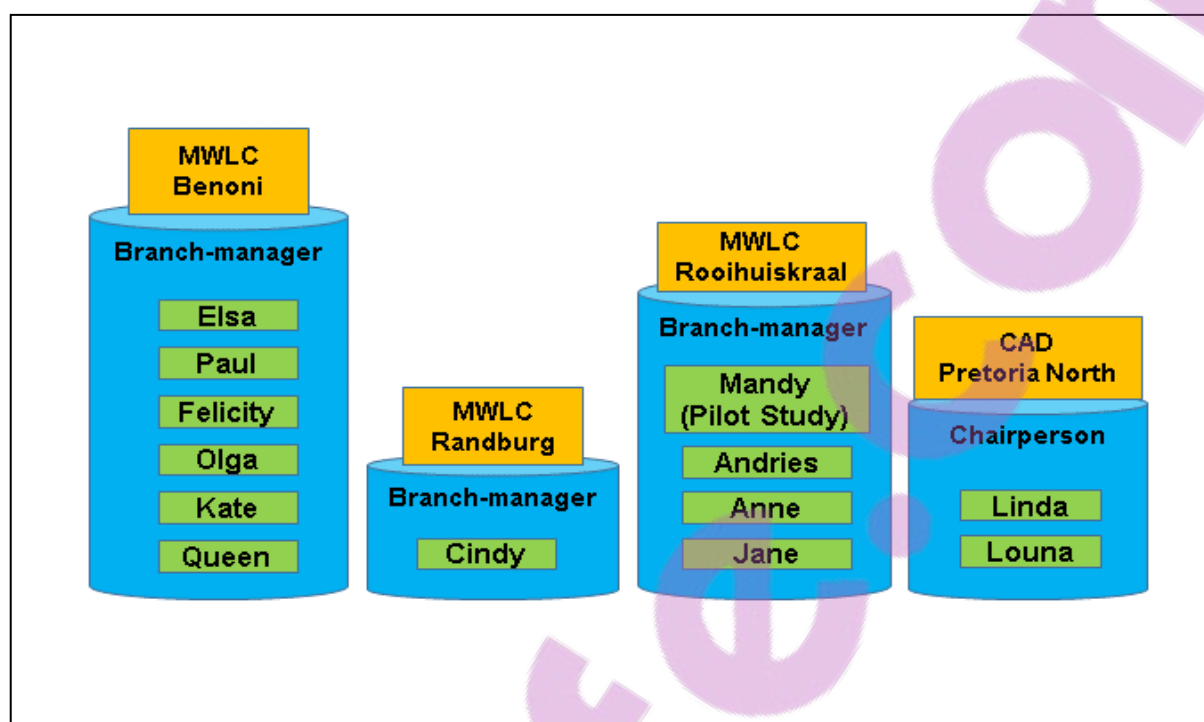
Pretoria, was keen to assist but, as was the case with the two social workers in private practice, there were very few CSOs of a partner with a SUD and there was also the ethical issue around engaging patients in her practice in research endeavours. She did, however, link me up with an organisation she heads up called “Counselling-At” that, amongst other things provides services through a Drug Action Committee in Olievenhoutbosch. The chairperson from the Drug Action Committee in Olievenhoutbosch was accommodating but they prioritised the youth with SUDs and did not feel that the CSOs in their community would understand enough about the problem of SUDs to participate.

The four organisations that I did not manage to access included three support groups namely; the AA, Nar-Anon and Al-Anon as well as the treatment centre, Castle Carey. The persons at AA and Nar-Anon, I identified and contacted, strongly felt that their commitment to their group members’ anonymity, as well as structure and purpose of the meetings would not make accommodating me feasible, thus they were unwilling to accommodate my request. The contact person at AA indicated that they provided support for persons with a SUD and could not foresee how they would be able to involve the CSOs as the primary interest group for my research. Three telephone calls and two follow-up emails to Al-Anon and verbal undertakings from their side to discuss my research requests at their meetings came to nothing. Two emails to Castle Carey ended with no forthcoming responses.

The challenges experienced in relation to contact persons cum gatekeepers of some of the organisations would probably tie in with what Heath et al. (in Dempsey et al., 2016:493) refer to as the so-called “over-protecting gatekeepers”. In denying individuals the freedom to exercise the choice of whether or not they wanted to participate in a research project would not be right.

In Figure 2.2, (on next page) the participants, including the CSOs who participated in the pilot study, are all reflected. The data obtained from the participant recruited for the pilot study was not included in the data set that was analysed and the findings reported in Chapters Three and Four of this report. All the participants recorded comply with the inclusion criteria and their partners also consented to participate.

Figure 2.2: Overview of the organisations and support groups and their contact persons who acted as gatekeepers and the CSOs recruited through them



Although permission was obtained from the Board and Director of MWLC to conduct the research, each of the managers at their branches in Randburg, Benoni and Rooihuiskraal were approached and consulted individually. These managers as well as the Chairperson of CAD (Pretoria North), showed an interest in the research project and expressed a willingness to take up the task of gatekeeping. They were thus instrumental in the process of recruiting a sample of CSOs of partners with a SUD. The process of involving these settings and their respected gatekeepers unfolded as follows:

- *MWLC Rooihuiskraal-branch*

Located in the south of Pretoria, this branch caters for persons with SUDs and their families in the Pretoria area. Except for the CAD in Lyttleton, the MWLC-branch in Rooihuiskraal is the only other facility providing support to CSOs in this area. This branch caters for an average of 15 to 20 persons with SUDs on a weekly basis and

five to eight CSOs, with the latter including both partners and parents. The group for CSOs are facilitated separately from the persons with SUDs and in this branch parents and partners are in the same group because of their limited numbers.

The Branch Manager at this Centre, has, for a few weeks consecutively, announced the research project at their meetings held for CSOs and invited individuals who were keen to participate in this study to come forward. After the third consecutive announcement, two CSOs volunteered their participation. The one was a parent of a child with a SUD but since the focus was on the partner of the person with a SUD, she did not meet the first criterion for inclusion. The other individual, Mandy, who met the criteria for inclusion, was recruited as a participant. I decided to use her for pilot-testing the data collection methods and procedures, to which she agreed.

After completing the pilot study and in agreement with my supervisor, we agreed that we could continue with the research. Once more the Branch Manager announced the research project, and Mandy, by word-of-mouth supported the announcements. This branch sporadically has a low “sign-up” rate of CSO-partners so not many could come forward to participate at the time of the research. The Branch Manager, continued to announce the research project and requested individuals who would be willing to participate to come forward. As a result and over a period of time, Andries, Anne and Jane, all of whom met the criteria for inclusion, were recruited through this branch of the MWLC and became part of the sample of CSOs.

- *CAD: Pretoria North*

This branch of the CAD is situated on the premises of a treatment facility, Stabilis, in the north of Pretoria catering for persons with SUDs and CSOs in the northern, eastern and western areas of Pretoria. Although they cover a fairly large area, it is one of a number of settings in the delimited study area providing assistance to CSOs of persons with SUDs. Other settings in the area, also catering for the CSOs of persons with SUDs) includes two treatment facilities, Stabilis and Castle Carey, and two support groups namely HEAL and Al-Anon.

The CAD runs group meetings simultaneously for the persons with SUDs and their CSOs. Topics to be covered at the respective group meetings are announced in advance and are mainly informative in nature. On three different occasions, spanning a period of almost one year, the Chairperson of the CAD, Jansie Nel, invited me to address the meeting on the topic of the effects of SUDs on the family. She allowed for open discussion afterwards. I was also given a time slot at each of the meetings to talk about the research project. The convenor at the end of these group sessions also encouraged CSOs to participate in this research project by emphasising the need for research endeavours like this. Through these appeals, three individuals, Linda, Louna and Nancy communicated an interest to participate in the study. Nancy later withdrew from the CAD for reasons unrelated to this project. Another prospective participant who initially expressed an interest to participate withdrew a day later as her intention to participate in this research project as her husband did was not received well. In the end, I managed to recruit Linda and Louna to become part of the sample of CSOs.

- *MWLC Randburg-branch*

Similar to the Rooihuiskraal branch, the Randburg branch covers a large geographical area as it is the only one that caters for CSOs in the north-western side of Johannesburg. The average monthly sign-up for this branch totals 18 persons with SUDs, and eight to twelve CSOs of persons with a SUD. The groups for CSOs are separately run from the groups for the persons with SUDs. The CSO-support groups are further sub-divided into a parent group and a partner group. The partner groups also include adult children with parents that abuse substances.

When the involvement of the researcher was announced in this branch for the first time, one CSO who met the requirements immediately volunteered to participate in the research project. Cindy was included as a participant.

- *MWLC Benoni-branch*

This branch is the biggest of the three MWLC-branches and is located towards the east of Johannesburg. The average sign-up, monthly, is about 50 persons with a SUD and between 12 to 20 CSOs. It is one of a number of settings which directly or indirectly provide assistance to CSOs. The other settings are: REACH (Benoni and Boksburg), Re-group (Kempton Park) and treatment facilities like Horizon Clinic (Benoni) and Elim Clinic (Kempton Park) and SANCA out-patient treatment programme.

As was the case with the other branches, regular announcements were made to inform the CSOs of the research project. Over a period of about nine months, eight CSOs who met the criteria were included, namely, Elsa, Donna, Paul, Felicity, Olga, Melany, Queen and Kate. Donna left the programme as her husband had a relapse and Melany withdrew when her husband was taken into hospital because of a serious car accident. These losses left me with six CSOs from this branch.

Recruiting the partner with the SUD took a different format and did not follow the classic route of snowball sampling. Initially, when recruiting the CSOs for the study, one of the inclusion criteria (see Chapter One: Subsection 1.6.1) was that the partner with the SUD had to agree with their decision to participate. All the partners of the CSOs who were included in the sample of CSOs agreed to the other person's participation. As indicated earlier, I decided during the pilot study to expand the population parameters and to also include the partners of the CSOs in my study, a decision my supervisor condoned. I requested the partners of CSOs to join the research and in so doing formed the sample group of persons with a SUD. For all practical reasons, I had to use an existing network (the CSOs-sample group) to obtain the sample of partners with a SUD.

2.5.2 The screening and selection process followed with potential interested participants and the initial orientation for data collection

The CSOs of partners with a SUD who came to my attention by way of gatekeepers or after my presentations at their group meetings, and who expressed an initial interest to participate in the research project, were individually screened for suitability for inclusion in the study and subsequently officially selected.

Upon establishing the CSOs' eligibility for participating in my research project and after a verbal agreement that they wanted to participate, I provided them with detailed information about the research. This was done verbally and in writing (See Addendum A and B). It contained information about what their participation would entail, and the logistics related to it. I also stated their rights, the ethical consideration I vouched to observe, not only in the fieldwork, but also in the whole research endeavour. This explanation in part also served to introduce them to and prepare them for the process of data collection, should they eventually agree to participate. Thus, the following points were explained to them:

- They would be requested to write the story (a written narrative) of what it is like for them to live with a partner with a SUD by sharing their experiences, coping strategies and challenges. They were at liberty to write this narrative when and where they pleased to do so.
- I would study the narratives they wrote to prepare a first in-depth interview. In this interview, the information shared in the narratives would be revisited, further explored and clarified.
- In addition, they would be required to participate in a further in-depth interview in which they will be asked for suggestions on how they, as CSOs living with a partner with a SUD, and others in the same boat, would like to or could be supported by social workers. These recommendations would ultimately inform the guidelines for social work intervention aimed at this client-system group.
- That the partners with a SUD agree that they participate in the study.
- That the partner with a SUD will be included in a separate interview to share their perceptions of what is required for assisting a CSO living with a partner with a SUD with me as the researcher initiating this project.

I reiterated that, apart from obtaining their consent in writing to participate out of their own free will in this study, they could exercise the right to withdraw from the study at any time without a penalty. I observed the ethical principles of confidentiality and anonymity. They were given pseudonyms so that their real names could not be linked to any of the branches. In addition, the sequence of the transcriptions for analysis was not connected to a specific time or place, making further identification of participants impossible. Based on these measures it was not possible to identify any of the participants or their partners. As the participants were considered to be a socially vulnerable population in the sense that emotional information was discussed, it might cause further emotional pain when re-living certain circumstances and situations (Dempsey et al., 2016:482; Flora, 2012:314; Raholm, 2008:66; Horowitz, Ladden & Moriarty, 2002:328). They were also informed that counselling services related to the research would be available free of charge.

Following the explanation described above, the individuals still interested in participating were requested to consent to this by completing the Informed Consent Form (see Addendum B) and attaching their official signature. In addition, I requested them to obtain the agreement and willingness from their partners to participate in the study. For this I also gave them a blank informed consent form (see Addendum C) for their partner to complete confirming that they grant them permission to participate in this research study. This had to be returned to me as well. Before proceeding with the process of data collection I provided them with copies of the signed consent forms.

Concerning the **recruitment of the partners with the SUD** the following transpired: Eight of the couples⁹, meaning the concerned significant others and their partners with a SUD were seen as a couple together to check their eligibility for participation. After this the partners agreed verbally to participate and were informed about what their participation would entail (as described above). I then focused on the partner with the SUD informing him/her about the participation in an in-depth interview, what

⁹ These couples were: Paul and Grace, Louna and Stefan, Olga and Danny, Andries and Ida, Anne and Dicky, Queen and Tom, Jane and Honey and Linda and Conrad

the focus would be, and the ethical considerations I would adhere to in this regard. Four of the couples (the partners Cindy and Mike from MWLC in Randburg, and Felicity and Zane, Kate and Barry, and Elsa and William from MWLC in Benoni, could not as individual couples meet at the same time and I therefore checked the eligibility of the partner with the SUD for participation and orientated them in view of data collection individually after having discussed this with the CSOs earlier. This was done as I wanted to be transparent and not allow opportunity for any suspicion with either party.

During the recruitment, screening and selection of participants to sample participants for this study, I was confronted with the question of how many participants should be recruited. For deciding the sample size, the qualitative researcher should be less concerned with the number of participants, but more concerned whether a detailed understanding of a phenomenon would be obtained (Hennink et al., 2011:84). In essence, this boils down to the fact that the research questions must be sufficiently answered (O'Reilly & Parker, 2012:190). I did not plan to include a set number of participants when the research started but focused on demonstrating that "saturation" had been reached. Saturation or "data saturation" refers to the point where the data being collected start to repeat itself (O'Reilly & Parker, 2012:192; Hennink et al., 2011:88).

During the data collection process, I noticed fairly early on with the seventh CSO-participant that the feedback about experiences as well as the suggestions for social work intervention started to repeat itself. Despite this, I continued with five more participants to ensure that I had clearly reached the saturation stage, and I was satisfied that this was so. Reaching saturation of data from the participants with a SUD happened later with repetition of data only becoming apparent when I reflected on the information shared by the tenth participant. The supervisor confirmed this as he also scrutinised the transcription of each interview that was made available soon after an interview had been conducted.

2.5.3 Conducting a pilot-study - pilot-testing the data collection instruments and methods and the trial run of the actual data collection process

A pilot study or trial run, as per the original plan (Chapter One; Subsection 1.6.4) was conducted before the process of data collection with the recruited participants had commenced. In qualitative research, a pilot study serves various purposes. These are –

- developing and refining research instruments such as the development of topical questions to be explored during interviews, or formulating instructions for writing a narrative focusing on the research topic (Singh, 2015:137; Gillham in Sampson, 2004:385);
- fine-tuning of the logistics and activities related to data collection and the implementation of the data collection methods (Singh, 2015:138; Yin, 2011:37; Kim, 2010:191);
- gauging the researcher's ability and readiness to execute the qualitative data collection process and to implement the chosen data collection techniques adopted for the study (Beebe & Lancaster in Kim, 2010:191; Neale et al., 2005:1588).

The first CSO-participant, Mandy, who, after being screened and found eligible for participation, (see Chapter One: Subsection 1.6.1 for inclusion criteria) was selected and informed that she would form part of the pilot study. The aim of pilot-testing the data collection instruments and the methods used is to test the trial run of the actual data collection process. She was informed that she would be exposed to the same suite of data collection methods, and the sequence of the process of data collection as was planned for the main study as mentioned under Subsection 2.5.2. This I explained to her, and prior to officially engaging in the pilot study, I requested her to consent to participating in writing. At this stage, it was not yet apparent that the partner would also participate although he had agreed that about her being involved in it, should the need arise.

I reiterated that the purpose of the pilot study was to trail run the data collection process and pilot test its methods. She would complete a written narrative. I would

analyse it by extracting themes to be covered in a first follow-up interview. At this interview the contents of the narrative would be explored further and issues clarified. Another interview would be arranged during which she would be requested to forward suggestions on how social workers could support CSOs living with a partner with a SUD and use these recommendations to develop guidelines for social work support. The in-depth interviews, with the participants consent, would be digitally-recorded. The recorded interviews would be transcribed afterwards with the participant's details being anonymised and submitted to the study's supervisor for scrutiny and feedback. In addition, and after each data collection activity, time would be set aside to reflect on the participant's experience and to obtain feedback about the methods and processes of data collection that needed to be changed for a more successful main study. An account of the unfolding of the pilot study is given below.

- *The writing of the narrative*

The activities of the MWLC-Rooihuiskraal Branch are held on the premises of the Dutch Reformed Church of Rooihuiskraal and I met with Mandy in its Boardroom. This was a quiet place with no telephones which could cause interruptions and the desks were comfortable for writing. To facilitate the process that would allow Mandy to write her story, I handed her a pen and homemade journal-type exercise book and requested her to write her story. The content was to detail her experiences on how it was for her to live with a partner addicted to a substance¹⁰. I asked her to elaborate and reflect on the feelings and challenges she experienced, and what she did or how she managed to cope with living with a partner addicted to substances.

On completion of the written exercise, I requested Mandy to reflect on the task she had just done by asking: *"What was it like for you to sit down, think through and write your experiences as instructed?"* Mandy's response was: *"I would say, if you look at emotions, there were feelings of hurt, disappointment, loss... trust... there were a lot*

¹⁰ I deliberately decided not to use the concept "substance use disorder" as this not a concept generally used by those who are affected. I also invited her to write in the language of her choice. Furthermore, I highlighted that this is not a test, there are no right or wrong answers and it is not a literacy exercise where grammatical correctness would be assessed.

of emotions going... rejection... If you read this when you write it out I see I actually went so far and gone through so much, but again, I am standing strong and I am still going forward so... I always believe God won't give you something if you are not strong enough to handle it. It also gives me time to think about myself ... I must tell you that after I wrote that letter it created a greater awareness in terms of what I should and should not be doing ... Especially now, in practical terms I need time to think about myself, ... it is going to raise questions for me about myself ... it will allow me time to think ...". Based on this reply, I agreed after consultation with my supervisor that this written exercise decided on was well suited to collect information on the topic being investigated.

- *First follow-up in-depth-interview to explore the content of the written narrative*

In view of preparing for the first follow-up interview to further explore the content of narrative written by Mandy, I immersed myself in her story, looking for aspects to be clarified and themes to be further expounded upon. This interview was also held in the church's boardroom, the same venue where Mandy wrote her story. During this interview, which was digitally recorded, I probed further by saying: *"in your story you mentioned this, can you elaborate?"* and *"from your story I made some discoveries, I like to call them 'themes', which I want us to discuss and to know more about."* In the end, I requested Mandy to reflect on this experience of writing her story.

I enquired about her experience of the session and what she thought needs to be changed about its organisation as this was its first follow-up interview, after the written exercise envisaged with the other sampled participants of the main study. Mandy replied the following: *"After the session I am strong enough for whatever is going to come my way; if I look at "caring" that is something I definitely focused a lot on ... AHM ... but then again you need to look at yourself ... yes, I am caring and loving and whatever but at the end of the day, and this I am neglecting, I need to put myself first. I am a person that would give my last one Rand [ZAR currency] to someone else than use it on myself. That is where I am now ... I need to focus on myself. The way we discussed the research and my role was very understanding ... I like helping others, maybe I am a "people pleaser" but I have to work on it ... I would*

not want to change the session". Although Mandy emphasised the therapeutic value of this session for her and the insight she had obtained, her experiences from what she wrote down were explored and elaborated on, disclosing themes, including feelings and coping strategies. These which could be valuable guidelines in the actual research project.

- *Second follow-up interview to explore suggestions in view of formulating guidelines for social work support to the CSOs of partners with a SUD*

Similar to the contract with the CSO-participants of the main study, Mandy, in the pilot study was also requested to grant me another interview where the focus was to invite suggestions on how social workers could support them as CSOs living with a partner with a SUD. In a friendly way the session was introduced with the following question: *"Against the background of the experiences shared in the previous session, what do you think and perceive as aspects with which you and others in similar situations like yours need help? Suggest some ideas and specific ways how this could happen."*

After having exhausted all the possible suggestions by way of using the skill of probing and follow-up questions on the information Mandy shared, I requested her to reflect on the experience and the organisation of the questions asked. She was specifically asked if anything in connection with this interview, its presentation and questions need to be changed. To this she replied as follows: *"... make it compulsory ... I am serious ...make it compulsory. We cannot advise people to come all the time and continuously encourage people, to come like a parent ... I see it with my brother, he is growing, but my parents don't come, and they are not growing, you see it. So, we have to accept there are people that don't want to come because they think they don't need it. The questions are fine ... but will be different for different people ..."*

Mandy's response indicated that the format and questions should stay the same, but that it might have to be adapted to accommodate the level of comprehension and needs of the different participants I will be likely to encounter. Furthermore, she felt it would be worthwhile to involve her partner, Philip more actively in the research: *"It*

may be interesting to hear from the addict's side, what HE thinks needs to be addressed"

This suggestion was acted upon and the parameter of the population was expanded to also include the partners of the CSOs. My supervisor and I discussed this point and decided to include the partners.

- *Pilot study with the person with the SUD (i.e. partner of the CSO who participated in the pilot study)*

After the second follow-up interview with Mandy, I approached Mandy's husband, Phillip, who attends group sessions for persons with a SUD at MWLC in Rooihuiskraal. He knew me and was aware of the research project as he had agreed to Mandy participating. I briefed him more fully about what the next session of the research was about and asked whether he would consider participating to particularly share his views of what somebody like Mandy would be likely to need as social work support. He indicated that he had been inquisitive about the sessions and was happy to become involved. I informed him about the ethical considerations and clearly spelled out that he was under no obligation to participate. He nevertheless agreed to participate and we set up an appointment for a week later where he would be willing to sign the consent form before participating. He was informed that he was part of the pilot test and that his information would not form part of the data set to be reported on as part of this study's research findings. He accepted that he could reconsider his involvement at any stage.

The questions formulated for the sampled group of persons with SUDs to be piloted with Phillip stressed that answers had to be from their own perspective. They were formulated as:

- how would you describe the effect that living with a person with a SUD as has on a partner?
- how could social workers assist partners living with a person with a SUD?
- with what could social workers support the partners living with a person with a SUD?

In respect of the last two questions I posed follow-up questions and probed for all possible suggestions. Since this interview conducted with Phillip, constituted the pilot study with person with a SUD, he was also requested to reflect on whether the questions posed were clear enough and comment was also sought on the format of the interview, and if necessary, changes needed to be effected.

Feedback from Phillip was: *“Look I am not saying that the supporter [CSO] must change and all those things ... I understood the questions and why they were asked ...My programme would be for people [referring to CSOs] who want to be better than they are ...to look at flaws, to look at things, to walk in honesty and make better people out of addicts ... I can still learn a lot about my life going forward, so ...My commitment to my plan is lifelong ... That is the answer for me.”*

As was the case throughout the session Phillip continuously took the focus back to himself and indicated that CSOs must change to help the partner, something that was described by Mandy and which led to the inclusion of the partners of CSOs as another sample group. Despite this trend, I obtained new insights confirming that the involvement of partners with a SUD in the research project can add valuable and rich information. Involving the partners with the SUDs, by default served a dual purpose: first, as a participant themselves, they provided additional information about what is needed to provide social work support to CSOs, and second, it engaged them in a project the CSOs are involved in, contributing another meaning to their relationship.

- *Reflecting on the pilot study - peer-consultation*

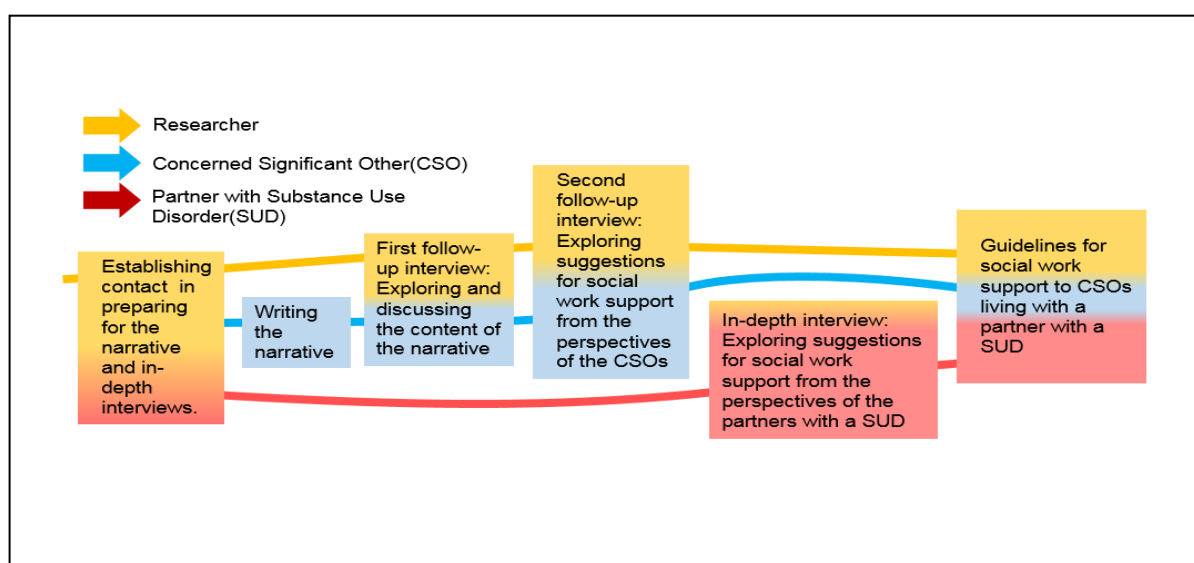
After I had completed the pilot study with Mandy and Phillip and considered the feedback received from them, as well as my own thoughts on the process, the following decisions were taken in respect of the methods and logistics around the methods of data collection for the main study. I, in peer consultation with my supervisor decided to stick with the writing exercise, and to keep to the instructions as originally formulated. Whilst the CSO-participant in the pilot study completed the written exercise in my presence, we decided that participants would be granted the additional option to complete this electronically and submit it via email

communication. The format of the first follow-up in-depth interview to further explore the written narrative was left unamended, as well as the second follow-up interview focusing on suggestions on how social workers could support the partner of a person with a SUD. As for the in-depth interview with the person with the SUD on their suggestions how partners living with a person with a SUD could be assisted by social workers, the guiding question remained unchanged. My supervisor, however, cautioned me to probe for more alternatives and guard against leading the participants by consciously practising the skill of bracketing.

2.6 COLLECTING THE DATA

The pilot study with the CSO-participant served as confirmation to retain both methods of data collection, a written exercise and two individual in-depth interviews as initially decided. This was followed by a decision to conduct an in-depth interview that included the partners with the SUD about their perceptions regarding assistance being given to the CSOs. In Figure 2.3 (below) the process of data collection is depicted by indicating the role players involved in the data collection and the sequential process of the data collection, which will subsequently be described.

Figure 2.3 Overview of the role-players involved in and the sequential process of the data collection



2.6.1 Establishing contact and preparing for the narrative

After the CSOs had been recruited and consented to participate in the research project, they were briefed about writing of the required narrative. They were informed that they would write their story detailing their experiences on how it is (was) for them to live with a partner addicted to a substance. Concerning the place for the writing of the narratives, the participants could either choose to write the narrative at a venue of their own choice where I would be present. Alternatively, they could receive the information about how to complete this written exercise in advance and complete the exercise as a homework assignment and forward it to me via email communication within a week.

Three of the participants, namely Andries, Linda and Anne chose to write the narrative where I would be present. With Andries and Linda an agreement was reached that I would meet them at their place of work, while Anne opted to be at the church offices where the MWLC Rooihuiskraal Branch has their meetings.

Nine of the participants opted to write their narratives at home. These participants were informed that they would be asked for some biographical details (see Addendum D) at the first follow-up session before discussing the content of their narrative. It would be their age, noting their gender, how long (time-wise) they and their partner with a SUD had been in a committed relationship, how many children, if any, highest educational qualifications, employed or not, religious affiliation (if applicable), whether they have used/abused drugs themselves and if they have gone for help for themselves or the partners with a SUD. The purpose of this information was to help me understand the participants' responses better, visualise their circumstances and interpret their responses in context.

2.6.2 Writing the narrative

In the situations where the story was written in my presence, I opted to obtain the participants biographical information already at this contact. Prior to this, I set out to create a warm and welcoming atmosphere by enquiring about their well-being, while

observing their non-verbal behaviour looking for any signs of stress or discomfort, which could affect the session negatively. None were sensed.

We then proceeded to the written exercise. Pen and paper were provided for the participant. I then continued by verbally giving the instructions for this exercise. *“Write your story detailing your experiences on how it is (was) for you to live with your partner addicted to a substance. Elaborate on the feelings and challenges you experienced and what you did and do to manage to cope with living with a partner addicted to substances.”*

The exact wording of the instruction (as given above) was adapted and simplified if warranted by the level of understanding of the participant. I also (as I did with the pilot study) refrained from using the concept “partner with a substance use disorder” as this term is not generally used and understood by the CSOs and their partners. Before they started writing, I put them at ease by informing them that there was no right or wrong sequence in writing the story, no need for grammatical correctness and they could scratch information out and change it. They were welcome to use sketches or graphics if they wanted to explain anything. They were also given the option to write in Afrikaans, which was the home language of a number of the participants. No time limit was set for completing this exercise. No further guidelines on what to write were given so that they could write freely and react spontaneously. On completion, the written document was handed back to me. I enquired about their experience of writing their story as follows: *“What was it like for you to sit down, think through and write your experiences as instructed?”* Table 2.2 reflects the responses of the three participants (see the next page)

Table 2.2 CSOs reflections on the writing of the narratives

Participant	Reflection on writing experience
Andries	<i>"To be honest I did not feel much when I was writing this down, in fact, I expected that you will ask me a list of questions to respond to ... Actually, I found this exercise to be physically stressful. I am not used to writing and my hands became quite sweaty. I did not feel emotional about this at all... but then I value to have written this down instead of responding to a list of questions".</i>
Anne	<i>"I feel I learnt a lot about myself [when thinking and writing her story]... I reflected back a lot to my own childhood years ...I was on a tremendous high; I was a company director ...I was on a high and suddenly it dawned on me that my husband is an addict ...and although it may not have been his intentions, his behavior ruined me ..."</i>
Linda	<i>(After a long silence and trying to fight her tears) Linda uttered: "... I am going to cry ...Let me just get some tissues ... [Getting up and finding some in a drawer]. It is as if the feelings become raw again ... I want to put a cap on it to keep it down. I don't want to think about it. [Crying] But it is there ... I want to ignore it and forget about it, but I can't."</i>

I processed the information shared and debriefed the participants. In Linda's case, I spent roughly five to ten minutes during which I allowed her to ventilate some of her suppressed feelings of sadness, hurt and disappointment. I drew the respective contacts to a close, informed them about what would happen with information from the narrative exercise, and set a date and time for the first follow-up interview. In this interview the contents of what they shared in their written narratives, and the themes that emerged from that will be revisited, further explored and clarified.

For the participants who opted to write their stories on their own, the same information was conveyed verbally at the session where the participants were screened and selected. This was after they had given their consent to participate in the study. The instructions were emailed to them and they were requested to complete the narrative electronically and to forward it to me via email as an attachment in PDF-format to ensure authenticity. For the sake of confidentiality, I

advised them to save the narrative on a password protected computer. While they were given the opportunity to write their story at a time and place of their choice, I requested them to do so within a week, which they all agreed to do. They all returned their narratives via email as an attachment in PDF-format to ensure authenticity, after which I sent them arrangements I had made for the first follow-up.

2.6.3 First follow-up interview: Exploring and discussing the content of the narrative

Upon receiving the participants' written narratives, both the ones written on their own and those written in my presence, I immersed myself in reading their stories and began to analyse them. I made notes on aspects that I wanted to investigate further in the first follow-up interview with them. Three participants wrote their stories in Afrikaans. I subsequently translated these into English and emailed the translations back to the participants for them to check¹¹ to see if I had captured their stories correctly.

Table 2.3 Locations for narrative writing and follow-up interviews

CSO-participant	Writing the narrative	First follow-up interview	Second follow-up interview	Interview with partner
Andries	Participant's office Centurion	Participant's Office	Participant's Office	MWLC Rooihuiskraal
Linda	Participant's office Pretoria	Participant's Office	Home	Home
Kate	Home	MWLC (Benoni)	MWLC (Benoni)	MWLC (Benoni)
Elsa	Home	MWLC (Benoni)	MWLC (Benoni)	MWLC (Benoni)
Cindy	Home	MWLC (Randburg)	MWLC (Randburg)	MWLC (Randburg)
Anne	MWLC (Rooihuiskraal)	MWLC (Rooihuiskraal)	MWLC (Rooihuiskraal)	MWLC (Rooihuiskraal)
Louna	Home	Home	Home	Home

¹¹ This relates to aspect of member checking which will be presented further in this chapter as a strategy to enhance the trustworthiness of the research findings.

CSO-participant	Writing the narrative	First follow-up interview	Second follow-up interview	Interview with partner
Paul	Home	MWLC (Benoni)	MWLC (Benoni)	MWLC (Benoni)
Felicity	Home	MWLC (Benoni)	MWLC (Benoni)	MWLC (Benoni)
Queen	Home	MWLC (Benoni)	MWLC (Benoni)	MWLC (Benoni)
Jane	Home	MWLC (Rooihuiskraal)	MWLC (Rooihuiskraal)	MWLC (Rooihuiskraal)
Olga	Home	MWLC (Benoni)	MWLC (Benoni)	MWLC (Benoni)

Once I had completed the analysis of the participants' stories and made notes about the aspects needing further exploration, I made appointments with those who had completed the exercise electronically for the first follow-up individual in-depth interview. These were arranged for a date, time and place convenient to them. In Table 2.3 (see previous page) the venues where the respective data collection activities took place are indicated.

A variety of alternatives were available for conducting the interviews which suited the participant. However, for practical reasons like privacy and not being disturbed, the options were limited to participant's homes, their office or suitable workplace area or the premises of MWLC-branches.

This aim of the first follow-up in-depth interview focused on exploring the story the participants wrote. Before discussing the content of the written stories, participants who submitted electronic versions of their stories were requested to reflect on their experience of writing: *"What was it like for you to sit down, think through and write your experiences as instructed?"* The responses of the participants are captured in Table 2.4.

This request not only served as an introduction to the discussion by reflecting on the exercise and linking it to their stories, but also for some of the participants it created an opportunity for ventilation and putting them at ease. They were required to share the detail of their stories in writing and this was expected to be difficult. I too acknowledge, as Dempsey et al. (2016:482) do, that the topic being researched is

sensitive and recounting a personal experience of it could evoke emotions for someone participating in an interview of investigation. Moreover, based on the experience of Mandy reflected after the in-depth interview during the pilot study that she found it to have had therapeutic value, I had to guard against the session unfolding as such by being aware of this during an interview, and not turning it into a therapeutic session when interrogating their written narratives.

Table 2.4 CSO's reflections on the experiences of writing the narrative on their own and by way of e-communication

Participant	Reflection on writing experience
Cindy	<i>"I feel, for me it was quite simple. When my husband was in addiction I was asking God a lot of questions, including why this is happening to me... I feel that things happen for a reason and now I can help other people who are in a similar situation."</i>
Felicity	<i>"Yes, I am fine. I felt a bit teary when I wrote some things, but I am fine now ..."</i>
Paul	<i>"This has proven to be a lot harder than I initially thought it would be ..."</i>
Queen	<i>"A lot of hurt and disappointment (starting to cry) ... ja ... it brought back a lot of things ... these things are very personal for me."</i>
Kate	<i>"Finally, somebody wants to know who the supporters are ... I think it is at least as important for the supporter as it is for the addict..."</i>
Olga	<i>"Wow, it was very confusing ... you sit down having suppressed everything for so long ... you know there were times that I was sad and angry at times and wanted to cry, saying to the children, "please go and play, mommy needs a moment ...". So, it all came back one shot, the wall was broken down ..."</i>
Elsa	<i>"I am embarrassed ... as I have to admit that my husband is an alcoholic ... I have to admit this to somebody whom I have never met until now ... uhm ... and I am sad."</i>
Louna	<i>"It's fine. I hope it makes a difference for others ... there will be more people like me who may benefit... If only one person benefits, I will be satisfied that I made a contribution towards this."</i>
Jane	<i>"Somebody is paying attention to what I have to say ... everything is aimed at helping the addict ... I feel like somebody now ..."</i>

Having completed the exercise of having the biographical information of the participants, where applicable, I shifted the focus of the interview to concentrate on the information shared in the narratives and the themes I deduced from it. These were elaborated on, clarified and further explored. In doing so, the participant and I became “co-inquirers” (Anney, 2014:273; Ezzy, 2010:164; Daly, 2007:18) in the process of interrogating, identifying, clarifying and meaning-making of their circumstances. As the content of the written narratives, the focus areas and themes deduced informed the probing questions, I did not use a predetermined set of questions contained in an interview-guide to facilitate this interview. The focus areas/themes deduced for further exploration and elaboration concerned the participant’s experience of and feelings related to living with a partner with a SUD; the ways in which they coped and managed their lives; as well as the challenges they encountered in this context.

2.6.4 Second follow-up interview: Determining the needs of CSOs for intervention

In the second in-depth interview the focus was on exploring the participant’s opinions as CSOs living with a partner with a SUD and their opinions about how they would like social workers to support them. This discussion was focused by posing the following question to them *“Against the background of the experiences shared in the previous session, what, in your perception/understanding could be important aspects or suggestions for social work support to assist you, and/or persons in similar situations like you?”*

With a number of the participants, I had to use follow-up questions and guidance to assist the participants to come up with suggestions, especially in situations where the participant had no idea what a SUD was as they had not been exposed to intervention of this nature before. The guidance and probing focused on topics without the interviewee being offered any detail at all and covered aspects such as the participant understanding of their partner’s SUD, the stage when intervention for a CSO should be introduced, the state of readiness for their involvement as a

partner, the type or nature of involvement, information programmes about substance abuse, and the specific needs that might have to be addressed.

2.6.5 In-depth interview with the partner with the SUD – intervention needs for CSOs according to the partner with a SUD

The partners with the SUD were welcomed to the individual in-depth interviews and I expressed my appreciation for their willingness to participate in the study. I briefly summarised the information discussed at the contact session where they were selected for participation after agreeing to participate voluntarily. I also explained why I did not include them in the previous discussion with the participants. The reason was that I did not want them to be influenced by their contribution. The partners with a SUD were asked the following:

From your perspective -

- how would you describe the effect that living with a person with a SUD as has on a partner?
- how could social workers assist partners living with a person with a SUD?
- with what could social workers support the partners living with a person with a SUD?

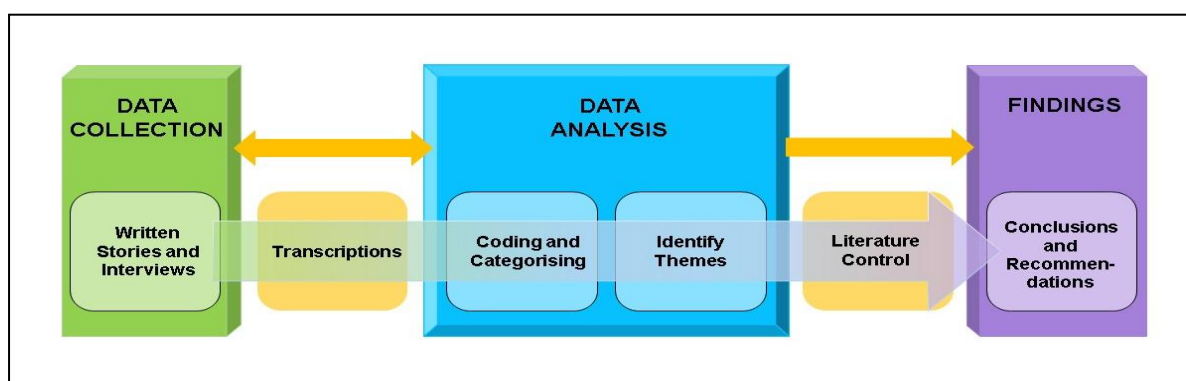
After every interview conducted with each participant, I transcribed the recordings of the interviews by changing the recorded material into text. This was a necessary precursor to commencing the analysis of the interview data, a method King and Horrocks (2010:142-143) suggested. I also submitted the transcribed interviews to the study's supervisor for scrutiny and feedback, together with a copy of my interviewing procedure and the questions to be used for probing. As mentioned earlier in this chapter, I noticed that by the time I had interviewed the seventh CSO-participant, the shared information had started to repeat itself. However, after interviewing another five participants the study's supervisor confirmed that data saturation for this sample group had been reached. As for the people with the SUD who were included as participants, data saturation became noticeable much later at the tenth interview.

Once the data collection was completed, I immersed myself in the activity of data analysis that will be described next.

2.7 APPLICATION OF DATA ANALYSIS

In explaining the concept of data analysis by way of a recap Wu et al (2016:500) write that during data analysis “data are systematically transformed through identifying, defining, interpreting, and describing [themes] that are meant to comprehensively describe the phenomenon or the abstract qualities that they have in common”. Departing from Creswell’s (2014:195) claim that qualitative data analysis will proceed from data collection to the reporting of the research findings and the conclusions about and recommendations from the study the place of data analysis in the qualitative research approach can depicted in the figure below as adopted from Lichtman (2014:328).

Figure 2.4: Context of the process of data analysis in qualitative research



Data analysis is dependent on the written transcripts of the collected data (King & Horrocks, 2010:142-143). The written narratives as well as the verbatim transcriptions of the digitally-recorded interviews of the twelve CSOs, and their twelve partners with a SUD, were all included for analysis. This number excludes the CSO-participant and her partner who participated in the pilot-study. The transcriptions included written reflections of my observations during the interviews. In view of the phenomenological and the collective instrumental case study designs adopted for this study, I followed what Lichtman (2014:336) refers to as a “generic approach” to data analysis because I had looked for themes in the data set. Both the

interviews and the written narratives were transcribed. In addition to this, and especially in relation to the collective instrumental case study design, I followed Tight's (2017:162) suggestion of the technique of cross-case comparisons. This technique relates to assessing whether relationships between the themes exist, and indicating how they are inter-connected. The outcome of this cross-case comparisons will be indicated in Chapters Three and Four where the linkages between themes, Subthemes and categories (where applicable) will be indicated. The services of an independent coder who was versed in the process of analysing qualitative data, was employed to conduct a thematic analysis of the data set independent from me. After this a follow-up consensus discussion, which the study supervisor facilitated and where the independent coder and I presented the themes derived at following the data analysis.

As per the original plan I followed the eight steps proposed by Tesch (cited by Creswell, 2014:198) to conduct a thematic analysis systematically. How I applied the respective steps are described below:

- **Step 1: *Obtaining an overview of the content of transcripts to be analysed:*** Upon starting with the activity of data analysis, I read through the written narratives and all the transcripts of the interviews. The purpose was to get a sense of the whole – getting a picture of what it was like for the CSO-participants to live with a person with a SUD. My thoughts and ideas that emerged from reading the transcripts were noted after having read all the material as part of my attempt to contextualise it.
- **Step 2: *Determining underlying topics:*** After having read all the material (as per the previous step), I selected Anne's (one of the CSO-participants) written narrative together with the transcripts of the recorded interviews I conducted with her. My decision to start with the data set of this participant was based on the fact I regarded this participant's accounts to be particularly information rich. Hence, and in my view, it was regarded as a suitable point of departure. I attentively engaged with this narrative and the interview transcripts. All words, topics and phrases that I perceived to be relevant were noted. Once done, I followed the

same procedure with the remaining eleven CSOs, either using the same words, topics and phrases or adding new ones. When the material of the CSOs was completed, I worked with the transcriptions of the interviews with the twelve partners with a SUD.

- **Step 3: *Categorising and grouping the topics*:** In executing this step, I revisited and sorted the topics and then grouped similar topics. For example, the CSO-participants' references to life with a person with a SUD being "stressful", "trapped" and "feeling isolated" were grouped under the topic (which was later adopted as a theme) - CSOs' experiences of living with a partner with a SUD.
- **Step 4: *Coding of topics*:** Following the categorising of the topics, I started allocating an abbreviation and finding descriptive words for each of the identified topics. I then returned with the list of topics and their accompanying abbreviations to the data sets and placed the abbreviations next to the segments of data corresponding with the respective topics.
- **Step 5: *Turning topics into themes*:** When I was satisfied with the categorising and coding of the topics, a final decision was about the wording of each topic. Each one had to be specific and clear, and then adopted and/or reworded as a theme. The two diagrams in Chapters Three and Four respectively indicate the themes and Subthemes that were eventually deduced and verified at the consensus discussion (See Chapter Three: Subsection 3.3 and Chapter Four: Subsection 4.3).
- **Step 6: *Alphabetically ordering the final theme list for future re-coding purposes*:** A final decision was made in respect of the abbreviations allocated to the respective themes and they were placed in alphabetical order to simplify re-coding should it become necessary.
- **Step 7: *Do a preliminary analysis*:** The data belonging under each theme was assembled and a preliminary analysis of the ordered data was done. The data

with reference to the specific storylines/quotations were then cut from the data set and pasted under theme, Subtheme and category (where applicable) it belonged.

- **Step 8: *Decide if further recoding is required*:** Once the process had been completed and I had gone through the themes and Subthemes, no further re-coding was required. The research findings are documented under Chapters Three and Four of this thesis.

2.8 THE TRUSTWORTHINESS PROTOCOL APPLIED

As indicated in Chapter One (Subsection 1.6.6), qualitative research primarily focuses on interpreting and describing the subjective meaning of experiences (Lichtman, 2014:8-12; Rubin & Babbie, 2013:40; Popay, Rogers & Williams in Fossey et al., 2002:723) to develop a greater understanding of a phenomenon. To comply with scientific standards, especially to obtain trustworthiness and validity, both rigor as well as subjectivity and creativity must be incorporated (Rubin & Babbie, 2013:261; Sarantakos, 2013:102; Johnson in Whitemore et al., 2001:522).

For this study, I have chosen to follow Guba's classical model of trustworthiness in qualitative research as referred to by various authors, for example Lietz and Zayas (2010), Shenton (2014) and Krefting (1991). Four general criteria to assess research that apply to qualitative research were used credibility, transferability, dependability and confirmability. How the strategies to ensure the study's trustworthiness were proposed under the research plan (see Chapter One: Subsection 1.6.6) are presented below according to the aforementioned criteria.

2.8.1 Credibility and strategies employed for its enhancement

A study can be regarded as credible or legitimate if it reflects the meanings the participants conveyed correctly and present findings that correspond with their reality descriptions of human experience. They should also be immediately recognised by individuals that share the same experience (Sandelowski in Cope, 2014:89; Silverman, 2013:285; Tracy, 2010:842; Onwuegbuzie & Leech, 2007:239; Freeman

et al., 2007:26; Shenton, 2004:64 and Sandelowski in Krefting, 1991:216). In this study I employed the following strategies to enhance the credibility of the findings:

- *Prolonged and varied field experience*: Prolonged engagement for Onwuegbuzie and Leech (2007:239) “involves conducting a study for a sufficient period of time to obtain an adequate representation of the ‘voice’ under study”. Spending time in engaging with participants on more than one occasion, does not only breed familiarity, but encourages participants to open up and share more and at a deeper level, especially where the researcher managed to establish rapport and a trusting relationship (Krefting, 1991:128) This, in turn, allows the researcher to explore data below the surface thereby to present “thick descriptions” (Tracy, 2010:843).

In line with the suggestion by Shenton (2004:64), I familiarised myself with organisations where the contact persons agreed to take up the role as gatekeepers before engaging in the data collection process. I managed to build good relationships with the three Branch Managers from MWLC and Chairperson from CAD in Pretoria North, which eventually became the gatekeepers of the organisations where the participants became involved. My visits to MWLC often included consultations and assessments of persons with SUDs unrelated to the research and allowed to build a presence of involvement and familiarity in the organisation. By default, this development implied that I became a familiar face on the premises and a relationship with participants and prospective participants was established easily and naturally.

I have also been invited as speaker on several occasions at CAD, something which has had a similar effect as with MWLC. In addition to these visits, I engaged with CSO-participants formally to execute a data collection task on three occasions and also liaise with a partner with a SUD participant twice. From the responses of participants in general, it is my opinion that there was a relationship of trust with participants and that they were comfortable to share information, albeit about emotional and sensitive matters which, in turn, contributed to the credibility of the study.

- *Thick descriptions:* To achieve credibility, collecting rich and think data on the topic being investigated, the addition of thick descriptions to substantiate themes, Subthemes and categories (where applicable) with quotations from transcribed interviews are vital to enhance the understanding of phenomena (Geertz in Tracy, 2010:843; Onwuegbuzie & Leech, 2007:244). In this study, written narratives further enhance the study as they too were analysed, and this information thickened the data by providing more ideas obtained from the in-depth interviews conducted. In the chapters where the research findings are presented the participants' voices are reflected in the direct quotations extracted from the participants' narratives as well as those from the transcribed interviews that too support the thematic discussion.
- *Triangulation:* This strategy involves the use of different and multiple data collection methods, investigators, sources and theories to obtain corroborating evidence, and in so doing enhances a study's legitimacy. (Thomas, 2017:153; Cruz & Tantia 2016:87; Onwuegbuzie & Leech, 2007:239; Shenton, 2004:66). In this study I have used different data collection methods (narrative writing and in-depth interviews) to gain insight into the experiences, challenges and coping strategies of CSOs living with a partner with a SUD, as well as seeking their suggestions for social work support. I consulted different participants or data sources, even after adding the partners with the SUD. I sought to explore their perceptions on how social worker can assist the partners living with a person with a SUD. I also referred to different scholarly works to serve as a literature control for the research findings. The strength-based perspective, ecological systems and the resiliency theories were used as theoretical triangulation and served as coat hooks to hang the data on and assisted with interpreting the findings that emerged.
- *Member checking:* This refers to the activity of obtaining feedback from the participants or subset of the sample, on the data collected (Silverman, 2013:288; Lietz & Zayas, 2010:194; Tracy, 2010:844); Krefting, 1991:219). I have not engaged in member checking directly for this study other than to obtain feedback from the participants about the narrative writing activity. I also

employed a sort of member checking action by forwarding their written narratives, translated into English; to the three participants who wrote in Afrikaans back to them to check that were a true reflection of what they had shared.

- *Peer examination:* Feedback by peers, colleagues or academics experienced in a specific research or qualitative research study, can assist a researcher to refine or revise a research method, thereby strengthening an argument and input in it (Lietz & Zayas, 2010:196; Shenton, 2004:67; Krefting, 1991:219). I consulted my supervisor regularly during the course of the research process on research methodology matters and decisions that I had to make as well as self-reflection issues and the research process. On occasions, I discussed the matter of treating substance use disorder matters and its treatment with knowledgeable colleagues in the field.
- *Interview technique:* As Roulston (2010:200) indicates, confirming the stance of Krefting (1991:220), it is imperative that the quality of the research interviewing skills used are scrutinised to allow for information-rich data to be collected. This will give a vivid and recognisable description of the phenomenon being investigated and this will improve the credibility of a study. The techniques mostly applied during the interviews were probing, paraphrasing and summarising. The purpose of these techniques was to ensure that I correctly understood what was meant and simultaneously keeping participants focused on the topic of discussion. During the sessions where I tried to determine suggestions for social work support, on a few occasions I slipped to bracket. In a few instances I guided participants, especially where the partner with a SUD was clueless about what a significant other's recovery needs and regime could involve.
- *Structural coherence:* Structural coherence results when the trustworthiness of a study is realised and all the collected data is captured in the research report in a logical and holistic manner (Krefting, 1991:220). For this study, I used the services of a coder who independently and without me, analysed the

data. I also analysed the data set and afterwards we came together for a discussion facilitated by the study's supervisor to reach consensus on the themes deduced from the data. My supervisor played a pivotal scrutinising role in ensuring that the themes with the corresponding storylines were captured logically and a holistic account was provided on the topic that was investigated. This report had to meet the standards of scientific and academic writing. The final document was also linguistically edited by a professional editor.

- *Referential adequacy*: This criterion refers to the record of any additional training and instruction the researcher was required to account for and do that related to the study to improve the skill and application of its research methodology (Krefting, 1991:220). I kept a record of the different workshops I attended to gain available knowledge and skills known to be associated with the field of qualitative research and SUDs (See Addendum I).

2.8.2 Transferability and strategies employed for its enhancement

The criterion of transferability in the context of qualitative research can be defined as the degree to which research findings relate to theory, practice and future research (Lincoln & Guba, in Lietz & Zayas, 2010:195), implying that its documented findings are applicable to the field's "wider population" (Tracy, 2010:846; Shenton, 2004:69). Cope (2014:89) avers that a qualitative study passes this criterion if its findings have meaning to an individual who was not involved in it, and that the findings resonate with the reader's own experiences. However, it must be noted that it was not the aim of the researcher to conduct a transferability audit, but for the readers of the report to do so. The researcher merely needs to provide the "tools" that enable the readers to do an appropriate audit (Lincoln & Guba in Krefting, 1991:221). According to Onwuegbuzie & Leech (2007:244), "rich and thick descriptions inform the reader about transferability ... with such detailed information, the reader is able to transfer information to other settings and context" and to assess whether, and because of "shared characteristics", the findings can be transferred. In this report I endeavoured to provide a detailed description of the research plan (see Chapter One) and how it

was applied (as described in this Chapter). I endeavour to place on record a detailed account of the research findings in Chapters Three and Four, where I substantiate the themes, Subthemes and categories, where applicable, with quotations from the transcribed interviews and the participants' narratives. The participants' narratives serve as "tools" to enable the readers of the report to assess the study's transferability potential.

2.8.3 Dependability and strategies for its enhancement

Dependability is concerned with the degree to which the research procedures are documented enabling someone outside its domain to follow and survey the research process and conduct a dependability audit (Lietz & Zayas, 2010:195; Nicholls 2009:645; Shenton 2004:71). For the audit trail I provided a detailed plan for this research project (presented in Chapter One) and for this current Chapter Two, I devoted it to how the plan was applied providing the "trail" for such an audit. In addition, member-checking and thick description of the research process followed and the research findings (as earlier explained) were used as strategies to further enhance dependability.

2.8.4 Confirmability and strategies for its enhancement

Confirmability points to confirm and corroborate the findings of a particular study (Lietz & Zayas 2010:197; Nicholls, 2009:645). For this reason, the onus is on the researcher to ensure that the findings are embedded in the participants accounts and experiences, honestly reflected, free of bias, and not those the researcher prefers (Lietz & Zayas, 2010:197). Confirmability can be assessed by leaving an audit trail (Carcary, 2009:15) (explained earlier in this Chapter). Such audit would consist of keeping a record kept of all the researcher decisions and actions, the levels of participations, transcription details, challenges faced and how the researcher adapted to them. I have provided this in this chapter and did so in Chapter One when referring to the proposed research plan. Also included are a record of all activities undertaken during the research, including methodological descriptions, my thoughts and actions during the research process and discussions

with my supervisor such as the tools for an audit trail. In addition, I had employed the strategy of peer-examination, as described earlier, step-wise replication as strategy where the researcher and the independent coder independently apart from each other, analysed the data and compared the results to enhance the confirmability of results.

2.8.5 Reflexivity

In responding to the realisation that the qualitative researcher is both part of the context setting, and the phenomenon being investigated (LaBanca, 2011:1161; Schwandt, 2001:224), I realised the study was multifaceted. A person's "social background, assumptions, positioning and behaviour impacts on the research process" (Finlay & Gold in Hennink et al., 2011:19) and a reflexive stance and orientation need to be adopted. A high measure of reflexivity is regarded as a classic principle in conducting trustworthy qualitative research because it helps to clarify and position the researcher's thinking, values, purpose and beliefs (LaBanca, 2011:1161; King & Horrocks, 2010:126). In explaining the concept "reflexivity" both Schwandt (2001:224) and Hennink et al. (2011:19) refer to reflexivity being -

- a conscious and continuous process of critical self-reflection and stocktaking on the part of researchers,
- a chance to aim at making their biases known; as well as acknowledging their theoretical predispositions and preferences, personal history, professional standing and interests that brought to them to this research, and
- to reflect on the influences these aspects have on the research process from start to finish (Houghton et al., 2013:15; Gough in King & Horrocks, 2010:127).

Employing reflexivity as a strategy for enhancing a study's trustworthiness has the following benefits that LaBanca (2011:1161) highlights: it -

- makes a call for rigorous research which, in turn, will result in more transparent data.

- encourages researchers to be open, disclosing their personal and theoretical preferences, commitments, decision pathways and positionality, and in so doing allow for a confirmability audit to be conducted.
- assists with determining the impact of previous knowledge and experiences on the research process, the data collected, and the interpretations made.
- “increases sophisticated understanding of research methodology. It allows for the development of a thorough, concise, and elegant conceptual framework with a systemic, yet flexible, and potentially emergent, research design” (LaBanca, 2011:1161).

Reflexivity can be personal or interpersonal (Hennink et al., 2011:20). With personal reflexivity researchers critically reflect on how their own background, beliefs and experiences might influence the process of the research and data creation (King & Horrocks, 2010:128). Interpersonal reflexivity points to the aspects of how the interview influences knowledge creation and the dynamic interpersonal dance between the researcher and participant (Hennink et al., 2011:20). Willig (cited in King & Horrocks, 2010:19) adds “epistemological reflexivity” aims to encourage researchers to reflect on the assumptions they made about the world as constructed during the entire delimited research endeavour.

Against this background information about reflexivity, the focus of the discussion will now shift to how I applied it in this thesis. As Dempsey et al. (2016:481) suggest, I kept a reflective journal¹², (see Addendum J) used the skills of bracketing (to be explained further on) during the interviews and my supervisor disclosed and challenged my self-deceptions during peer-debriefing sessions. I will arrange the order of my discussion on reflexivity as personal, interpersonal and epistemological reflexivity.

2.8.5.1 Personal reflexivity

¹² A research journal can be regarded as a record of the researcher’s beliefs, biases, interpretations, understandings and actions during the research process (Ortlipp, 2008:695)

Insofar as personal reflexivity is concerned, I pondered the question about *what brought me to wanting to do this research*. I realised that the answer was both personal and professional. Whilst engaging in critical self-reflection, I became aware how my own personal history and my professional standing drew me to embark on this research journey.

My upbringing and childhood experiences, in hindsight, ignited in me the fire to fight the cause of the “underdog” which eventually led to my decision to become a social worker. Allow me to share my story: *I grew up in South Africa during the second half of the twenty-first century, an era characterised, amongst other things, by a rigid conservative and cultural system with pre-conceived ideas about people, including people of different races and gender orientations. I was brought up in a white middle-class family and have two sisters younger than me. Family life has been strongly influenced by the views of society of the time, but also by the ongoing conflict between my Afrikaans father and Dutch mother, primarily due to their different perceptions of life; a ‘mom’ growing up as over-protected teenager during the second world war and a ‘dad’, a sanguine artist with his head in the clouds but emotionally explosive when crossed.*

At school, as a physically small boy with a strong Dutch accent, I was made fun of until Grade 5, often reprimanded by teachers for ending up in fights when I caught those teasing me. In my father’s eyes I was not “man” enough to put a stop to this, so I eventually learnt to survive by becoming like them. However, in High School the visits from our family in Holland usually led to discussions about society and politics, creating an awareness to no longer “be like them” as what is generally stood for was unjust.

So, both at home and outside home I learnt when and how to become emotionally involved but also how to keep a safe distance, both physically and emotionally. Helping others in need became a strong drive and eventually contributed to my motivation to qualify as a social worker.

In my career as a social worker, spanning more than 40 years, I have become astoundingly aware of the influential effect and unjust situation the partners of a SUD cause in a family household. Not only have I come to realise this in my own involvement in rendering social work services to clients involved with and affected by SUDs, but my childhood experiences have also informed me that it does exist. In my view, the CSOs of partners with a SUD are willingly and/or unwillingly being trapped in and traumatised in such unjust situations. Moreover, other scholars are increasingly researching such dilemmas like Bradshaw, Shumway, Wang, Harris, Smith and Austin-Robillard (2016:23). Even when it comes to a tailor-made treatment regime for them *per se* to support them with this conundrum they find themselves in, they are the underdogs. They are seldom the central focus in the narrative of the treatment of the partner with the SUD (Wilson et al., 2017:57).

My personal background and experiences, as well as my professional standing, not only as social work practitioner but also as a lecturer in the discipline of Social Work, contributed to my belief system, dynamic in nature, which I brought to the research process. This can be summed up as follows: *I accept and value the differences in people and believe there is a "place in the sun for all of us". I acknowledge we live in an imperfect and broken world, but if we make sufficient effort we can overcome many, if not most, of lives difficulties. I accept the fact that for most things in life there is no answer and it does not matter; yet the flip side of the coin is that every problem must have an answer; the tricky bit is to find the answer. I like to analyse and philosophise about situations. I like people, but I like to be alone more.*

Emanating from this self-reflection, I came to the realisation that my belief system or my philosophy of life, impacted directly on my choice of theoretical framework adopted for this study. I was drawn towards the strength-based perspective, resilience and eco-systems theories. The strength-based perspective encapsulates the belief that people have the capacities to change, drawing from a well and wealth of intrapersonal, interpersonal and environmental resources, eco-systemically speaking, when given the opportunity (Jones, Hardiman & Carpenter, 2007:261; Freeman, 2001:239; Powell, Batsche, Ferro, Fox & Dunlap, 1997:4). The strength-based perspective ties in with the notion of resiliency or the individual's capacity to

bounce back from adversity, to become more resilient when discovering their strengths and learning skills on how to address these situations impacting upon them (Guo & Tsui, 2010:235; Roberts, Galassi, McDonald & Sachs, 2002:56).

2.8.5.2 Interpersonal reflexivity

As far as interpersonal reflexivity was concerned I became conscious of aspects related to the dynamic interpersonal dance between me as researcher and the participants, especially when I engaged in the processes of data collection.

The methods of data collection adopted for this study had for many of the participants therapeutic spinoffs, as it allowed them to share their experiences, challenges and coping strategies in relation to their living circumstances with their own partner with a SUD. It provided opportunities for catharsis, self-reflection, clarification and hope. Having said this, various scholars caution that while researchers must be empathic and responsive to the participants' needs, they are not counsellors, but researchers (Dempsey, et al., 2016:485-6; Hennink et al., 2011:122). With the CSO-participants being aware of the fact that I was a social worker, and how I actively listened to them and responded with empathy to their stories, has on a number of occasions led to a situation where the boundary between research and social work counselling became blurred. What brought on this state of affairs was the fact that the research interview skills, such as active listening and empathic responding, clarifying and probing being used purposively are very similar to those of social work or therapeutic counselling skills which would tend to strengthen this role of confusion and blurring boundaries on the part of both the participant and myself as the researcher.

Rizq (2008:42) refers to a similar dilemma by quoting Dickson-Swift et al. who reported that qualitative researchers were concerned about the 'therapeutic' role of the research interview, and frequently found it difficult to manage the boundary between research and counselling. To avert this situation, I followed the advice of Murray (as cited in Dempsey et al., 2016:485) to deliberately retain clear boundaries that would prevent me, as the researcher, from becoming or being the therapist. In

addition, I used the skill of bracketing. Bracketing means: “to hold all preconceptions in abeyance”, which is to proceed from the “unknown to the known”. This simply means to consciously try to limit the contamination of data and manipulating the direction of the interviews and the responses of participants (Beech, 1999:35). I bracketed by consciously reminding myself about my role in this context – that of being the researcher and not the social worker. I also made my role in our relationship very clear to the participants. We were both engaged in doing research performing definite functions. I am the researcher in a research partnership with them. It is not a therapeutic relationship where I am the “helper” and they are being “helped” (Bullpitt & Martin, 2010:11). In this partnership these roles are switched. Here, I am being “helped” to use my interviewing skills to explore the breadth and depth of a chosen, named and planned topic that is being investigated.

I am a social worker and a University lecturer in the discipline of Social Work and acutely aware of how my positionality can translate into power relationship between interviewer and interviewee (Hennink et al., 2011:122). I acknowledge and accept this research function that goes with my professional standing, which is linked to my occupation, that of being who I am and what I do. In thinking about what the actual acceptance of the presence of a person in a position of authority could have on a participant in the group like this, and its inbuilt power, I realised how quickly a barrier between us could develop, even unintentionally. This would mar the quality of the shared data and influence the data collection process. To side line a possible breakdown or misinterpretation of communication and expected flow of communication, I adopted a ‘position’ of acknowledging and regarding the participants as the “experts” while I played a role of being a learner student. According to Milena et al. (2008: 1279), Guest et al. (2013: 153), use of this technique effectively can result in a levelled playing field. In retrospect, I also became aware of the fact that the participants and I were both from the same generally recognised economic middle class and shared similar Christian norms and standards, which too might have narrowed the distance gap between varying power relations. Considering that in interviewer-interviewee research partnerships are common, the possibility of transference and counter-transference occurring cannot be ruled out. I acknowledge the fact that due to the age difference between myself

and most of the participants, with me being significantly older, some of them might view or relate to me as a father figure, confidant, or guru. I constantly and consciously kept reminding myself not to fall into this trap by reacting accordingly and remember to prevent it by mentally relating to my role in this relationship and the purpose of the research.

2.8.5.3 Epistemological reflexivity

In reflecting on the assumptions made about the world constructed during the whole research endeavour, I need to declare the following:

During the research activity of participant recruitment, an aspect that had a markedly negative impact on my research was to access participants from the Black African culture groups and the reasons were **prevailing cultural beliefs** and recovery from a **western perspective**. The issues of concern were how the treatment of a partner with a SUD was viewed, and the role and position of the CSO-partner in such a relationship. Allow me to explain: The organisation “Counselling At” is a voluntary organisation providing community-based services in a number of areas towards the south of the City of Tshwane, in Gauteng, South Africa. During a meeting with “Counselling At” in Centurion (July 2016), the problem of SUDs in Olievenhoutbosch and problems encountered with the treatment and support of persons and family with SUDs were discussed. They established a drug action committee with the main focus on the youth with SUDs. However, the committee members indicated the need for assistance in the families but were not sure that the communities understood what the treatment and support for addicts and the family meant.

At a follow-up meeting with the Drug Action Committee in Olievenhoutbosch, I explained what the research was all about and I also expressed the need to include individuals from these predominantly African communities as part of my sample, should they be eligible for participation. The understanding of the committee was that such treatment was solely directed to the person with the SUD and not for the CSOs. Their role was primarily to **support sobriety**. When asked about the impact of SUDs on the family this was not regarded as important for treatment and indicated that a

female partner can never take control or prescribe ways of behaving. A woman was not allowed to set boundaries in her relationship with her husband, including the male partner with a SUD. The understanding of marriage in their culture even in a westernised community currently cannot accommodate this.

Through this research endeavour I got a glimpse of **how partners of a person with a SUD is labelled**, and a subsequent effect of this labelling. At the organisations that assist people in such a situation, CSOs are generally referred to as “supporters” confirming the perception that it is their role to assist the person with a SUD. When they initially become involved with their partners’ recovery or treatment, they do so with the belief of “helping them” (Wilson et al., 2017:56). This can also be linked to the CSOs dropout rate when they stop their involvement with that person, or the person with the SUD stops treatment, or relapses again, or they cannot help them any longer. Upon reflection, I realised that such a label may deny them the right to treatment as person in their own right, as they perceive themselves in the role of *assisting* their partners.

Another assumption constructed through this research endeavour, is that some of the participants with the SUD’s are ignorant about their partner’s experiences of the situation. This definitely implies a need for **social work intervention** and knowledge about the nature of such intervention. Due to the SUD they have become so entangled and self-consumed and pre-occupied with their substance use that they effectively became estranged, emotionally and physically from their partners (Gostecnik, Repic, Cvetek & Cvetek, 2010:366).

Ethical considerations as they have been applied during the research process are described under the next heading.

2.9 A DESCRIPTION OF HOW THE ETHICAL PRINCIPLES ADOPTED FOR THIS STUDY WAS APPLIED

While the concept ethics was introduced in Chapter One (see Subsection 1.7) expanding on it is deemed necessary to set the scene for its application. As ethics in

the context of social research is regarded as “principles of conduct about what is right and what is wrong” (Thomas, 2017:520) it calls on the researcher to display academic integrity and honesty. Punch (2016:23) stresses respect for other people. Addressing ethical challenges and a consciousness about it have to be observed and considered throughout the research endeavor from its conception to its completion (Richards, 2015:15).

I considered ethical principles as part of the research plan and ensured they would be observed in this study as the exposition (see Chapter One: Subsection 1.7) illustrates. I adopted the following ethical principles for this research project obtaining informed consent, confidentiality and anonymity minimising, harm and debriefing, as well as management of information. How these were applied will be discussed further below as well as the other ethical considerations added during the course of the research project. In this plan I vouched to adhere to the following ethical principles and in the discussion to follow I describe how these principles were applied, a process that began with a research proposal.

Before commencing with the research project, I had, as suggested by various scholars (Thomas, 2017:44; Richards, 2015:15; Sarantakos, 2013:15, 16) submitted my research plan to an ethical committee or institutional review board of a tertiary institution. In this case I submitted it to the Departmental Research and Ethics Committee of the Department of Social Work at the University of South Africa where I was enrolled for my doctoral studies. The official function of this Committee was to assess whether the research plan submitted adhered to methodological and ethical soundness and provide ethical clearance. My proposal was submitted to the mentioned Committee on 18 September 2014 and I obtained approval (Ref. DR&EC_2014_008) in November 2014.

2.9.1 Obtaining informed consent

Prospective participants for any research project have to be informed about the nature of the research, the extent to which they can make an informed choice as to whether they want to participate or not and whether they or will not be coerced into

participating (Lichtman, 2014:59; Hardwick & Worsley, 2011:33). Consent for participating in a research project should be based on the premise that the person who consent is adequately informed, competent to do so, and does it voluntarily (Allmark in Flick, 2015:33). Since consent indicates an agreement between a participant and a researcher involved in managing a research project, participants must know what this agreement entails. Moreover, including the details of the format and process of the research and how the information will be handled, explaining exactly what is required of the participant during the entire research as planned should be clearly specified (Thomas, 2017:47).

In addition, the identification of the researcher and sponsoring institution must be disclosed, the role of the participant and any risks or benefits associated with participation too should be disclosed (Thomas, 2017:46; Hennink et al., 2011:63; Creswell, 2009:89; Padgett 2008:65). All this information must be conveyed in a simple and understandable manner (Lichtman, 2014: 59). Once this is clear and the participant is assured of absolute anonymity, written consent must be requested, although this may be withdrawn at any given stage (King & Horrocks, 2010:115; South Africa, 'Ethics in Health Research: Principles, Processes and Structures', 2015:17).

After having obtained permission from participating organizations (Addendum C) and gatekeepers for the research, I proceeded with the recruitment, screening and selection of participants. During these activities, all information regarding the research, as described in the previous paragraph was individually discussed in detail with the participants. Following this discussion and once I was convinced the prospective participants understood the information, those who met the criteria for inclusion and who, together with their partners volunteered to participate, were selected for inclusion in the study and requested to sign the consent form (Addendum B) and return it to me.

2.9.2 Do not harm or minimise harm and debriefing

Not harming participants, according to Lichtman (2014:57) forms the basis of all ethical conduct. In the context of social research “harm” can include physical, legal and emotional or psychological harm such as shame or embarrassment, reliving painful emotions or trauma or rejection too (Sarantakos, 2013:18; Hennink et al., 2011:67; Hardwick & Worsley, 2011:31; King & Horrocks, 2010:106). Hence it is advisable not to include any person who is likely to face unnecessary threat of harm, even if they represent the target population that may benefit from the research (South Africa, ‘Ethics in Health Research: Principles, Processes and Structures’, 2015:16; Lichtman, 2014:56).

To not harm, remains a delicate and unpredictable affair, in any research endeavour. While a researcher’s intention is not to harm, collecting data, especially qualitative data through narratives and interviewing (Creswell, 2009:91) can accompany a risk of harm. This is even more true when involving vulnerable groups, and focusing on sensitive topics that may evoke strong emotions from those participating in it. Then is difficult to anticipate or determine the level of harm that could result from a process of obtaining information and putting a remedial plan in action in place to minimise the harm (Dempsey et al., 2016:482). Acknowledging this conundrum, I endeavoured to structure the process of data collection in such a way that they would feel confident to deal with their situation. Even though participants in a research endeavour do so voluntarily and willingly give their consent if obliged to, they should not leave it feeling worse off and more unsettled than before their involvement (Rubin & Babbie, 2007:38). For this reason, Padgett (2008:69) advises that in situations where such risks cannot be avoided, measures should be taken in advance to address this possibility.

From the start of this research project I was mindful of the fact that the topic being investigated did carry a risk of harm for the following reasons:

- The CSOs of partners with a SUD can generally be regarded as a vulnerable population and the topic being explored is a sensitive one (Dempsey et al., 2016:482; Valtonen et al., 2009:39-60; Chapter One: Subsection 1.6.3).

- As the collecting of data is about experiences while living with a person with a SUD, the chance of it opening up painful or traumatic feelings could be encountered.
- Exploring experiences and challenges by means of in-depth interviews could reveal hidden or unresolved issues the CSOs have, not only pertaining to the partner with a SUD but probably even some that stem from earlier or childhood experiences.
- Tension in the relationship between the participant and their spouse, fiancée or partner who agreed to the engagement in this research, could arise.

An effort to minimise the risk of harm as described in the aforementioned scenarios was considered in the management of this study's research plan by putting the following measures in place.

During the recruitment phase I mentioned to all participants that, should they at any stage of the research process feel uneasy, unsettled or perturbed by participating in the research they could withdraw from the study. Importantly, they could exercise the right to do without penalty or negative consequences and this ties in with what Hennink et al. (2011:63) refer to as "self-determination". This vision and intention has been upheld throughout the research process adopted for this study. Not one CSO-participant withdrew from the data collection process except two who left because their partners with a SUD unilaterally terminated the SUD treatment they were having, the one partner had a serious car accident.

Another measure to minimise harm that was put in place was debriefing. Debriefing takes place in that an opportunity is created to allow the participant to deal with traumatic or painful emotions as they came up during the research interview (Hennink et al., 2011:75) and even to refer a participants for counselling to deal with matters unearthed during the interviewing process. Hennink et al. (2011:175) point out that such debriefing can be handled by the researcher, a professional or lay person attached to the organisation, or an external professional person. Both the participant, by being transparent about their feelings, and the researcher, by being sensitive and alert to the feelings of the participant, have the responsibility to identify

and respond to the need for debriefing to the fore when required (Rubin & Babbie, 2007:39).

Throughout the research project in my dealings with the participants, given their vulnerability, especially that of the CSOs, and the sensitivity of the topic, I remained attuned to their well-being prior to and following every contact time I had with them. I have always been available to facilitate a debriefing session if necessary and used the service of a fellow colleague, well versed in such debriefing. However, none of the participants ever requested being referred for either professional counselling or outside debriefing while being involved in this research project.

2.9.3 Privacy and anonymity

Many scholars support the standpoint of Hennink, et al. (2011:71), who postulate that *full anonymity* cannot be ensured, as the members of the research team have access to the data collected and the identity of the participants. Hence, anonymity involves the protection of the identity of the participants in any and all the documents and data resulting from the research (Sarantakos, 2013:18; Hennink et al., 2011:71; King & Horrocks, 2010:117; Rubin & Babbie, 2007:40). The major difficulties encountered with anonymity during qualitative research are the small number of participants and the type of method of data collection chosen for the sourcing of data. Inevitably, having the researchers themselves gathering the data means they will have access to documents that would have information about the identify of all the participants (Padgett, 2008:65; Rubin & Babbie, 2007:40). Such availability confirms the claim that research can expose an organisation's or an individual's privacy and anonymity (Lichtman, 2014:56). This exposition fits the researcher and supervisor's situations that confronted the management of this research project, and explains how the research was ethically executed.

As Silverman (2013:162) felt was necessary, it is the researcher's responsibility to ensure that both the research data and the sources from whence it was obtained had to remain confidential. I agreed, and used of two different organisations, (MWLC) and (CAD) of which MWLC has three different branches in different geographical

areas. Although the organisations and gatekeepers had no objection about their involvement being indicated in the research, the anonymity of participants was ensured in that they could not be linked with any of the organisations or branches due to the pseudonyms I had given to each of the participants. Research interviews took place over twelve months, which further complicated any attempt to establish identification or links to specified participants connected to organisations. Finally, pseudonyms were used and secured to hide the true identity of participants as effectively as possible.

2.9.4 Confidentiality

Confidentiality in research involves preventing the public from being able to link certain information with specific people who participated in a known investigation (Rubin & Babbie, 2013:290). This includes the revealing of any information emerging from the research which could embarrass the participants or endanger their home life (Rubin and Babbie, 2007:39).

In this research particular care had to be taken in three areas regarding confidentiality:

- **Written narratives:** As part of collecting data, CSOs were requested to write their experiences, challenges and coping strategies in a narrative form and some opted to do this electronically and email their stories to me after completion. The emailed narratives and the hard copies of the narratives that the participant who completed this exercise in my presence handed to me, were allocated a pseudonym and saved the stories under their respective pseudonyms using a password that was on a protected computer. I removed the stories received as attachments from the email server.
- **Biographical information:** This information was compiled in the report in such a manner that the participants could not be linked to the personal information they provided.
- **Interviews:** During the final interview as part of collecting data included both the CSO and the partner with a SUD, care was taken not to disclose any

information provided by CSOs in earlier individual sessions in such a way that the partner could link it with the CSO.

2.9.5 Establishing and maintaining ethical boundaries and researcher-participant relationships

Obtaining meaningful and useful data during the interview, especially from people considered as being vulnerable and topics considered sensitive, underscores the importance of establishing trusting relationships, bonds and connections between the researcher and participant (Thomas, 2017:202; Dempsey et al., 2016:485; Lichtman, 2014:252; Sarantakos, 2013:288). Although face-to-face individual interviews rely on close personal contact, various authors caution that participants must not perceive the relationship friendship (Thomas, 2017:202; Lichtman, 2014:61; Seidman, 2006:98). Even more important in this relationship context is that the researcher does not become a therapist/counsellor. For this reason, retaining clear boundaries between participants is advocated (Dempsey et al., 2016:485).

Although the data collection with the CSOs centrally amounted to a minimum of four to five contacts per participant, I remained mindful that the participants are part of a vulnerable population and took care to see that my own boundaries were clearly in place. Additionally, I paid constant attention to keeping my role well defined during recruitment, not allowing participants to become emotionally attached to me, nor did I enter the role of the social worker. In line with the advice Jones (2009:114) advocates, I was being conscientious, met my commitments and objectives, and kept my promises, holding myself accountable for directing the research process strategically and sequentially. Through all this concentrated thought, my aim was to model respect for the participants.

2.9.6 Managing the possibility of intruding on the participants' privacy time and space-wise

Although participants gave their consent to partake in the research project, it does not allow the researcher to be overly disturbing by intruding in the time, space and

personal lives of participants (Lichtman, 2014:61). Qualitative research and more specifically the methods of data collection, implies the recruiting and involving of participants in research, something which requires a significant portion of their time and energy, disclosing personal information to so-called strangers (Rubin & Babbie, 2007:37, 38). As research is dependent on the cooperation of an individual or a group of participants, their consent for participating has to be obtained. In addition to minimising any intrusion, I timeously scheduled appointments at a time and place convenient for the individual participants and did not exceed the agreed upon time for the interview.

2.9.7 Management of information

Once all the required data from the research was obtained, it should be handled in such a way that it is safe and secure to ensure maximum protection of information, including the anonymity and confidentiality of the participants, and that it is only utilised for the purposes of the research (Thomas, 2017:46; Hennink et al., 2011:72; King & Horrocks 2010:104; McMillan & Schumacher, 2010:72). However, Creswell (2009:91) points out that the data, once analysed, must be accessible for a minimum period of five years before it is destroyed. An accurate account of the information is required at times to be verified before being destroyed.

For this study, the original hardcopies of all the information, including the signed consent forms, were safely stored in a file that only I could identify, and they were locked in a cupboard. All electronic copies were saved on the computer which was password protected and under their pseudonyms to ensure further safety. Back-ups are made on memory-sticks kept in two different places.

2.10 CHAPTER SUMMARY

In this chapter the practical application of the research plan was represented. I started off with a general introduction to the chapter, which was followed by an applied description of the nature and characteristics of qualitative research. A total of

12 characteristics of qualitative research were highlighted in table form and how they were applied in this research endeavour indicated.

Following the discussion on the characteristics of qualitative research, I went into a detailed description of the research design, referring to the collective instrumental case study and phenomenological design as well as a description of the explorative, descriptive and contextual designs in qualitative research. The description of the implementation of the research design was followed by the application of the research methods, starting with identifying the populations of CSOs of partners with a SUD as well as those who struggle with substance use disorder and organisations who provide services to these groups. Sampling and sampling techniques were described as well as a detailed account was provided on the recruitment and selection of participants and preparing them for data collection. The implementation of a pilot test was introduced and changes which were brought about in the research method resulting from the pilot study before giving account of the collection of data by means of narrative writing as well as in-depth interviews with the CSOs and their partners with a SUD.

The data analysis including the process of developing the themes and Subthemes was discussed, followed by the application of the trustworthiness protocol referring to credibility, transferability, dependability and confirmability with a strong emphasis on reflexivity as integral part of the protocol.

To close, the application of the ethical considerations under the headings of informed consent, do no harm and debriefing, privacy and anonymity, confidentiality, ethical participant-researcher relationship and the management of information, concluded the chapter.

In the third chapter, I provide biographical details of the CSO-participants and the themes of the experiences, challenges and coping strategies of the CSOs comparing it with available literature.

CHAPTER THREE

RESEARCH FINDINGS (PART ONE): THE EXPERIENCES, CHALLENGES AND COPING STRATEGIES OF A CSO LIVING WITH A PARTNER WITH A SUD

3.1 INTRODUCTION

In the previous chapter of this thesis, I provided a detailed description of how the research process adopted for this research project was applied. The activities began with identifying the population for the study, the recruitment and screening for participants to be included in the samples. The preparation for data collection, the data collection itself and then its analysis followed as well as the strategies employed to ensure the trustworthiness of the research findings.

In this chapter the focus turns to the presentation of the first section of the research findings, focusing exclusively on the experiences, challenges and coping strategies of the CSOs living with a partner with a SUD. I will start out by providing the biographical information of the CSOs of the partners with a SUD who had been sampled. This will be followed by a thematic presentation of the research findings, noting their experiences, challenges and coping strategies. These themes emerged from the processes of data analysis conducted by an independent coder and myself.

After the completion of the data analysis processes, in a consensus discussion facilitated by the study supervisor, the themes the independent coder and I had identified were further crystallised and consolidated. To substantiate a particular theme, subtheme or even a category deduced from the datasets, storylines from the participants' narratives and the interview transcripts will be given and used to underscore a research finding.

Quoting words, phrases and sentences from the participants' interview transcriptions in substantiating a theme that emerged is not uncommon in qualitative research

reports. Sandelowski (1994:479) exposes this technique as one of the devices researchers use to make their claims. In his work this author states that quoting the participants' words provides substantiation for a point the researcher wants to make. It can also fulfil the function of exemplifying an idea, or "to represent the thoughts, feelings or moods of the persons quoted or to provoke a response in the members of the audience for the research report" (Sandelowski, 1994:480).

In addition to quoting storylines from the participants' narratives and the interview transcripts to underscore a research finding, literature speaking to a particular theme, subtheme or a category (where applicable) will be used to either introduce a theme, subtheme or category, or to confirm and/or contrast a theme and/or storyline.

3.2 THE BIOGRAPHICAL INFORMATION OF THE CSOs

A person's SUD impacts strongly on and affects various relationships, especially the intimate relationships with a partner or spouse (Wilson et al., 2017:57; McCann et al., 2017:2; Rodriquez, Neighbors & Knee, 2014:294; Hudson et al., 2014:106). This can be ascribed to the interdependence of such a relationship and the fact that a partner's SUD affects their "shared life" on both an emotional and practical level (Rodriquez et al., 2014:295). Having stated this, Lander, Howsare and Byrne (2013:194) emphasise that "each family and each family member is uniquely affected in terms of their needs left unmet in such close relationships, their emotional wellness, physical safety and financial security".

In Table 3.1 (on the following page), the biographical information obtained only about the CSOs of a partner with a SUD who participated in the study is included. However, to create a context and a link with Chapter Four where the biographical details of the partners with the SUD are introduced their allocated identification and pseudonym is also listed with that of the CSOs but is written in italics underneath in brackets. The biographical information tabulated will be discussed afterwards.

Table 3.1: The biographical information of the CSOs only with listed names of partners with a SUD

CSO-participants Pseudonyms (Partners with SUD – pseudonyms)	Age	Gender	Race	Qualification	Employment	Nature of the relationship	Length of the relationship in years	Number of children in care of CSO	Time of sobriety of partner with the SUD (in months)	Seeking help for self or partner	Use of drugs by the CSO
Andries (<i>Ida</i>)	44	Male	W	B. Comm.	Self-employed - auditor	Engaged	3 years	1	Relapsed	No	No
Linda (<i>Conrad</i>)	45	Female	W	Grade 12	Hospital – book- keeper (clerk)	Married	27 years	2	Still using substance	Yes	No
Cindy (<i>Mike</i>)	34	Female	C	M.A. Social Work	NGO – Social worker	Married	8 years	-	18 months	Yes	No
Louna (<i>Stefan</i>)	61	Female	W	Grade 12	Pension – previously housewife	Married	35 years	3	36 months	Yes	No
Felicity (<i>Zane</i>)	42	Female	W	Grade 12	Retail	Married	6 years	2	7 months	Yes	No
Paul (<i>Grace</i>)	43	Male	W	Grade 12	Self-employed – graphic designer	Married	11 years	3	36 months	No	Yes
Queen (<i>Tom</i>)	28	Female	W	Grade 12	Security	Married	6 years	2	2 months	No	No
Olga (<i>Danny</i>)	31	Female	C	Grade 12	Marketing	Engaged	13 years	2	2 months	No	Yes
Elsa (<i>William</i>)	54	Female	W	Grade 12	Self-employed - Horse riding instructor	Co-habiting	4 years	None	4 months	Yes	No
Kate (<i>Barry</i>)	23	Female	C	Grade 10	Reception	Co-habiting	3 years	2	2 months	No	No
Jane (<i>Honey</i>)	29	Female	W	Grade 12	Marketing	Civil union	3 years	None	Relapsed	No	No
Anne (<i>Dicky</i>)	37	Female	W	B. Fin. Accountancy	Corporate sector	Married	15 years	2	5 months	No	Yes

3.2.1 The age distribution of the CSO-participants

Concerning the age distribution of the sample of the CSO-participants, depicted in Table 3.1 it becomes clear that the youngest participant was at the time of the study 23 years of age and the eldest 61 years of age. Two participants each were in the age ranges of 20-29 and 50-59 years of age. Three participants fitted within the 30-39 years age range, four into the 40-49 years of age range and one participant in the range of 60-69 years of age.

When fitting the participant's respective ages into Erikson's (in Donald, Lazarus & Lolwana, 2010:60-64) life stages of psycho-social development, progressing from infancy, toddlerhood, preschool, childhood, adolescence, young, middle to late adulthood (Dunkel & Harbke, 2017:59), six of the twelve participants fit into the stage of young adulthood (ranging from 18-40 years). The other six participants between the ages of 40-65 years match the middle adulthood stage. Each of the life stages involves a basic conflict, psychosocial crisis or emerging challenge, primarily brought about by social demands placed on the individual. To progress at each stage, the acquiring of a competency or attitude is needed for the successful resolution of the psychosocial crisis that will result in the development of a sense of competence (Dunkel & Harbke, 2017:58; Lefrançois, 1993:547, 555).

In young adulthood the basic conflict is between "intimacy" versus "isolation". In this life stage the individual tackles the developmental task of achieving intimacy by establishing interpersonal relationships with people they can be "close to" and can be trusted, while retaining the autonomy and personal identity achieved at the earlier developmental stages (Linerós & Fincher, 2014:41; Donald et al., 2010:64; Lefrançois, 1993:555). The ultimate aim is the ability to successfully form a relationship with somebody with whom they can share their life, together with being committed to each other in the confines of a romantic relationship in which love can be experienced as a psychological strength (Dunkel & Harbke, 2017:59). Failure to achieve intimacy will result in isolation and loneliness. A person's SUD could hamper the psychosocial developmental outcome of achieving intimacy by establishing intimate relationships. For the person with a SUD, who is in relationship with a CSO,

the aim for both in achieving mutual intimacy is hampered, as the SUD has the propensity to absorb, and isolate the person abusing chemical substances but also their CSOs (Kinney, 2012: 202; Hagedorn & Hirshhorn, 2009:48).

In confronting this threat to intimacy and to break the isolation, the CSOs of partners with a SUD have to take in the unenviable position of confronting the partner's substance abusing behaviour (Hawkins and Hawkins in McNeece & DiNitto, 2012:261), despite the trust being broken between them (Kirst-Ashman, 2013:448).

The developmental task emerging in middle adulthood according to Erikson's life stage psychosocial development theory is that of "generativity" versus "stagnation" (Donald et al., 2010:64; Lefrançois, 1993:555). With reference to this life stage, Dunkel and Harbke (2016:59) write: "As a middle-aged adult Erikson believed that individuals begin to realize the reality of death and contemplate their legacy". As a result, and in a pursuit to acquire generativity, the maturing adult needs to establish a smorgasbord of caring family, friendship, and work relationships in giving back to and benefitting the community (Donald et al., 2010:64; Lefrançois, 1993:555). Through generativity, care as a psychological strength is gained (Dunkle & Harbke, 2016:59). Opposing productivity is becoming self-absorbed; discontented and stagnant. Resolving this duel between generativity versus stagnation does not imply abandoning all thoughts of self, but rather reaching a balance between self-interests and interest of others (Lefrançois, 1993:555). In applying this life-stage of generativity versus despair to both the CSOs and their partner with the SUDs, the SUDs encroach on their ability to acquire generativity in the true sense of the word. The reason for this is that the partner with the disorder becomes so self-absorbed in the addiction that it may lead not only to stagnation but deterioration at multiple levels too (Rowe, 2012:60; Kinney, 2012:201).

3.2.2. The race, gender distribution of the CSO-sample group

As shown in Table 3.1, nine of the participants were White and three were Coloured persons. Although both MWLC and CAD are non-racial faith-based organisations and they accommodate persons from all races and diverse religions, only Coloured

and White CSOs that met the criteria for inclusion at the time of the research project volunteered their participation (see Chapter Two: paragraph 2.5.1 – Population, sampling and process of participant recruitment and paragraph 2.5.2 – Screening and selection process followed with potentially interested participants).

The *gender* participation of CSOs involved in this study comprises ten females and two males (Andries and Paul). This domination of female CSO-participants in this sample can be attributed to the fact that, world-wide more males than females are inclined to get involved in abuse of chemical substances. Rodriguez, Overup & Neighbors, (2013:628) state that the ratio of male to female is about three to one. Sudhinaraset, Wigglesworth and Takeuchi (2013:35) set the ratio at 10% for males to 3.5% for females. Cranford et al. (2011:21) aver that the number of married and cohabiting alcoholic males in the United States (age 18 year and above) outnumber the female alcoholics in the mentioned age group by a ratio of more than 2:1.

3.2.3 The educational level (highest qualification) and current employ of the CSO-sample group

Concerning the *qualifications* of participants, nine of the participants stated Matric as their highest educational qualification. Kate, who indicated Grade 10 as her highest educational qualification, went on to qualify as a hairdresser but currently works as a receptionist. Three of the participants (Andries, Cindy and Anne) had tertiary qualifications.

Concerning *employment*, from the information in Table 3.1 all the CSOs, except for Louna (a housewife and now on pension) were gainfully employed at the time the fieldwork was being done. Andries, Paul, and Elsa were self-employed, offering financial auditing and bookkeeping, graphic design and horse-riding instruction services respectively. Anne was employed in corporate finance, while Felicity, Olga, and Jane worked in the retail and marketing sectors. Linda was a clerk in a hospital, and Cindy a social worker at an NGO. Kate worked as receptionist at a surgery. Queen was employed as administrator for a security company. The participants emphasised how their employment was a measure of financial stability amid the

financial turmoil their partner's SUD created, an opinion also confirmed by Hudson et al. (2014:106; 107) and Wilson et al. (2017:57). Andries, Linda, Olga and Anne openly admitted to "throwing" themselves into their work to help them cope with the state of their current situation.

3.2.4. Nature and length of the CSOs' relationships with the partner with the SUD and number of children in their care

The *relationships* of the participants in this study lasted an average of just over eleven years. However, if we remove the two participants, Louna and Linda who were married for 35 and 27 years respectively, the average drops significantly to just over seven years. Considering the average age of forty-year-old participants we can conclude that CSO relationships started late in their lives and generally did not last long.

In Table 3.1 (see Section 3.2), it is documented that Cindy, Elsa and Jane did not have *children*. It was a matter of choice; Elsa was too old (54) to have children and never had children of her own before this relationship; Cindy said "no children by choice" until her partner showed he could be sober for at least three to five years; and Jane said that they wanted to adopt children but when the substance abuse started did she decide against it. Andries had one child and was considering leaving his partner. Paul and Louna each had three children of their own. Having children under these circumstances brings additional responsibilities for the CSOs. These issues have been itemised for discussion in more detail under the titled themes.

When considering the matter of *children* in families with SUDs, Husaarts et al. (2011:38) mention that an average of five individuals is directly affected. The impact of SUDs directly falls heavily on family relationships, habits, communication and finances (Wilson et al., 2017:56; McCann et al., 2017:2; Hudson et al., 2014:106, 107; Lander et al., 2013:195; Benishek et al., 2011:82). The children, especially when young are powerless, and helpless, to deal with the tension caused by an unpredictable and dysfunctional system and they become entrapped with suppressed feelings of fear, sadness, anger and humiliation (Black, 2001:11, 15).

When the parent with a SUD is the mother, [as is the case with Ida and Grace], the children spontaneously comment that they feel unloved and neglected and often experience abuse and abandonment (Brakenhoff & Slesnick, 2015:217). CSOs of partners with a SUD know this, as they themselves are caught up in these circumstances, having to take care of children while they themselves struggle for their own survival.

3.2.5 State of sobriety of the CSOs' partners with the SUD

At the time of the research, Andries' wife, Ida, Linda's husband Conrad and Jane's life-partner, Honey experienced intermittent states of sobriety in that they were either still using or had relapsed into a SUD condition. With Linda's husband Conrad, there had been a history of relapses; while with the other two (Ida and Honey) they had only experienced one relapse each. Queen and Olga's partners had been clean for two months; Elsa, Kate, Olga, Queen and Felicity's partners managed to remain sober for two months and up to but less than one year. Cindy, Paul and Louna's partners (Mike, Grace and Stefan) were sober for longer than 12 months, with Mike and Grace being sober for 24 months and Stefan for 36 months.

3.2.6 CSO-participants' attempt to reach out for professional help

It seems that generally a CSO would be the person to reach out for professional advice for their situation being caught up in a SUD (McCann, et al., 2017:56; 57; Toner & Velleman, 2014:147). I therefore decided to enquire about this tendency in my delimited study area. Linda, Louna, Cindy, Felicity and Elsa informed me that they sought professional help and advice. Cindy, a social worker by profession, searched for information on the phenomenon of SUD on the website and started attending a support group, while simultaneously threatening divorce, should her partner not stop using drugs, and agree to go for help. Louna went to speak to her church minister. The other three, Linda, Felicity and Elsa had not gone for help to professionals, of whom Linda and Felicity later and currently still belong to support groups, having joined one previously.

3.2.7 CSOs' accounts of abuse of chemical substances

As part of collecting biographical information I enquired if the CSOs themselves had or are abusing any substances. Paul mentioned that he had a brief encounter with using illegal substances. Olga and Anne admitted that they used alcohol and occasionally drank too much alcohol in an attempt to deal with their partners' SUD. The other participants did not report any noteworthy substance abuse.

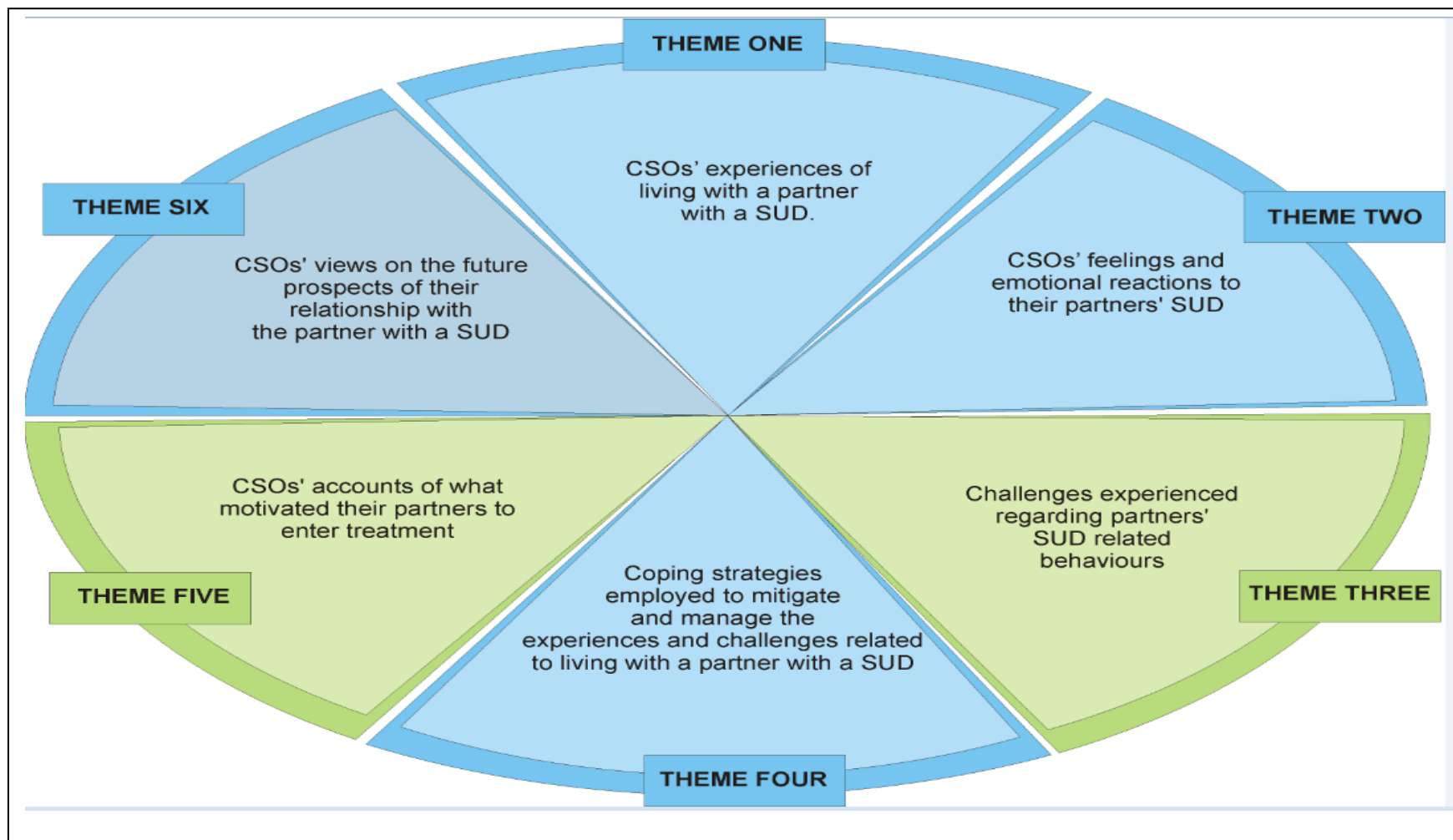
Having presented the biographical information about the sample of CSO-participants, the focus of the discussion will now centre on the themes and subthemes that were derived from the processes of data analysis as well as the consensus discussion on the topical information gathered from the participants.

3.3 PRESENTATION OF THEMES AND SUBTHEMES ABOUT CSOs' EXPERIENCES, CHALLENGES AND COPING IN LIVING WITH A PARTNER WITH A SUD

The themes and subthemes are presented in the ensuing part of this chapter, focusing specifically on the CSO-participants' experiences, challenges and coping strategies in the context of living with a partner with a SUD. These themes and subthemes were informed by the information presented in the written exercises they completed and the first face-to-face interview I had with them. During this interview, the information shared in the written exercise was explored further and gaps were filled in. Their suggestions on how and in what way they and others having similar experiences would like to be supported by social workers, would be thematically presented as part of the fourth chapter of this thesis that covers the second part of the research findings.

In Figure 3.1 (on the next page) an overview is provided on the themes related to the CSO-participants' experiences, challenges and coping strategies in living with a partner with a SUD.

Figure 3.1: Overview of the emerged themes subsequent to the processes of data analysis and the consensus discussion¹³



¹³ The subthemes and categories (where applicable) and related to each theme will be presented in table form and deliberated in detail in the discussion of each theme.

I will now proceed with the presentation of the themes and their related subthemes, starting at Theme One and ending with Theme Six. In substantiating or exemplifying a theme or a subtheme, or the thoughts, feelings or moods of the participants (Sandelowski, 1994:480), I will quote directly from the participants' narratives and/or the verbatim transcriptions of the first follow-up interviews I had with them. The identified themes and subthemes, with their supporting storylines from the transcripts will be compared and contrasted with the body of knowledge available from literature sources as a means of literature control.

3.3.1 THEME ONE: CSOs' EXPERIENCES OF LIVING WITH A PARTNER WITH A SUD

The CSO-participants' accounts are compiled from information shared both in writing and verbally. They describe the regular happenings that occurred in their lives when they lived with a partner with a SUD. Analysis of this data is presented as themes with related subthemes and illustrated in tabulated format as Table 3.2 (see below). Perusal of it clearly points out that overall it was a negative experience.

Table 3.2 Overview of subthemes related to the theme of CSOs' experiences of living with a partner with a SUD

THEME ONE	SUBTHEMES
CSOs' experiences of living with a partner with a SUD	1.1 CSOs living with a partner with a SUD experience their relationship as stressful 1.2 CSOs living with a partner with a SUD experience their partner as distrustful 1.3 Partners' substance abuse turned them into unfamiliar persons by taking on different personalities 1.4 CSOs living with a partner with a SUD experience emotional enmeshment and feelings of ambivalence 1.5 CSOs living with a partner with a SUD experience isolation and feel being trapped 1.6 A CSO-participant's initial, but short-lived relief experienced when coming to know the reason for his partner's erratic behaviour

3.3.1.1 Subtheme 1.1: CSOs living with a partner with a SUD experience their relationship as stressful

All the CSO-participants testified to the fact that living with a partner with a SUD was, and for some still are, particularly stressful and challenging. Nagesh (2015:373) confirms this when stating: “emotional stress is one of the greatest effects of alcoholism and drug use on family life”. Constant arguments with the partner, the partner’s spells of aggression and abuse were regarded as the primary contributors to this stress (Wilson, et al., 2017:57; McCann, et al., 2017:2; Rodriguez et al., 2014:294; Hudson et al., 2014:106). Living with a family member with a SUD in a micro-level relationship context of a marriage or family structure is, to say the least, a painful, conflict-inducing and stressful situation (Wood, et al., 2017:36; Gupta et al., 2014:81; Alexandercikova, Walton, Chermack, Cunningham, Barry & Blow, 2013:269; Cox et al., 2013:162; Neal & Neal, 2013:725; Denning, 2010:165; Darling, 2007:204). Various scholars note that the substances used by the person with the SUD, could lead to this person becoming emotionally intimidating, aggressive and violent towards the partner, causing physical and verbal harm (McCann et al., 2017:2, 4; Macy, Renz & Pelino, 2013:881-902). For the partner at the receiving end of such aggression, violence and abuse, it is a hurtful and nerve-wracking experience (McCann et al., 2017:4).

While some of the participants have equated the experience of living with a partner with a SUD as walking on eggshells all the time, **Louna’s** written account succinctly typifies this: “*Your daily life becomes stressful more and more*”. In the first follow-up interview she touched on the effect of stress of living with a partner with a SUD: “*You know all the difficulties and stress over the years have aged me, not physically as much as it did emotionally. Stress is the one thing that breaks you down more than anything else in life...*” In addition, she also mentioned that at times she became desperate, where she would say to her husband: “*... I can’t continue like this, just stop drinking. The moment this was said, I would have lit a fire for huge arguments*”.

Apart from this experience Louna shared, Queen, Andries, Olga, Kate and Paul's accounts (presented below) serve as testimonies of the frequent arguments and/or abuse experienced in the context of living with a partner with a SUD.

Queen exposed the following about the arguments and violence she experienced, in her written narrative: *"There were always arguments in the house but never physical until last year. Always something got broken/hitting doors and walls [referring to Tom's behaviour when angry and under the influence of Khat] ...The arguments got worse and one day he gave me a smack in my face, I was very hurt and annoyed for him lifting his hands to me for not getting his way"* Queen described another incident further on in the interview: *"... he hit me, pushed me around, jumped on me, threw me on the floor and then threw the glass top of the hob to my head cutting me open. I ran out the back door with the children ... My head was bleeding profusely, and I could not stop it ... I was covered in blood. Luckily, my hairdresser who stayed around the corner from us took me in".* She continued: *"I first tried to phone my mother, but he saw me with the phone and wanted to take it away from me. He really lashed out at me. Nobody heard or could help at that point... I was terrified. I could not breathe and deliberately tried to inhale to get oxygen into my body."*

Andries wrote in his narrative, depicting the situation as follows: *"Firstly I need to acknowledge that I have a situation where, for a long time (more than two years), I was challenged in my relationship with my partner while she was addicted, but without my knowledge of the fact that she was addicted. I felt overwhelmed and could not understand why we have a relationship with constant arguments, distrust, resentment and many other negative emotions".* He elaborated on the arguments: *"...we would have an argument for instance, and I would not necessarily understand why we are having this argument in the first place and then...there would be no solution to the problem, no working together or understanding of each other's point of view, arguments get totally blown out of proportion. We would be upset with each other for days on end."*

Olga also mentioned the arguments and abuse: *“Every chance he got he was drinking, and he would be fine one moment and then in an instant, arguments would flair, breaking things swearing etc. And then the accusations started that I was not faithful in his time away [when working and staying away from home], and that has been an ongoing one. That broke me because I was never that girl, I was a virgin till he and I got together, and then that [accusing me for being unfaithful] was one of the huge trigger points for arguments”.*

Kate wrote the following: *“He used crystal meths and tried to stop using but did not really manage to. He became very aggressive. I asked him why, but he lied to me. That really hurt me...When he is under the influence of drugs he would always swear and shout. Then I knew. It recently became progressively worse and he would push and shove me and also hit me. It broke me down tremendously. One day I would be a good person and then the following day everything was wrong. One day I phoned the Police to come as he would not stop. It made me very afraid”.* In the follow-up interview Kate again referred to Barry’s aggressive behaviour when he was using the illegal substances: *“Every time there was a change in behaviour I knew he used. He also became aggressive more often...he would shout, scream, swear, bump me around, and hit me...”*

Paul articulated the arguments in this way: *“...the nightmare was basically...I would want to say due to [her behaving] unpredictability, but her behaviour was so chaotic that it almost became predictable. I knew what was going to happen...I mean she was drinking heavily...and sometimes getting away with it; how I am not sure...she was high [being under the influence of the stimulant Khat] most of the time, something I quickly learnt to pick up. And that just led to her not being her anymore ... she would lash out, she would pick fights to say ‘oh, okay I am going now...’ because that is what she wanted to do; to get out, to run ... and her way of running was getting to a bar and...pick up a man...”*

Cox et al. (2013:164) reports that, in general, thus not particularly pertaining only to SUDs, partners in intimate relationship who are normally prone to using violence,

have several recurring characteristics. These include high underlying aggression and anger, anti-social behaviour, jealousy and are inclined to avoid responsibility. Turning to the topic CSOs with partners with a SUDs, several scholars aver that these partners, are at risk of experiencing domestic violence, stress, anxiety and relationship challenges (Wilson et al., 2017:56; Hudson et al., 2002:171).

In a recent Australian qualitative study about the experiences and coping strategies of family members affected by aggression and violence due to a SUD, McCann et al (2017:209-220), found similar responses. After collecting data from 31 participants, the researchers identified two primary themes. First, namely that the violence and aggression experienced resulting from a family member's SUD was particularly stressful and emotionally demanding. Then, second was that they had difficulty in preventing and/or coping with the consequences of these circumstances. In a separate subtheme, participants point out that they were very concerned about the violence, which took the form of shouting, insults, criticism and provocation. Also worrying were the lies and manipulation to force them to accept their stories or comply with their wishes (McCann et al., 2017:214). They also mentioned that they had to constantly be on the lookout for signs of aggressive behaviour with one participant sharing some of my participants' sentiments: "When he's drinking I am walking on eggshells because he gets angry so fast" (McCann et al., 2017:215).

The negative effects of the stress and violence Louna and Olga described as breaking them down; Andries felt being overwhelmed; and Queen's being terrified resonate with that which O'Doherty, Taft, McNair and Hegarty (2016:227), claims. Their view was that a victim's experience of violence resulting in stress results in feelings of "fear, self-doubt and threatens the person's life-goals, safety and even survival". In addition, O'Farrell and Schein (2011:202) state that the stress and fear experienced from violence can be due to substance abuse that contributes to the CSO becoming resentful and losing hope for their future.

3.3.1.2 Subtheme 1.2: CSOs living with a partner with a SUD experience their partner as distrustful

Contemporary society regards and perceives the family, a micro-system within Bronfenbrenner's (1979) ecological systems theory, as a place where emotional involvement "intimacy, love and trust" (Jesuraj, 2012:34) is experienced and encouraged. Trusting, according to Black (2001:36), implies relying on somebody to meet your needs and make you feel safe, and having confidence and faith in that person. A person's SUD has a negative effect on the development and maintenance of trust within a relationship, especially since it is commonly known that family members with a SUD notice that, as the SUD progresses the sense of honesty within the person with the addiction deteriorates. They become more compulsive as the SUD progresses and they often lie about their substance use, hence become more dishonest and continue using substances irrespective of the consequences it has for their relationships (Fletcher, 2013:328; Nastasic, 2011:94). In addition to the dishonesty and lies, O'Farrell and Schein (2011:202) also draw attention to the fact that the CSOs, even when their partners are sober, live in fear about the possible return of substance abuse in the future.

Andries and Felicity's accounts below point out how their partners' SUDs eroded the trust in their respective relationships.

Andries in an explanatory-fashion stated: *"There still is an issue with trust. But it is different now [during the first follow-up interview she was attending a treatment programme and not using drugs]. Previously, before my understanding...or before I came to understand that this [referring to his wife erratic and strange behaviour] is an addiction problem, I could see that she is lying to me, telling me nonsense stories. She said things that did not make sense and I could not believe her. So, from that perspective I did not trust her... I am not sure how long the process will take...if she is challenged by things, you know, if she feels helpless and needs a way to deal with reality, if that then drives her to have a relapse again, she will probably lie about it..."*

In my mind there is a different focus now that I am aware of her situation...it is not that I don't trust her, it is that I don't trust the power that the drug has on her. I just don't know. It is something I cannot measure".

Felicity wrote that Zane's behaviour turned her into: "... becoming like a detective. Every time he did anything I would check up what and why he is doing it...I never had difficulty trusting anybody. I always believed that if you want to go out and do something wrong, it is going to bug you, not me..." She wrote earlier: "It hurts that for 3 years (if it's the truth I don't know) [time she started suspecting that he was using Khat] everything was just about you and for 3 year I've been living a lie. How should we ever have trust in you? You didn't even appreciate or acknowledge that I put the family first and let myself go."

Distrust in the partner with a SUD is described by Denning (2010:165) as follows: "Today's optimism, induced by fervent promises of 'never again', is replaced by tomorrow's disappointment when these promises are broken". As O'Farrell and Schein (2011:202) and Perkinson (2008:409) point out, the constantly changing circumstances that family members are exposed to, prevent them from trusting the partner with a SUD; they fear the unexpected, they attempt to hide it from others, they are afraid to hope that things will improve as result of all their disappointments (Perkinson, 2008:245). Moore, Biegel and McMahon (2011:19) support these scholars with the view that while there is still hope¹⁴ for the person with the SUD to change at the outset, the continuous embarrassments, disappointments, confusion and conflicts eventually lead to a distrust in the person and their ability to want to change (Dethier et al., 2011:151; Black, 2001:34). On many occasions, the CSOs finds themselves experience conflict when being undecided about remaining loyal or giving up (Denning, 2010:165).

¹⁴ This hope can be seen as a problem-solving coping-style. Bradshaw, Shumway, Wang, Harris, Smith & Austin-Robillard (2015:318) cite Shumway and Kimball defining hope in the context of addiction as a healthy coping skill that includes the willingness and ability to reach out to others for help.

3.3.1.3 Subtheme 1.3: Partners' substance abuse turned them into unfamiliar persons by taking on different personalities

Cindy, Olga, Linda, Louna, Elsa and Paul shared how their partners showed different personalities, when intoxicated. They became someone else, unfamiliar, not the partners they initially were attracted to and got involved with. Their storylines concur with a result O'Brien, Ermentrout, Rizo, Li, Macy and Dababnah, (2016:68) reached about women surviving intimate partner violence. A CSO-participant in their study described their SUD partner as having a "dual personality" when he became intoxicated.

Cindy explained: *"It was very strange. My husband Mike had been in addiction since the age of fifteen...and when we met he was two years clean already...he told me he was in addiction but I never went into any details about the extent of it ...I knew him as vibrant and funny and someone who has his life together ... but a month or so before we got married I saw him [referring to Mike being under the influence of alcohol] and his father explode and him [Mike] showing his true colours... what I realise now with him being in recovery is that there are two people, he is a different character now [being sober] compared how he was then [abusing alcohol and other substances] ... He is a totally different person than when I met him..."*

Olga described the two sides of her fiancé, Danny, as follows in her written narrative: *"So from him being: ... a spiteful, money hungry Monster at times, Aggressive Accusing, Not caring, Hurtful and much more in his drunk states. And this is what hurts the most, I call it the Dr Jackal/Mr. Hyde effect, he is actually the sweetest person, but as soon as booze is involved things get out of control".*

Linda also spoke of her husband's the double personality: *"...he refers to himself as 'twins'...You know what? We can sometimes sit down and discuss his drinking, and he will acknowledge he has a problem in so many words. Then he will try and stop his drinking. He really tries and will manage to not drink for maybe one week, sometimes two weeks. After this time he feels like having a beer. He would buy one*

at first, the following day he buys two beers and so it escalates... If I point this out he replies saying that he does not think he has a problem...he can control it... he is two persons..."

Louna shared during the first follow-up interview: *"He [referring to her husband, Stefan] was brilliantly clever...he is brilliant...but you know what? He drank it all away. He is very precise in what he does. But the moment he started drinking he became a different person, totally different person...he became a stranger ...At times I felt 'how can you [referring to the alcohol] squash the good person in him'. You know, he was actually drowning the good person in him...after the second or third large whiskey he consumed he changed totally, he transformed into a monster... [when] ...sober, he was a wonderful man who changed radically in a second when he was drunk".*

Elsa with the following remark summed up how William's (partner) personality would change when under influence of alcohol: *"If William has one drink it is as if somebody flicked a switch...he becomes nasty and sarcastic..."*

In his narrative, **Paul** wrote: *"In my mind it was not Grace who was doing this but it was the drugs fault – turning her into this unrecognisable monster"*. It is indicated by O'Brien et al. (2016:68) that partners with a SUD, when intoxicated become financially, emotionally and physically abusive. Dethier et al. (2011:152) cite Stanley highlighting the fact that the CSOs are regularly exposed to severe verbal abuse, including blame, insults, swearing and shouting at by the partner with the substance addiction. Conduct such as this puts these CSOs at an increased risk of being physically and sexually assaulted, domestic violence and behaviour that could well fit the description of Paul's "monster" (DSM-5, 2013:492; Kleber & Weiss, 2007:31).

3.3.1.4 Subtheme 1.4: CSOs living with a partner with a SUD experience emotional enmeshment and feelings of ambivalence

The concept “enmeshment” is explained by Askian et al. (2016:277) as a condition in which a person has difficulty to independently differentiate self from others. Enmeshment is often touched on in the addiction literature as describing “co-dependency” (McNeece & DiNitto, 2012; Kinney, 2012; Denning, 2010; Gudzinskiene & Gedminiene, 2010) where CSOs put their own life, goals and dreams on hold and become pre-occupied with the partner with a SUD. Perkinson (2008) notes this that would happen all at the risk of losing their own identity. Nagesh (2015:374) in referring to this co-dependency and enmeshment writes: “the wife or partner of an alcoholic becomes a kind of 'little helper' for the alcohol addict. They do everything for the alcoholic while ignoring their own emotional and physical needs”.

Cindy's account of her emotional enmeshment endorsed the literature quoted above when stating: *“I was emotionally enmeshed in keeping him happy, living in fear and feeling satisfied because somehow I thought I had everything together balancing my work and personal life”*.

Queen confessed being emotionally enmeshed in her Tom's substance addiction causing feelings of ambivalence along the following lines: *“I am caught up socially and emotionally in a situation I can no longer manage as it is getting worse...”*

Apart from becoming emotionally enmeshed in the relationship where one partner is entangled in a SUD situation, is the self-sacrificing behaviour that CSOs could adopt to sustain their relationships or keep their families together. Such self-sacrificial behaviour plays out when the non-substance abusing partner sacrifices taking care of themselves to focus on the welfare of another person, despite its negative consequences exceeding the benefits of the relationship (Askian et al., 2016:270; Benshoff & Janikowski, 2000:157).

Elsa explained how she had given up her own life for her husband who abuses chemical substances: *“...I came out of an eleven-year abusive relationship ... my ex-husband also drank... And now I want to think that I am a lot wiser ... the night that he [her partner, William] fell over that balcony I was done...I saw what it did to his kids, I saw what it did to his family...I was just the girlfriend then. When he came out of hospital I said he could come and stay with me ... I will try my best to look after him. We lived together prior to this. I became the one that looked after him; I’m the one that took care of him. I’m the one that gave up my life for him ...”*

Elsa’s behaviour depicts what Gudzinskiene and Gedminiene (2010:167) and Perkinson (2008:243) describe as taking on the “care takers”-role, a situation where the person’s life revolves around looking after the partner with a SUD. This in turn could lead to a situation where the CSO becomes so “over-involved” while the partner with the SUD remains disinterested and disengaged (Craig, 2004:17).

3.3.1.5 Subtheme 1.5: CSOs living with a partner with a SUD experience isolation and feel being trapped

Isolation, or becoming isolated, is one of the consequences of living with a person with a SUD (Jesuraj, 2012:40), as a person’s SUD could lead to or result in “damaged peer relationships” (Randle, Stroink & Nelson, 2015:81) as well as “limited freedom of movement” (McCann et al., 2017:5) for the CSOs. This was also the case for some of the participants as can be deduced from their accounts presented below.

Paul explained the reason for the isolation he experienced and felt it had resulted from feelings of loneliness (to be presented as subtheme 3.3.2.2 - CSOs felt trapped and lonely as result of their partners’ SUD). His story read along the following lines: *“One aspect I clearly remember was the loneliness. Extreme physical loneliness ...The ... [isolation] was brought about by the fact that I didn’t want anyone to know what Grace was up to...I had nobody to turn to, to talk to, to have help me or Grace”.*

Louna echoed this when she wrote: *"You become a lonely person!!"* In the follow-up interview she expanded on this by stating: *"We have lost so much over the years. We did not have any friends; you can't invite friends over; you cannot afford to organize going out anywhere ... you never knew what to expect so you avoided everything which can create an opportunity for him to drink. You become secluded..."*

Elsa reiterated the isolation experienced as resulting from William's addiction: *"I don't have friends and live an isolated life"*. This was after I requested her to elaborate on this response she explained: *"Through all of this I have become withdrawn and isolated myself and where possible, I avoid socialising as I don't want William to embarrass me."*

Queen wrote the following in testimony to the isolation she experienced: *"I was too scared to say /talk to him [referring to Tom] about things that are happening and what my feelings were as there was no care for what I feel and what my needs were. I was never allowed to go out and see friends/colleagues, till today I do not feel it is fair as I never had anyone to talk to"*.

Olga equated her experience of living with Danny, her fiancée, being addicted to Khat: *"... like a jail sentence. Some days are good and some days are bad; when it is good, it is super good, but when it is bad it is super bad"*.

Cindy's experience of living with her husband, Mike who became an addict was for her a dream turned into a nightmare, in which she felt trapped and isolated, and from which she could not escape. She worded as follows in the written exercise: *"After being single for five years by choice, I met the man of my dreams. Six months into our marriage, my husband chose addiction, staying out late, going to wild parties and when we were together he was intoxicated, unable to engage with me and arranging his next fix. My dream turned into a nightmare. I was alone, entrapped in fear and felt like there was no way out. I really wanted children but decided that there was no way I was going to have a child in a marriage like this. I knew I was going to*

be a single mom even though I was married because my husband was not there for me". Cindy's account resonates with Nagesh's (2015:374) view on becoming disillusioned by the partner's substance addiction when stating: "The wife of an alcoholic, who enters into marital life with a heart full of expectations, becomes disillusioned when she faces tough life situations, from the alcoholic husband".

From the participants accounts as presented it became clear that a person's addiction taking place on a micro-level scale or in the confines of the family and marriage relationships "alters social interactions" (McCann et al., 2017:5). However, this not only takes place at micro-level, but also at the interface with meso-systems. Being caught up in their own survival struggle, the CSOs could isolate themselves from the outside world (Gudzinskiene & Gedminiene, 2010:168), as was the case for Paul, Elsa, Olga and Cindy. For Louna and Elsa avoiding social activities and losing friends out of fear of embarrassment led not only to their isolation but, by implication, deprived them from access to potential support as McCann et al. (2017:5) documents. In Queen's case the situation was even worse as she was not allowed to have friends.

On the point of being isolated and deprived from reaching out for support as result of a partner's SUD, Ahuja, Orford, and Copello (2003) with their research illustrate how religious backgrounds can be a determining factor. They cite examples of the spouses of British Sikh husbands with SUD, who, based on their strong Muslim principles, disallowed the participating partners in their study get help or support, that left them isolated with "the burden of their problems" (Ahuja et al., 2003:4, 7).

3.3.1.6 Subtheme 1.6: A CSO-participant's initial, but short-lived relief experienced when coming to know the reason for his partner's erratic behaviour

On finding out that his wife Ida was abusing drugs, **Andries** was initially relieved but found it was not as simple as he had thought. He shared the following in his written narrative: *"When I realised that I am sitting with an addiction problem, I was upset and disappointed for a very short time and almost immediately felt relieved to know*

what the reason was, which put me in a position to solve the problem. At that moment I felt strong and convinced that the problem is manageable and can be solved. In hindsight I have on more than one occasion felt that this feeling was naïve. I could not have imagined how much effort it would take from me as a supporter [CSO] to beat the addiction. Effort here being defined as physical (time and money) and emotional. I believe that this would be one of the big lessons learnt. There is a huge impact on the supporter and the supporter has to play a big role in recovery. It sometimes feels that I have to make many sacrifices for the recovery program to succeed. That I remain a victim, even more so during recovery as before recovery”.

Andries’ account corroborates with the view of Perkinson (2008:241), noting that feelings of relief are felt when a CSO’s partner agrees to treatment. This reprieve is actually in reality short-lived when the CSO gets confronted with the complexities and demands of what treatment entails.

Closely linked to the theme of CSOs’ experiences of living with a partner with a SUD presented in the preceding discussion are the feelings and emotional reactions the CSOs experience in relation to their partners’ SUD which is presented as the next theme with related subthemes.

3.3.2 THEME TWO: CSOs’ FEELINGS AND EMOTIONAL REACTIONS TO THEIR PARTNERS’ SUD

It is widely recognised in scholarly literature that the substance abusing behaviour of a family member caught up in a SUD has a devastating effect on the family members and relationships within the family, as micro-system (Klostermann & O’Farrell, 2013:235; Jesuraj, 2012:40; Kinney, 2012:214; Denning, 2010:165). Family members find themselves in situations where they experience “high degrees of anger, feelings of fear, hurt, abandonment, guilt and hopelessness” (Giordano, Clarke & Furter, 2014:121). These effects are even more severe on those who are emotionally the closest to the person with a SUD, such as the partner with whom they share an intimate relationship (Wilson et al., 2017:56; Nagesh, 2015:374;

Klostermann & O'Farrell, 2013:244). In the context of the intimate marriage or partner relationship, a partner's substance addiction can result in emotional "dysregulation" that implies over-reaction or inappropriate emotional responses. This can lead to a breakdown in communication and skewed perceptions of the real issue at hand (Bryant, 2014:719; Lee, 2014:3), that, in turn, can increase interpersonal conflict and stress and a decrease in psychological and social adjustment and functioning (Hudson et al., 2002:171). Against the introductory remarks to the second theme divided into subthemes, will be presented next (depicted in Table 3.3 below).

Table 3.3: Overview of subthemes related to the theme on CSOs' feelings and emotional reactions to their partners' SUD

THEME TWO	SUBTHEMES
CSOs' feelings and emotional reactions to their partners' SUD	<p>2.1 Feelings of anger and frustration experienced in relation to a partner's SUD</p> <p>2.2 CSOs felt trapped and lonely as result of their partners' SUD</p> <p>2.3 Feelings of sadness; embarrassment; shame; humiliation; despair and hopelessness experienced as result of a partner's substance addiction</p> <p>2.4 Feelings of fear experienced in relation to a partner's SUD</p> <p>2.5 CSOs felt inferior and blamed themselves for the partner's SUD</p> <p>2.6 Feelings of hurt and shame experienced as result of the partner's SUD</p> <p>2.7 CSOs experienced an emotional detachment from their substance dependant partners</p>

3.3.2.1 Subtheme 2.1: Feelings of anger and frustration experienced in relation to a partner's SUD

Feelings of anger and frustration described as a "love-hate" relationship where the CSOs could love the person but their substance addiction and its resultant behaviour manifestations do upset them (Johnson, 1990:181). The majority of this study's

participants mentioned this in the data collected from them and to be mentioned in the accounts given below. Various other authors mention that amongst the feelings and emotional reactions experienced by CSOs in relation to their partner's substance addiction, they feel afraid and frustrated, and also at times even depressed (Wilson et al., 2017:56; Nagesh, 2015:374; Perkinson, 2008:241).

Olga shared her feelings of anger and frustration with Danny's substance addiction along the following lines: *"After Danny had crashed the car [taking it without her consent], 'I was furious; oh I was just so furious. I sold it there and then. Somebody brought six grand and I said just take it. I had such a bad taste in my mouth and I did not want to sit with the memories as well. I just got rid of it...I was furious...There were many a time I felt like that. There were times I became physical with him, times I would lose it ...I would really lose it. Times I could not stop myself, I was so angry...but I have gotten better"*. Olga recounted another experience where she reached a breaking point so angry she was: *"My breaking point recently came in where I got call from the school and them asking me if he's on medication they don't know what's wrong with him he's lying on the playground, mean time he was as drunk as a lord, I had to leave work and go get my kids, I was so angry I think I could have knocked his block off in that moment."*

Louna described her anger on occasion where Stefan again broke his promise to stop drinking: *"I already was angry when I started talking to him...I was so angry then that I felt like strangling him. And every time that he would fall over I became angry, extremely angry, as I had to pick him up and put him to bed. He really falls to the ground very hard..."* She also commented on the outbursts she had as a result of Stefan's alcohol addiction and his behaviour when under the influence of alcohol: *"I ascribed it to the terrible stress I carried... I at times spoke out things before thinking it through, I would explode verbally at times, it just erupts ...and then it often happened at the most inappropriate occasions. I would then feel guilty and regret it and the process will start all over again...in a way it is both a climax and an anti-climax...the climax being the explosion, the anti-climax the regret afterwards"*.

Elsa wrote about the reason for her anger in this way: *“I was angry that my life was being controlled by alcohol, as every time we went out or had visitors I had to try and make sure that William did not drink before and had to watch how much he drank during these times. I was frustrated with William as he did not seem to realise or care how much damage he was doing to our relationship ... and with that also came a lot of anger and resentment”*. In a follow-up interview she again admitted: *“...I am incredibly angry. For the last years we were expecting to be doing something else ... but we are stuck at home because we can’t go out or we can’t have people over because of what is going to happen ...”*

Anne wrote: *“In November 2015 I was busy unpacking a cupboard with linen and Dicky was helping me, when I came across a pill bottle that was not familiar. I could see in his eyes that something is amiss. I opened the bottle, and like a bottle of worms; we were confronted with the truth. Small plastic zip-lock bags and straws. I immediately knew what it was. The wall broke, all the months of suspicion and begging for the truth, in my hands. It felt as if all the blood and energy drained from my body and every single hole were filled with disappointment and anger. I immediately thought to myself; ‘this is why you never have money to contribute to the household; you can’t even buy one loaf of bread’. And I have taken a second job to provide to the needs of the kids and him. I thought that he was the biggest loser that I have ever met and I wasted 16 years of my life”*

Paul articulated his anger about Grace’s addiction thus: *“It [finding out about her addiction] was crippling. It was soul destroying. It made me angry...but again, if I detach this Grace [referring to her when using the addictive substance] from my Grace... so I was the ‘moer’ in with the addicted Grace. I would always say to her ‘but this is not you...can’t we bring the other Grace back?’ but it never worked ...”*

Linda expressed how worry built up and turned into anger: *“...one worries because anything can happen...so all this worry builds up so that when he does arrive, and is drunk, all these feelings turn into anger straight away... one is concerned about his safety, but in the meantime, he messes up...”*

Felicity's anger was such that she even had thoughts of murdering her husband, Zane: *"I wanted to kill him. We avoided contact with each other. I would go and sleep in the spare room. Then at times he would approach me lovingly and I would believe it was okay just for him to fall back on old behaviours...it worked in three-day cycles"* [referring from being sober to relapsing again]

In **Jane's** narrative the feelings of anger experienced towards Honey's addiction came to the fore in these words: *"But I am angry! I have to now put my life on hold during her treatment because she wanted to be high. It feels like having to live in a jail and everything else is pushed aside. We are without a car and everything is her fault, yet, I sometimes wonder if it wasn't perhaps my fault? What did I do to deserve this? A woman who only got the best for the past three years and gave it all up in a heartbeat to do drugs. I am angry, disappointed and empty! I stay on because I took an oath before God that I will stay on irrespective of the circumstances. But where does one draw the line? How do you hold on to something that threw you away like dirt? How will I ever manage to love her again as I am supposed to? And she has no idea why I feel the way I do and why I have difficulty touching her again. On the one hand my heart tells me to love her like never before, but the same heart tells me to run away as far and fast as possible..."*

On reflecting on these storylines, and apart from the obvious anger and frustration the participants mention in relation to their partners' SUD and accompanying behaviour, other feelings of disappointment, despair, inner conflict and even hopelessness were mentioned too. Such feelings are characteristic of the ones people experience in the midst of a crisis (Bryant, 2014:719; Lee, 2014:3). In cases where anger with resentment are experienced, avoiding contact and communication with the partner with a SUD can happen unnoticed (Klostermann & O'Farrell, 2013:235).

3.3.2.2 Subtheme 2.2: CSOs felt trapped and lonely as result of their partners' SUD

This subtheme that originated from the information Cindy, Louna and Anne shared (quoted below) and it ties in and corroborates with subtheme 1.5 under Theme 1 that focuses on the aspect of *CSOs living with a partner with a SUD experience isolation and feel being trapped*.

Cindy's experience was of being trapped and was described in this way: *"I was stuck; I felt trapped ... I just did not know what to do ... I think that disappointment was my biggest thing ... As I said in the beginning ... I thought that I did everything right ... I was well-behaved, I did not take drugs, [implying the use of drugs was unacceptable] I really was on the straight and narrow ... and my husband was very abusive during the addiction ... I felt hopeless....and I was trapped. Everything just ended up bad for me. There just was no way out"*.

Louna said: *"Yes I lived in a prison. There was no communication between me and my husband. We have never been able to sit down and have a proper conversation ... he never was sober enough. He in fact started drinking very early in the morning which did not invite any conversation either ... nothing was ever discussed."*

Anne: [confessed being] *"...very lonely...very lonely. And that for me was the worst of all. Being and feeling alone. And even though there were those who wanted to help or take advantage of this [referring to male colleagues and friends], I never gave in to this as I still was married. I told Dicky that I have never felt as lonely in my life"*.

Paul recollected the effect of Grace's alcohol abuse: *"One aspect I clearly remember was the loneliness..."*

Being trapped in this quagmire of a partner's SUD is an event CSOs are often simply not capable managing effectively. Black (2001:15) remarks that a family member's SUD instead creates a confusing family set-up with CSOs employing an array of both positive and negative coping strategies in an effort to preserve the family

system. As their attempts to “bring control to an out-of-control situation” continuously fail (Perkinson, 2008:406), and they eventually end up feeling trapped and drained.

3.3.2.3 Subtheme 2.3: Feelings of sadness; embarrassment; shame; humiliation; despair, and hopelessness experienced as result of a partner’s substance addiction

Feelings of sadness, embarrassment, shame, humiliation, despair and feelings of hopelessness were common threads in the overall participants’ shared accounts (depicted below).

Elsa mentioned the feelings experienced after the incident where Tom physically assaulted her: *“I felt ashamed, humiliated, scared, and hopeless. I literally felt like a hobo that day, no clothes, no shoes, had nothing for the kids, no car etc.”* Elsa, in sharing her story, again referred to feelings of hopelessness, embarrassment and humiliation: *“...and then there is the absolute hopelessness ...you can talk and talk and talk...If the person is not listening...I have withdrawn a lot...I have been embarrassed and humiliated too many times in public, with friends and family, that we stopped going out and stopped entertaining”*. These feelings resonate with Dethier et al. (2011:152) when they point out that frequent abuse by the partner with the addiction problem contributes, amongst other things, to feelings of uselessness, worthlessness, and self-blame in CSOs. More than half of the ten Jewish-women participants in Peled and Sacks’ (2008:398) study perceived their inability to prevent their partners’ addiction and deterioration as a personal failure, as they saw this as what is expected of a normal wife. This failure filled them with guilt and shame and caused them to isolate themselves from the more competent “others” – the ones who had a normal life and marital relationship.

Anne’s word-picture of the feelings of shame she experienced arising from Dicky’s drug addiction reflect her anguish: *“There were people I could approach but I was too ashamed. I was not prepared to go out and ask for help...saying that my home is falling apart...I was ashamed and needed help but did not know how. I can’t just*

walk in to somebody's home and say my husband is a drug addict...There was a time I spoke to my mom about this, but in her opinion, I was paranoid. So, I felt if my own mother does not believe me, how will somebody else believe me?" Shame (as described by Anne), together with guilt and the stigma attached to a partner's SUD are mentioned by Wilson et al. (2017:56) as a key barrier to a CSO seeking help.

Cindy experienced a mixed bag of feelings, so severe, that she contemplated taking her own life: *"I was entrapped in shame, and intense feelings of inadequacy, inferiority and self-loathing. In front of others I felt exposed, humiliated as if they could see my flaws. I remember myself thinking 'why don't I just throw myself from the second floor?' I was in such despair and state of hopelessness. But it was actually too overwhelming, so I just left it ..."* In underscoring Cindy's reference to "I felt exposed", Tangney and Dearing (in Hernandez & Mendoza, 2011:376) confirm that shamed people feel exposed. They continue to define it as "an acutely painful emotion that is typically accompanied by a sense of shrinking or of 'being small' and by a sense of worthlessness and powerlessness". These authors state that shame as an emotion provokes thinking such as "I am bad," whereas guilt elicits thoughts such as "I did something bad".

Linda explained how she felt ashamed of her husband, Conrad, when he was under the influence of alcohol: *"I am ashamed of him when he is under the influence; his speech is slurred, and his appearance is not well, etc. He looks like an alcoholic. He does not believe that he has a problem; according to him I am the one who has a problem with his drinking"*.

In elaborating on and confirming the feelings of shame experienced by Elsa, Anne, Cindy and Linda, these words Gostecnik et al. (2010:371) write apply: "The wives/husbands ...of the alcoholic will feel guilty for his/her addiction; they will blame themselves; they will carry the alcoholic's feelings of shame, unacceptability, feelings of not being loved, of not belonging, of insecurity and a sense of being different from others, and will, themselves, start to live in an atmosphere of denial or the minimization of the alcoholic's dependence, thus cooperating with his/her addiction".

This observation also refers to the CSOs' self-blame which is presented as a subtheme further on.

3.3.2.4 Subtheme 2.4: Feelings of fear experienced in relation to a partner's SUD

Living with a partner caught up in a SUD can be described as harsh and scary (McCann et al., 2017:4), inducing feelings of fear and self-doubt. This is exacerbated by the partner's behaviour when under the influence or high on the chemical substances which fuels arguments, physical and emotional violence and abuse, jeopardising the non-using partner's aspirations, security and being (O'Doherty et al., 2016:227; Johnson, 1990:183).

Elsa's account provides a glimpse of the fear experienced in living with William: *"I was too scared to say/talk to him about things that are happening and what my feelings were as there was no care for what I feel and what my needs were. I was never allowed to go out and see friends/colleagues... I never had anyone to talk to... I have walked on eggshells for many years; too scared to say anything or the wrong thing, for fear of the repercussions and consequences"*.

This fear, not to say anything, or to refrain from pointing out what is wrong Gudzinskiene and Gedminiene (2010:166) confirm that CSOs living with a partner with a SUD find their circumstances, frightening and feel "forced" to lie about how they really feel. This is even truer in situations where the CSOs fear violence and hurt again if expressing any positive or negative feelings (Nissan in Gudzinskiene & Gedminiene, 2010:166). Being afraid of their partner with a SUD can eventually lead to the situation where the CSOs avoid them (Klostermann & O'Farrell, 2013:235).

3.3.2.5 Subtheme 2.5: CSOs felt inferior and blamed themselves for the partner's SUD

Feeling inferior and blaming oneself for somebody else's behaviour is noticeable amongst families crippled by a family member's SUD and resultant behaviour.

Family members in a situation like this tend to perceive themselves as failures, unworthy, inadequate and unloved and want to take the blame for their partner's addiction and their inability to change the state of the situation (Askian et al. 2016:276; Tangney & Dearing in Hernandez & Mendoza, 2011:376; Peled & Sacks, 2008:398; Perkinson, 2008:245). This notion is supported in the participants' descriptions below:

Anne admitted: *"I feel that I failed as a wife ... why did he have to go and use those substances...and work long hours...I felt he was happier in a world of which I and also the children are no part of... I rather questioned if there were things I said or did ... but not that it was my fault really...I felt I was not good enough for him. I felt I was not good enough anymore ... I cannot do anything well ... I was insulted and broken down...I did not feel anything for myself anymore, if I can explain it that way...It [referring to her partner's SUD] breaks you down totally...one day you are good and the next you are good for nothing."*

Cindy wrote: *"I was entrapped in shame, and intense feelings of inadequacy, inferiority and self-loathing. In front of others I felt exposed, humiliated as if they could see my flaws. Trying to balance my husband's addiction, my work responsibilities, my extended family and my friends was impossible. Soon I was estranged from everyone, disconnected and found peace in a separation from others. It was easier this way; less people to lie to ... everything just became more and more. The more I tried to love him more, the more I felt he loved me less. The more I gave the less I got back and the more he rejected me...his addiction just took over... no matter how much I gave, I never got back to the value I put in."*

Jane also expressed her feelings about not being good enough: *"...it is all the lies and mask she carried ...I keep on thinking that if I was good enough she would not have found it necessary to use...I do (believe this). I am merely collateral damage. I unfortunately was the one that had to go through all of this ..."*

Andries doubted himself: *“...I think in the last few months just before I found out [referring to his partner’s addiction], this just used to happen more and more and on more regular occasions... you get to a point that you take a look at yourself and ask but is it actually me? Am I contributing to this [referring to his wife’s erratic behaviour]? Not knowing what it is, not knowing what the problem is ...you feel helpless and self-doubting to a point where you sometimes feel but this is your fault, you are the reason why this is happening”.*

Linda had similar doubts: *“...I at times began doubting myself...would wonder if there is something wrong with me, because why would I be the only one who is concerned about our situation and nobody else seems to feel this way...I feel like...I would always become the spoil sport...I constantly ended up sitting with a heaviness in my heart about his drinking...”* She went on to elaborate on her self-doubt by reflecting her inner conflict: *“I need to realise that his drinking is not something I caused... I am not responsible for this situation. I need to believe this. Especially when one often believes that it may be all your fault... I also constantly wondered what I could have done differently. One has to reach a point where you accept it must not affect your worth as human being...”*

Families caught up in a SUD could feel guilty and blame themselves for the situation it causes, often as consequence of the interaction between the partners in the relationship Boylin and Anderson (2005). However, these authors also point out that currently most authors view the abuser as solely responsible for the abusive behaviour.

3.3.2.6 Subtheme 2.6: Feelings of hurt and shame experienced as result of the partner’s SUD

Hurt in the context of SUDs, can be compared to a two-edged sword, as not only does the substance addiction hurt the abuser but it also pains the people living with this person (Johnson, 1990:182) on the micro-system level. Olga, Felicity and Jane

were amongst the participants who mentioned feelings of hurt resulting from their partners' substance addiction.

Olga acknowledged: *"I thought I could not hurt any more, I thought I blocked it out, but my hurt then started again when he hurts my kids. My breaking point recently came in where I got call from the school and them asking me if he's on medication they don't know what's wrong with him he's lying on the playground, mean time he was as drunk as a lord, I had to leave work and go get my kids, I was so angry I think I could have knocked his block off in that moment"*.

Felicity wrote about her being emotionally hurt as follows: *"Talia was born the Friday 31st October. Monday [a week after their baby was born] I started work from home because you were not prepared to support me [indicating him taking care or responsibility for her and the baby]...your exact words were 'YOUR DEBT IS YOUR DEBT' [she was responsible for all household expenditures]. So, from wanting a little girl, you rather chose picking your drugs above your family... this is devastating"*.

Jane expressed how her partner's words and attitude hurt her, when stating: *"Honey said to me that she does not care...She does not care, I saw it with my own eyes. Especially after the hurtful things she would say...I would cry and ask but why she responded that she feels nothing and said I must not come and cry in front of her..."*.

As explained by Weiss, Duke, Overstreet, Swan and Sullivan (2016:428), shame includes a "negative evaluation of the self as flawed or defective, resulting in a sense of worthlessness and powerlessness and urges to withdraw or hide from others" (also see Tangney & Dearing in Hernandez & Mendoza, 2011:376; Peled & Sacks, 2008:398). Apart from the fact that a partner's SUD can be a painful and hurtful experience, given the ongoing wounding and destructive interactions (Hawkins & Hawkins in McNeece & DiNitto, 2012:261,) it is also a shameful experience nurturing feelings of worthlessness and inadequacy. One of the participants in Peled and Sacks' (2008:395) research referred to shame as "living with an alcohol addicted

husband or family members is extremely difficult. First of all, there is the wish to hide, the shame". This according to Perkinson (2008:245) let CSOs develop the belief that there is something wrong with them and what they do is never good enough.

Cindy wrote: *"I was entrapped in shame, and intense feelings of inadequacy, inferiority and self-loathing. In front of others I felt exposed, humiliated as if they could see my flaws. Trying to balance my husband's addiction, my work responsibilities, my extended family and my friends was impossible. Soon I was estranged from everyone, disconnected and found peace in a separation from others. It was easier this way, less people to lie to, less revving myself up to pretend that everything was fine. I lost touch with every part of me and became a slave to being the caretaker. I lost friendships and family relationships were hard. At work I was one person and at home I was another – alone, confused and overwhelmed"*. On reflection, Cindy's account confirms the viewpoints of various authors that shame can cause a person to withdraw or hide from others (Weiss et al., 2016:428) Montgomery & Springer in McNeece & DiNitto, 2012:261; Peled & Sacks, 2008:398).

3.3.2.7 Subtheme 2.7: CSOs experienced an emotional detachment from their substance dependant partners

Emotional detachment in the context of being in a relationship where one partner has a SUD can be understood from two angles. First, one can be emotionally detached as a *consequence* of the partner's offensive substance addictive resultant behaviour; or second, choosing to be *deliberately* emotionally detached as a coping strategy to survive while living with the partner with a SUD (Hudson et al., 2014:106). Adding to this, Lewis et al. (2011:173) express it as a choice to disengage emotionally in order to work on one's own recovery and by stopping to take further responsibility for the person with a SUD.

Olga, Andries and Queen's narratives disclose the aspect of emotional detachment experienced:

Olga stated: *“Now, at this point [referring to where she currently was in relationship with her husband, Danny] I am at the end with him. I don’t care what he does, if he’s not here, if he disappears from the house for a few days, bonus! Peace for my soul. If he calls with a problem it’s not my problem, and I gradually started moving away from him”.*

Andries’ tendency of withdrawing, going into his cave not only speaks of emotional detachment, but it can also be interpreted as being one of his coping strategies. He explained: *“Unfortunately, my ultimate way in handling something is that when I don’t know what to do I close down. I shut down communication and then wait for a day or two and then maybe it works but then the problem is still there...the cause of the issue is still there, and I don’t know what to do as it just repeats itself ...”*

Queen explained the cause for her to withdraw from her partner’s addiction problem speaks of an anticipated action: *“...she [referring to her mother-in-law] has too much to say about everything...she is very judgemental. She does not listen to others and only hears what she wants to hear. And he is like her. For example, he went to an AA meeting earlier this week and he hears everything he has to...but he does not apply it; he would rather raise his voice and argue. This makes me to close up...I cannot think at that moment ...I once tried to talk with her, but it ended up where I was to blame. I tried to explain to both him and his mother in the hope they will understand, there is no proper communication, so nothing changes...it always came back to what I was doing...that is why I don’t talk”.*

The storylines presented under this subtheme related to CSOs experiencing and becoming emotionally detached tie in with Craig’s (2004:182) viewpoint that in this morass of a partner’s SUD CSOs become totally demoralised, emotionally numb, reaching a stage where they no longer care (see also Perkinson, 2008:244; Craig, 2004:180).

To sum up and in reflecting on the feelings experienced by the participants that are due to their partners’ substance addiction and represented in this theme, the words

of McCann et al. (2017:4) ring true when they state that for CSOs with a family member a SUD, the situation is both stressful and emotionally exhausting.

3.3.3 THEME THREE: CHALLENGES EXPERIENCED REGARDING PARTNERS' SUD-RELATED BEHAVIOURS

The CSO-participants' accounts shared under subtheme 1.3 testified to the fact partners' substance addiction changed who they were as persons and their behaviour. The challenges, introduced in Table 3.4 (below) as subthemes to be presented next, also mainly revolve around the partner's substance addiction and behaviour resultant from that.

Table 3.4: Overview of subthemes related to the theme on challenges experienced regarding partners' SUD-related behaviours

THEME THREE	SUBTHEMES
Challenges experienced regarding partners' SUD-related behaviours	<p>3.1 CSOs cited poor communication, arguments and accusations, even intimate partner violence as challenges experienced</p> <p>3.2 Partner with a SUD not taking responsibility as a challenge experienced by CSOs living with a partner with a SUD</p> <p>3.3 Partner's erratic and reckless behaviour as challenges experienced by the CSO-participants</p> <p>3.4 Manipulation of the CSOs by the partner with the SUD as challenge experienced</p> <p>3.5 The effect of the partner's SUD on the children as a challenge for the CSOs</p> <p>3.6 Partner's possible relapse as challenge experienced by the CSOs</p>

3.3.3.1 Subtheme 3.1: CSOs cited poor communication, arguments and accusations, even intimate partner violence as challenges experienced

It is commonly perceived that when someone is under the influence of a substance, they are no longer rational. In underscoring this perception Bryant (2014:721) notes that the marital relationship is adversely affected by a partner's substance abuse in that it impedes on the quality of the couple's communication and time spent together (Klostermann & O'Farrell, 2013:235; Dethier et al., 2011:151-152; Craig, 2004:173). Instead, a partner's entanglement in a SUD, exhibiting unpredictable behaviour, causes the marital relationship to be psychologically tense, fraught with conflict, arguments, accusations, even resulting in various forms of violence (Choenni, Hammink & van de Mheen, 2017:37; Wilson, Graham & Taft, 2017:123; Rodriguez, Neighbors & Knee, 2014:294; Hudson et al., 2014:106; Klostermann & O'Farrell, 2013:235). While I am of the view that it is the case with all chemical addictions, Gostecnik et al. (2010:370), in referring to alcohol addiction, writes: "it is an addiction of the psyche and the body, in that it is both a cellular and chemical addiction. Alcohol addiction is at its core, marked by an exceptional vulnerability of the alcoholic". Levin in Gostecnik et al. (2010:370) assert that it also comes with an outward aggression and lack of thoughtfulness and concern toward others. This aggressive attitude and lack of compassion on the side of the partner with a SUD is ignited by the substances consumed that hinders them from maintaining healthy functional relationships. The CSOs forming part of such dyads become the victims of the partner's addiction (O'Brien et al., 2016:68; Gostecnik et al., 2010:370).

Andries, Jane and Elsa's accounts point to how a partner's SUD can encroach on a couple's communication and turn it into an argumentative battlefield, causing the non-using partner to become hesitant and to refrain from airing their views and sharing their real feelings (Jesuraj, 2012:42; Gudzinskiene & Gedminiene 2010:168; Perkinson, 2008:245). The discontent with reference to the partner's abuse of substances and consequent behaviour impairs their communication (Dethier et al., 2011:151-152; Arkin, Lewis & Carlson, 1990:127), increase misunderstandings that

diminishes the empathy for each other and ultimately wears the relationship down (Ferrari, Smeraldi, Bottero & Politi, 2014:858).

Andries explained: “... we would have an argument for instance, and I would not necessarily understand why we are having this argument in the first place... arguments get totally blown out of proportion. We would be upset with each other for days on end. I have after the fact learnt that she would actually go out of her way to argue, to find reasons to go to places [pointing to places where she could buy drugs]... [She used arguing]... justifying her behaviour ... moving the focus away from the real issue to something else ... “

Jane wrote the following in her narrative: “Nights passed where she could not sleep, being full of energy and acting weird. The more I would enquire about her behaviour, the more we ended up in arguments. She became increasingly angry with me, something that had a negative impact on our marriage”. She further elaborated how her partner’s addiction adversely affected her communication negatively: “...our conversations are not the same anymore. These conversations also can become suffocating ... you are friendly with each other but before you realize it, an argument is on the verge of starting again ...”

In referring to the communication between William and Elsa, she stated: “Talking to William is impossible. Since the affair came out we have spoken more than the previous ten years ... He acknowledged that he did not realize the hurt and damage that he caused ... he does not know how I felt ... I don’t think he realizes it. I don’t know if all of this really matters anymore ...”

Olga described the conflict and how insulting Danny would become when under the influence of alcohol: “And all this time [referring to Danny’s alcohol addiction] obviously the relationship has been straining. Sex had also become a big issue, he always wanted it when he was drunk and if I refused hell would break loose and then I was a whore again, because I am probably getting it somewhere else. Always threatened to come to my work and find out who it was”. With reference to Danny

wanting to be sexually intimate when he was under the influence, Hudson et al. (2014:106) quote research stating that while substance abusing partners are emotionally less attached to the CSO partner they display a greater desire for intimacy with their partners(especially when under the influence of alcohol).

In her narrative, **Felicity** wrote about the insults and accusations she was a victim to and how it affected her: *"I was physically and mentally drained and heading for a breakdown. All I got was 'you are trash you are a whore', 'I'm deceitful, a manipulator, a liar'. Those words cut like a knife and may not heal at all; wounds heal but word stay with you for the rest of your life...Those words hurt more. I'm a broken woman who cared about a man that cared nothing about me or our family ..."*

Felicity, pointed to Zane's accusations: *"Zane was accusing me of all sorts of things that I was doing...He would wake me up and search me for he believed I was scratching in his cupboard for all kinds of stuff, stuff I was hiding. He accused me of having an affair... he was accusing me all the time... at one stage he even accused me of using drugs, showing me little packets...but they were sweets packets...then he would taste it and say it does not taste like sweets... We once had arguments again and this was when the issue with the bakkie came up [referring to a scratch on the car door] and he took me to the top room as we tried not to argue in front of the kids [but]... he basically set me up where he hit me with the phone, blaming me that I was bugging around".*

Queen wrote in her narrative said *"I'm useless and ungrateful, I do not appreciate anything he does for the family and I have no back bone. He permanently called me names. He was very aggressive and annoyed. I'm was always the wrong one and I started to feel, neglected, scared, I never do anything for myself dress inappropriately, neglecting myself as I felt exactly what he has told me, never had a smile on my face. It was like a person that was trapped inside of me that cannot escape from the world's worst war".* In the follow-up interview I had with her she further elaborated on the aspect of accusation, by stating: *"I don't wash the dishes properly. He never appreciates me cleaning the home. Everything I earn I use for the*

home, but he takes that for granted... 'I abuse him'... he says to me...He now has an attitude of 'I stopped using drugs for you, what are you going to do for me?' ... [He is accusing me for] ...the fact that ... I am not going to stop smoking ... he says he is making all the sacrifices and I am not sacrificing anything".

In her narrative **Cindy** provided a glimpse of her partner's growing addiction, as well the affect it had on him and how it affected her: *"As my husband's addiction grew (what felt like by the hour), he became more aggressive, rude and even abusive. ...there was this incident on the Friday...where he was physically abusive again. The Monday he had to be in court about issues with his father and when he came back from court he was abusive again and raised his voice...and I suddenly said to myself 'but I did nothing to deserve this' and the next day he went to work...I felt so weak it felt as if I was going to die...I just could not take one more beating and I could not care whether we are not together anymore...I lost all sense of care, even for myself... I called his mother and told her that I am going to move out. Please come home with me and get my clothes and my car. So, his mother helped me"*

Accusations and blaming are defence mechanisms which are implemented as a coping strategy to avoid psychological distress (Prout, Gerber & Gottdiener, 2015:124; O'Farrell & Schein, 2011:206)). The person caught up in SUDs uses defence mechanisms in an immature way, projecting their guilt, shame, misery and insecurity on to the CSOs, making them carry the responsibility for the situation. Acting in this way the partners with the SUDs dismiss themselves from the responsibility to deal with the problem (Gostecnik et al., 2010:371).

I conclude this subtheme with reference to Jesuraj (2012:38) noting that both CSOs and their partners revert to blaming each other as they are unable to constructively share their feelings about their helplessness over the SUD. The continued fights, arguments and aggression are characteristic of marriages and family relationships where a family member struggles with a SUD. It becomes a breeding ground for a myriad of negative feelings such as self-doubt, loss of self-confidence, loneliness and depression (Wilson et al., 2017:56; Nagesh, 2015:373; Gudzinskiene &

Gedminiene, 2010:167). Queen's narrative testifies to this. A partner's SUD and the resulting behaviour scars the psychological well-being of the CSOs (O'Doherty et al., 2016:234; Moore et al., 2011:20; Kelly, Halford & Young, 2002:269).

3.3.3.2 Subtheme 3.2: Partner with a SUD not taking responsibility as a challenge experienced by CSOs living with a partner with a SUD

A few of the personality traits and behavioural manifestations of a person absorbed in substance addiction is absconding from and neglecting their work and marriage and family responsibilities; impulsivity and lack of self-control significantly impacting negatively on their functioning at micro and meso-level systems (Hussaarts et al., 2011:38; Nastasić, 2011:93). Queen and Cindy's accounts testify to this challenge experienced.

Queen mentioned: *"The problem comes in that my husband's parents have always done everything for him ...he never had to take any responsibility. Now that he is an adult he cannot take responsibilities ... and the more you want to show him, the more stubborn he becomes. She added an example in this way: "Like this morning for instance; I tried to wake him up five times, but when he did not get up I left for work. So, he phoned later blaming me for not waking him up, being very angry. If he does not want to take responsibility for things, how am I supposed to deal with it?"*

Cindy was most concerned about how her husband's impulse spending was increasing and becoming a challenge for her as he was getting deeper into debt and this was troubling: *"I think there are two matters; the one thing was that financially I was not coping anymore as his spending increased [to maintain his addictive habit] and he got deeper and deeper into debt...it was my debt as I got into debt for him".*

Various scholars wrote about the financial challenges faced in marriages and families plagued by a relative's SUD (Nagesh, 2015:374; Randle et al., 2015:81; Gupta et al., 2014:82; Rodriguez et al., 2014:299). Cindy's account confirms this problem arose in her situation too. Such financial problems can often be attributed to

a loss of income when a person is dismissed from work because of substance addiction or incidences related to it; damaging household items that need to be replaced following an episode of intoxication; and the selling of household items to sustain their drug habit (Choenni et al., 2017:37; Young & Timko, 2015:65; Nagesh, 2015:374; Jesuraj, 2012:40; Benishek et al., 2006:33).

3.3.3.3 Subtheme 3.3: Partner's erratic and reckless behaviour as challenges experienced by the CSO-participants

It is generally acknowledged fact that being under the influence or addicted to a substance, causes a person's behaviour to become irrational, erratic and unpredictable (Prout et al., 2015:124; Hawkins & Hawkins in McNeece & DiNitto, 2012:260; Husaarts et al., 2012: 38). Being detrimental, it results in occurrences that impact heavily on the CSOs living with such a person and causing tension in their relationships (Kinney, 2011:201; Husaarts et al. 2011:38). Even in attempts to initially mask the involvement in chemical substance use and abuse, erratic and strange behaviour could be displayed. The tell-tale signs are many and varied like withdrawing from the marriage or the family; becoming secretive; obvious recurrence of erratic behaviour and mood swings; meeting old user friends; provoking conflict; and over-reacting to stressful situations (Kinney, 2012:253; Lewis et al., 2011:153). In confirmation of this subtheme and views from the authors provided, Paul and Olga's accounts are presented as support.

Paul shared how Grace's loss of control over the alcohol led to her behaviour becoming erratic, reckless and unpredictable, not only for him as her partner but for their friends as well. He wrote: *"The loss of Grace's control - in interactions with me and friends, especially when alcohol was involved. Unfortunately, alcohol was almost always involved around that time. Grace's behaviour became more erratic and more reckless week after week. 'Unpredictable' would be a good way to describe it. ...This was when I first noticed the excessive flirting and when the first affair took place..."* Paul later explained Grace's behaviour as follows: *"...her behaviour was so chaotic, it almost became predictable ...I wished I could control it, but there was no way..."*

Olga painted the following word-picture about her husband, Danny's irresponsible behaviour when under the influence: *"In January 2010 I got a car, and well this was fun, it's as if the drinking, aggression, and spitefulness, everything came with a vengeance. He bumped my car the first day he had it and still lied about, I was not even allowed to drive my own car to work. Well things were then downhill from there. At this point I also decided that I have a child now, drinking [for me] is out. From the moment I knew I was expecting. But when she was born I had a new drive a new power [referring to the new-born child]. I was a mother I would do whatever it took to keep her safe. He would argue with me to drive when drunk no matter what I said. I feared my and daughters' lives. He would disappear three-o'clock in the morning and say he's going to his mother, wake up my child when she was sleeping to spite me if I did not want to give him the car keys. He was irresponsible in the fathering department. And then he and a friend got into an accident with my car, drunk as usual..."* Danny, Olga's fiancé, got involved in another accident due to drunken-driving. She relayed the incident as follows: *"In one of his sprees, he disappeared the Friday and the following morning I get a call there's been an accident. I get there drunk as lord drive into someone else, my car was wrecked, and I sold it for scrap, I did not have the strength to fix it again and have it messed up".*

3.3.3.4 Subtheme 3.4: Manipulation of the CSO by the partner with the SUD as challenge experienced

Manipulation as it applies to substance abuse, is a defence mechanism used by the person with a SUD to try and prove that the situation is under control (Schultz in Mbedzi et.al., 2014:185), and can take the form of a "peace-offering" to compensate for their use or behaviour or making promises to stop using the substance being abused (Furnham, 2012:728). It can also take the form of threats or intimidation as will be noted from the participants' accounts presented below.

Anne explained in her narrative how her husband Dicky manipulated her: *"Dicky would manipulate me by saying if I leave him he will make sure that I never see the kids again. He will have them removed and he will have sole custody of them. I was a*

Director of a company; I even signed off as Director because he also threatened to ruin me financially”.

Paul’s narrative spoke of Grace’s subtle manipulation: *“...but even in addiction, Grace was a very good mother...to an extent. I mean when we had these things with our arguing and her leaving, [going out to visit a bar to drink] it was always when the kids were in bed already. When the kids were there, she would help with homework. She had a lot of energy...she’d help with homework, the house was clean...so the practical things when Grace was in addiction and at home were fine, at least that was before it came out that Grace had a big problem...”*

In the situation of **Queen** and Tom, the latter was less subtle in his manipulation and since going for treatment, he attempted to work on Queens feelings to make her feel guilty: *“He now has an attitude of ‘I stopped using drugs for you, what are you going to do for me?’ The fact that I for instance stopped going for a nail make-over to save money does not count for him. And I am not going to stop smoking ... he says he is making all the sacrifices and I am not sacrificing anything”.*

3.3.3.5 Subtheme 3.5: The effect of the partner’s SUD on the children as a challenge for the CSOs

Although the focus of the research was on the CSOs as partners, Anne, Louna and Linda spontaneously referred to the damaging effect of their partners’ SUD on their children. Its relevance relates to concern about the lifelong impact on the children’s development and behaviour. In the published literature on the effects of SUDs on the family, children are directly affected in various ways, such as feelings of anger, guilt, embarrassment, helplessness and at high anxiety levels (Lander et al., 2013:194-205; Hawkins & Hawkins in McNeece & DiNitto, 2012:256-284; Jesuraj, 2012:33-43; Perkinson, 2008:240-248; Copello et al., 2005:369-385). It is further noted that these children often have difficulty establishing trusting relationships with others and this trend could develop in becoming overly responsible in the relationships they establish (Lander et al., 2013:197; Black, 1982:22).

Anne explained about how her son had been affected by Dicky's substance abuse and behaviour: *"...it must have been very hard for the children. I can clearly see it in the achievements of my son; he never excelled in sport...he was good but not THAT good. But since I have managed to shift Dicky aside in our lives, he went to trials for Northern Gauteng hockey, he stands to be selected for Northern Transvaal junior rugby, even regional athletics in sprints and hurdles... all things he never excelled in. Since Dicky no longer affects him that much, he has managed to gain in confidence and do well at sport. I think my son must have blamed himself also for what happened in the home. Maybe he too [just like Anne] felt he was never good enough".*

Louna shared how their children experienced Stefan when sober; how she initially protected him and how their relationship with Stefan currently looks, now that they are all grown-up: *"... the day he stopped drinking ... they would say that they had to learn to know him as if it was the first time they met him. 'We never knew him'. They were small when he was already drinking. They would say that the person we see now is not the same person we grew up knowing. He never managed to make a conversation... spoke to them...when they came home he would go and sit outside. He had no ability to communicate with them. He would close up altogether in his communication ... and when this happens you have to compensate for it ... I would for instance tell them that their father is not feeling well today. But then later on I stopped doing it as I realised that the children are growing up and can see what is happening ... they experience it for themselves ... It has taken many years from the time he sobered up that the relationship between them would improve. Today they are able to have a constructive conversation with him ... But in the past, this was not possible at all".*

Linda referred to the issue of her children as follows: *"As far as the children were concerned, as they grew up ... my oldest son is a calm and peaceful person ... he would never look for trouble or get involved in any trouble [when his father was intoxicated he went to his room or out to a friend to avoid contact] ... where-as the youngest one is very cocky and won't keep quiet so he would more regularly end up*

in arguments with his father. The older one would rather keep the peace. But the youngest one not.”

A parent's SUD denies the child the opportunity to form and be in a relationship with a constructive role model and experience the warmth, security and care afforded by such a relationship (Kinney, 2012:215). This, in turn, could lead to the development of behavioural and relational problems manifesting in poor school performance, negative attention-seeking, impaired attachments and the risk of also becoming involved in a SUD (Ventura, de Souza, Hayashida, & Ferreira, 2015:140; Lander et al., 2013:194; Black, 1982:25). Children of parents with a substance addiction problem are likely to experience feelings of guilt, self-blame, embarrassment, helplessness, anger and anxiety at a high level (Lander et al., 2013:195; Jesuraj, 2012:36; Copello et al., 2005:370; Craig, 2004:184).

3.3.3.6 Subtheme 3.6: Partner's possible relapse as challenge experienced by the CSOs

Relapse, a term used in the field of SUD refers to returning to addictive behaviour after a period of abstinence (Witkiewitz, Lustyk & Bowen, 2013:351; Hsu & Marlatt, 2012:106; Kinney, 2012:279; Lewis et al., 2011:153). As Kinney (2012:279) points out, addiction is a chronic condition and a relapse is not uncommon - recovery can never be a “closed chapter”. Recurrent relapses unfortunately cause CSOs to relive their negative experiences and this leads to mistrust in the partner with a SUD (O'Farrell & Schein, 2011:202). Only two of the participants (Paul and Andries) touched on the topic of relapse.

Paul spoke about Grace's relapse as follows: *“Oh I was livid again [referring to his anger about Grace's recurring relapse] it was in the week of my fortieth birthday...She came out of the rehab and was making progress ...it wasn't a bed of roses, but we were working through our stuff. Then we planned the party for the Friday. She relapsed on the Wednesday. Not only was I having the disappointment of 'here we go again', but I was looking forward to my birthday and here everything*

came crashing down again. It was a tough time. However, I realised pretty soon that it wasn't 'here we go again'. Grace was almost as devastated as I was... for allowing herself to fall. Then she worked extremely hard here and at home... It was scary...you just don't want to go back there".

Andries found the fact that there is no simple solution for substance abuse and the possibility of a relapse very challenging as Ida had just relapsed over a week before, having been sober for five weeks: *"It was more on the topic of saying that I can feel there is a problem, but I don't know what the problem is. Now that I know what the problem is, there must be a way to solve it. That was the mind-set that I had. I felt that it was an easy thing to solve. But not having experienced anything like this before, I did not really understand what great hold this drug has on a person, how it effects your decision-making, because from my side I would just simplify things and say, 'well, this is an addiction and it is not good for your relationship, it is not good for your child, make out a case to stop it'. That is where my mind is, but I did not understand about addiction. I did not have an appreciation of the real challenge [of not using the substance again] the addict is going through...and how much work and effort and strength it would take to actually prioritise it like that. In hindsight, having seen and going through it and now experiencing the challenges ... my point is that I over-simplified it..."*

This concludes the discussion of the theme presented under six subthemes on the challenges experienced concerning partners' SUD-related behaviours. In the next theme the coping strategies employed to mitigate and manage the experience and its related challenges of living with a partner with a SUD will be presented.

3.3.4 THEME FOUR: COPING STRATEGIES EMPLOYED TO MITIGATE AND MANAGE THE EXPERIENCES AND CHALLENGES RELATED TO LIVING WITH A PARTNER WITH A SUD

Coping, as described by Hsu and Marlatt (2012:115) involves actively engaging and employing thoughts, feelings and actions to manage the internal and external

stresses caused by a situation or event. Being caught up in a relationship of a partner's existing and emerging SUD, measures are put in place and coping strategies applied by the non-using partners in an attempt to manage the substance use (Rodriguez et al., 2014:304). These responses or behaviours, can be described as “enabling” or “co-dependent” as several authors (Askian et al., 2016:268-283; Rotunda et al., in Cox et al., 2013:165; Adedoyin et al., 2014:592-593; Jesuraj, 2012:40; Denning, 2010: 166; Gudzinskiene & Gedminiene, 2010:165-168; Perkinson, 2008:246-248) point out. They should be considered as “normal” reactions the families are encountering because of the abuse of substances by one or more family members, especially the CSO-partners who are, in reality “normal” persons whose reactions become more disempowered by the SUD (Orford, 2014:2). This theme is now presented under various subthemes as shown in Table 3.4 on the following page.

Table 3.5: Overview of subthemes related to the theme on coping strategies employed to mitigate and manage the experiences and challenges related to living with a partner with a SUD

THEME FOUR	SUBTHEMES
Coping strategies employed to mitigate and manage the experiences and challenges related to living with a partner with a SUD	<p>4.1 Covering up the partner's SUD as a coping strategy</p> <p>4.2 Adopting the philosophy of “if you can't beat them, join them; as a coping strategy employed</p> <p>4.3 Setting boundaries and self-care as a coping strategy employed by CSOs</p> <p>4.4 Blocking out thoughts and feelings; focusing on work and keeping busy as coping strategies employed</p> <p>4.5 Threatening to leave or divorce, or requesting the partner to leave as coping strategies employed</p> <p>4.6 Obtaining a protection order and enlisting the help of the police as a coping strategy</p> <p>4.7 Avoiding or withdrawal from the partner and from social life, friends and family to spare embarrassment as coping strategies</p> <p>4.8 Taking control, managing home-life in an attempt to keep the family together as a coping strategy</p> <p>4.9 Reached out for professional help to manage and cope with the partner's SUD as a coping strategy</p>

The mentioned subthemes will now become the focus of the discussion.

3.3.4.1 Subtheme 4.1: Covering up the partner's SUD as a coping strategy

Covering up, or hiding is a strategy used by both the partner with the SUD and CSOs to keep the substance addiction concealed to avoid the embarrassment and/or humiliation, and other consequences that may follow when this secret is in the open (Jesuraj, 2012:37; Peled & Sacks, 2008:395; Perkinson, 2008:244). This cover-up could also manifest by denying the emerging or existing SUD (Askian et al., 2016:274; Jesuraj, 2012:37) and result in the non-using partner fulfilling an “enabling”-role (Hawkins & Hawkins in McNeece & DiNitto, 2012:263; Perkinson, 2008:244; Craig, 2004:176). Such behaviour entails, for example, denying and suppressing their own feelings (Askian et al., 2016:270), taking over responsibilities (Peled & Sacks, 2008:397; Craig, 2004:176) and lying and making excuses for partner with a SUD (Perkinson, 2008:244). This inadvertently allows the person with the SUD to continue abusing substances and maintaining the habit.

The narratives Queen, Cindy, Elsa, and Paul wrote contain recollections that confirm incidents that support both the essence of the identified subtheme and the quoted literature illustrating how they used covering-up as a coping strategy. Pretending that everything was well at the home front was also subtly implied.

Queen disclosed: *“I try so hard to make everything look fine...but I cannot carry on like this”*. She added: *“It is hard... I never spoke to anybody about this [referring to Tom’s addiction]. Afterwards my mother-in-law would ask me why I never told her, but she has no idea what I go through at home...it is easy to say to me to talk to her, but she does not have to sit with all of this...”*

Cindy admitted: *“... the harder I tried to cover things up the more covering up I had to do... everything just became more and more and more”*.

Elsa shared how she covered-up, Williams's drinking problem, when stating: *"I have tried over the years to pretend that everything is fine...that all is all right while it was obviously not...I am living a lie ...it puts a strain on any relationship. If we go out or when we entertain, I always have to check that he does not take a swig out of the bottle. You can't go out and meet friends you know...it is a never-ending story".* She continued: *"One would expect after the affair [referring to William] that I would pack up and go...but we still live in the same house. I try and keep things as normal as possible...for the children's sake and for the grandchildren... 'My niece is getting married in two weeks' time at my house in my garden...I will see this wedding through at all cost'. I will probably win an Oscar for my acting, but I have to keep things together".*

Paul stated how he covered up Grace's alcohol and Khat use for the sake of the children: *"The thing was that at that stage, we had three kids...my fear was mostly about their well-being. You see, even if her actions hurt me greatly, there was this added dimension [referring to his wife's addiction] that I had to keep it quiet from the kids...they were tiny...my oldest son is 13 now...it was already going on when he was eight...and he is the oldest, so...you see, I had to keep them safe and then also make them believe we are one big happy family. Not only the kids ... also the family, I tried to keep it a secret...that was the stress..."*

Queen, Elsa and Paul's references to shielding the children from their partners' SUDs resonates with one of the coping strategies identified by Kinney (2012:213), who adopted the idea of "maintaining a façade" and applied it to families living with SUD. This is in addition to other coping strategies described as "keeping out of the way, controlling, and resigning" or "giving into the state of affairs", also highlighted as coping strategies (Kinney, 2012:213).

3.3.4.2 Subtheme 4.2: Adopting the philosophy of “if you can’t beat them, join them” as a coping strategy employed

In support of this subtheme, Cornelius, Kirisci, Reynolds, Homish and Clark (2008:1233), and Craig (2004:183) point out that one way of coping with a partner’s substance addiction is for the CSOs to turn to using substances themselves. CSOs drinking with their partner with a SUD do so as an “adaptive process” which attempts to reflect closeness and intimacy in a relationship or their “self-medicating” could be an effort to deal with their own feelings (Levitt & Leonard, 2015:703; Gilchrist, Hegarty, Chondros, Herrman & Gunn, 2010:2). In situations where intimate partner violence is involved, CSOs have a five times higher rate of abusing substances themselves than others (O’Brien et al., 2016:61). To substantiate this subtheme and Craig’s (2004:183) viewpoint, Olga’s account is provided.

Olga was the only CSO-participant who openly admitted that she thought one way to cope was to drink with her Danny although she abandoned this idea later on. She admitted: *“Yes, it was something like ‘maybe if I drank with him...participated with him, things will be okay’. But then I became negative...if I see alcohol I would become angry and we will have an argument. But yes, I did drink with him to see if it makes things better. But it didn’t. So, I stopped. There were times, even now, that I don’t go out with him at all”.*

While **Anne** did not refer to her excessive drinking, Dicky, her husband, during the interview with him did speak about this as her way of coping with his addiction in that... *“...things were very difficult at home ... she began drinking a lot. Much more than usual. I am honest ...”* This information was confirmed by Anne during a separate discussion unrelated to this specific aspect of this research project. She described it as merely a temporary attempt to cope but also to spite her husband.

3.3.4.3 Subtheme 4.3: Setting boundaries and self-care as a coping strategy employed by CSOs

As Orford, Templeton, Patel, Copello & Velleman (2007:34) point out, a person can purposefully distance themselves from a SUD drug user and their sequential destructive behaviour and focus on themselves as an important way of surviving emotionally. Withdrawing, from the substance abusing person's violence, aggression and substance abuse can result in creating a successful coping environment, as McCann et al. (2017:2) highlight. The setting of boundaries can serve as a deliberate attempt to worry less and feel less guilty about the partner's substance abuse and addictive behaviour, also providing an opportunity to do practical things for oneself (Orford et al., 2007:35). In her story-line Cindy mentions her pleasure from simply running a bath or visiting friends. However, setting boundaries does require a degree of assertiveness. Smith, Saklofske, Keefer and Tremblay (2016:319) firmly emphasise that the effectiveness of this coping strategy depends on certain contextual and personal factors.

Cindy, as CSO-participant emphasised the setting of boundaries as follows: *"...the part of the Mighty Wings programme that really helped me is the section on boundaries... stick to my boundaries like when my husband [Mike] was in active addiction, the more I let go of it [referring to not keeping the boundaries in place], the more I lost myself. And in the boundary session I learnt to put boundaries in for myself... but not dictate boundaries for him. I think the biggest thing for me in the boundaries sessions was to self-care... there were practical activities afterwards (after the theory lessons) ...like 'what three things can I do now?' So for me the caring for myself was a big part of the boundary lessons... And I think if I derail and don't take care of myself, what I learnt in the lessons nudges me to reconsider... and small practical activities like taking a bath with my favourite ingredients, whatever, so setting up time with my friends who I let go of during my husband's addiction... so the boundary sessions helped me to re-grow my own life... I am still on that journey, but it gave me tools... so when it comes up to deal with it as we go along in our relationship...and also I don't know all my boundaries yet, so as new things come up*

like what I like and what I don't like...some boundaries we did discuss was zero tolerance for drugs in my house... that will never change... so the permanent boundaries we did discuss, but those that change with time not actually..."

Andries also referred to the setting of boundaries but applied it as agreed rules in their relationship: *"Although not everything [referring to the various aspects of SUDs covered in the information session for families] could have been answered... the big thing that came out for me was that the recovering addict needs to be clear about what the boundaries are... there was an example about a wallet in the house... I don't have to lock it up all the time... it should be respected as my personal belonging and any money in it should not be at risk if I happen to leave it... I have to say that for a big part of this process [learning about SUDs], I did not consider my needs... there was a discussion that we had where the social worker indicated that"*

3.3.4.4 Subtheme 4.4: Blocking out thoughts and feelings; focusing on work and keeping busy as coping strategies employed

In coping with a partner's substance addiction, blocking out thoughts and feelings and focusing on work and keeping busy are mentioned in the literature as coping strategies that displace the experienced feelings caused by the SUD in a relationship (Furnham, 2012:725). Described as avoidance, it refers to actions or activities to escape feelings of hurt or to avoid situations or circumstances that confront or remind a person of painful events [for example living with a person with a SUD] (Wrape, Jenkins, Callahan & Nowlin, 2013:112). Vatnar and Bjorkly (2016:882) define such situations as *"avoidance coping"* and mention two ways of disengaging from stressful circumstances. These are cognitive disengagement and behavioural avoidance. With cognitive disengagement, an affected person first processes an event by suppressing and blocking out thoughts about it and deliberately pays attention to other distractions. Then secondly, engages in behavioural avoidance by physically remove themselves from a painful situation replacing it by becoming occupied with other actions.

This coping strategy of withdrawal is seen by McCann et al. (2017:2) as a CSO partner's attempt to avoid the substance addicted partner's violence, aggression and their destructive substance abusing resulting behaviour. Amongst the constructive emotion-regulation coping strategies highlighted by Papalia, Sterns, Feldman and Camp (2007:425), adults are known to deal with a stressful life by securing support from family and friends, participating in an event to link with accepting reality, while keeping themselves occupied. Interestingly, these coping strategies can be seen to tie in with the following extracts from the CSO-participants Olga, Felicity, Anne and Andries. Information gathered from their narratives and other interviews conducted with them substantiate this subtheme, corroborating with evidence found in literature quoted that endorses the value of avoidance as a coping strategy for CSOs.

Olga underscored this subtheme in both her written narrative and the follow-up interview I had with her. She mentioned: *"I ... chose to skip certain things [referring to life-skills she was taught in her group session...But it did get better. I think over time I learnt to deal with things better. I also learnt to take emotions out of it...sometimes people would ask '...but don't you feel anything?' But I think it became a defence mechanism. At first it [referring to blocking out thoughts and feelings] may have been functional; as I did not know what to think, what to feel or how to deal with it... I started to shut things out...putting it in a box...the pain, the anger, the disappointment...we would have an argument the night and things will get broken, but when I stand up the following day I just say '...you know what, it is okay...that was last night, move on ..."* In her narrative she wrote *"It [referring to distancing herself from the circumstances] almost seems like I have been looking through a glass window at some else's life. It seems unreal. But then I start feeling again, and all the fear, frustration, anger all comes racing back and then I stop thinking and stop feeling. It seems to make things easier if I just live in the moment and concentrate on immediate surroundings it makes dealing with the past easier"*. Olga continued: *"... I busy myself...I cannot take the time to just sit and think about life. I will rather read, play computer games; watch a movie ... I will not allow myself to just sit and do absolutely nothing"* And later she added: *"I work to literally keep myself sane ..."*

Queen stated that being occupied to avoid her husband and her work was her coping hideaways: *“...nothing I do is right...so I walk in the house and clean up and become occupied to avoid him...I cannot even look in his direction...My best times are away from home when I am at work. So, work unfortunately becomes an escape for me...I am a family person. I like to be at home with him and the children. But I cannot be family with him. When he gets home the trouble starts as nothing is right in his eyes...”*

Felicity's account testified how work was her family's survival: *“...I pushed myself more at work... as we needed the money...”*

Andries also focused on his work and changed from working at home to elsewhere and this indulgence became his escapisms: *“I used to have an office at my home because I have a lot of space there. I don't really have to see clients at my office as when I see clients I can go to their offices. But the uncertainty...and this was one of the things I needed to do due to the situation was to move out of the house so that I have an office space I can escape to...if you want to call it that...where there is at least some sanity. So, this was one of the things I did before I understood about the addiction. And still this helps me now even after the fact, to leave the house in the morning and come to the office and switch your mind onto the work and switch off from the relationship issues and those kinds of things. But there needs to be a healthy balance with this as well...Before I found out about the addiction I have done that to escape to a degree that was not healthy because I was just totally ignoring any other issues. I was just working, working, working... [It became] ... certainly a level of escaping from reality...I focus my attention onto things that are under my control, that I know just to have...have a sense of achieving something. Be productive and spending time constructively”.*

3.3.4.5 Subtheme 4.5: Threatening to leave or divorce, or requesting the partner to leave as coping strategies employed

Threatening to leave, and actually leaving their partners with a SUD temporarily, filing for divorce or kicking their partners out, are all extreme measures taken by CSOs in an attempt to resolve the substance abuse situation (Gupta, 2014:84). McCann et al. (2107:2) refer to this as the coping strategy of “standing up” by challenging the partner with the SUD’s behaviour and seeking assistance from law enforcement and judicial agencies. This happens at a stage when the CSOs become desperate and feel that they have had enough. This situation is captured in the following storylines.

Kate left Barry a number of times but always went back: *“I wanted to help him in spite of the fact that I went to stay with my mother on a couple of occasions...I also left him on a couple of occasions to allow him to sort himself out ...Maybe I also felt somewhat hurt you know? Maybe somewhat heartbroken too ...also disappointed ...definitely scared at times...many people have told me to leave him, to break up with him, but I felt, ‘no, I wanted to help him...some way or other’...Every time there was a change in behaviour, I knew he used. He also became aggressive more often...he would shout, scream, swear, bump me around, and hit me...I would then go and stay with my mother for a month at a time...He got better...I would go back...I did not want to leave him...He would continue using for a while and then wanted me to come back when he stopped”*. In response to a question as to whether Barry pleaded with her to return or not, Kate said: *“Of course. But I would not immediately fall for it. I would go back so that I can work as my parents stay on a farm which is quite far. Also, my child attended school here, so I had to consider this also...every time he would start again though...He never stayed clean for more than a day or two at a time. There were times I tried to find help for him...”*

Paul separated from Grace to protect his children. He spoke about this as follows: *“Grace and I then separated again [Paul has requested Grace to leave the home on a few occasions during her use of alcohol]...I could not subject my children to the*

instability. We would see Grace a couple of times a week, but these were not pleasant visiting times and would invariably end in arguments, accusations, and the realisation that no progress was being made on getting 'clean'". Paul also told Grace on more than one occasion to leave, admitting that this was a coping strategy: "I think this was the way I tried to cope with it. Obviously we reached a point where this was no longer viable...I kicked out Grace many times...I think it was three times...I always took her back at some stage..." Paul recounted what led him to kick Grace out the last time he did: "...my son and daughter each had a friend over to sleep ...I played golf that day...and I phoned Grace at about ten o'clock in the morning to hear how she was coping...she was BLASTED! Now it wasn't only our kids but also other people's kids who she was looking after...and that was pretty much the last straw...she was now endangering other peoples' kids. This now became ridiculous...managing our kids clearly was bad enough, but even if there were no kids or just our kids...I was playing golf with my father. So, we went home, and I asked her 'how could you do this?'... and we took the children home..."

Queen recalled the one time she left: *"I did leave him for one week. He begged me to come back, and then everything was fine for about seven weeks...but he has hit a dip again and I can see how this is happening all over again..."*

Anne explained that filing for a divorce was her way of addressing and coping with Dicky's substance addiction: *"I already had an appointment to file for divorce. This for me was the final option. However, just before the appointment my daughter fell ill and I had to fetch her from school. Two days later before the next appointment, Dicky hit rock bottom ending up in hospital, which made me cancel the appointment".* Anne admitted that she would have gone ahead with the divorce as... *"He was in complete denial. He said this was the way he is. I cannot live with somebody like this anymore...at one stage he blamed it on the medication that the doctors and I make him take...I will divorce him. My stepsister's husband relapsed on eight occasions... she was with me at the hospital with Dicky and said to me, 'If he relapses once after this, leave him. He will relapse again and again. You don't need to be in the situation*

I am in'...I cannot have a repeat of the past three years. He will again deny everything, and I will again sit with the problems and he will again end up in hospital...also forcing me to find help...but I did not know how to help him".

Felicity also mentioned that she got to a stage where... *"I said to him that I no longer am prepared to do this, and I am filing for a divorce. And I said to him that if you are doing drugs, you will never see your kids as I am the only stable person. That was all I could threaten him with...I was using the kids by saying 'I am filing for a divorce and you will never see your kids'"*.

Louna went far in the divorce proceedings which triggered her husband going for treatment. She stated: *"A divorce was the only outcome I saw and I told him that. The only answer I got was, you're crazy! I went to see a lawyer. The day the court order was delivered at his work, it was war! He went into a series of quarrels before he realized I'm serious. He then agreed to go for help. I cancelled the divorce"*.

Despite the strong link in literature between substance abuse and divorce (Gupta et al., 2014:83; Rodriguez et al., 2014:299, 302; Rodriguez et al., 2013:627), none of the participants who threatened or filed for divorce went through with it. The underlying motive for the CSOs to take action like this was to force the partner with a SUD to stop using the substances or go for treatment (Refer to theme 5: CSOs' accounts of what motivated their partners to enter treatment – Subtheme 5.4).

3.3.4.6 Subtheme 4.6: Obtaining a protection order and enlisting the help of the police as a coping strategy

This coping strategy to arrest a partner's entanglement in substance addiction has been reported by various scholars (Rodriguez et al., 2014; Klostermann & O'Farrell, 2013:235; McCann et al., 2017:2, 6). It is not uncommon for partners to stand up to the situation and to seek help from legal and law-enforcement agencies as a way to manage the challenges experienced. This especially happens in situations where a partner's substance abuse and addictive behaviour becomes unpredictable causing

the marital relationship to turn into a battle field of conflict, arguments, accusations, and various forms of violence.

Extracts from Olga, Cindy and Kate's written narratives underscore this subtheme and the comments from the literature consulted.

Olga wrote: *"I even got a protection order to try and scare him into changing his ways but that did not work. Thus, the court order ... [led him] ... join the Mighty Wings programme"*.

Cindy, in writing, shared the following: *"... I had nothing left inside of me, no physical energy to fight, no emotional capacity to think about how wrecked my life choices was and when I looked at myself in the mirror and couldn't recognise who I was anymore, I realised I needed help. Lifeless, I saw how I started to live the lies of my co-dependency i.e. that I don't deserve to be happy and I'm not important. That day I realised that I would rather walk out of my marriage with the understanding that I need help and that this is not the life God intended for me than to stay in my marriage and lose the little bit of me that I still loved. I decided to get a protection order against my husband and although it was hard and came with much discomfort, I felt a deep sense of freedom moving out and looking out for me"*.

Although Kate never got a protection order she did have to call the police on occasions. **Kate**: *"There were times I had to call in the police..."* [This especially happened when Barry was under the influence of alcohol or Khat and he would become violent].

3.3.4.7 Subtheme 4.7: Avoiding or withdrawal from the partner and from social life, friends and family to spare embarrassment as coping strategies

This subtheme ties in with both Subtheme 3.6 and Subtheme 4.1. Under Subtheme 3.6, emotional detachment was presented as an experience some of the CSO-participants had that followed their substance dependant partner's addictive

behaviour and under Subtheme 4.1 where covering up, or hiding a partner's emerging or existing SUD as a coping strategy was presented. For the CSOs to withdraw from members of the extended family, friends and other social gatherings that can be regarded as meso-level system connections may serve two purposes. The one is to cover-up a real situation and the other is to be spared the embarrassment caused by the partner when in an intoxicated state (McCann et al., 2017:2; Kinney, 2012:210; Gostecnik et al., 2010:371).

Anne, Elsa, Louna, Cindy and Linda's accounts spoke of how they withdrew from social life to cope with or be spared the embarrassment from their partner's substance addiction induced behaviour.

Anne wrote in her narrative: *"Dicky's relationship with the kids deteriorated since 2014, because as I, they also felt a bit embarrassed to take him to school or social events. He will always be twitching, scratching and acting totally out of character. I could see how this irritated our friends and family. Withdraw from social events followed. I noticed that my kids did not receive any invitation so kids' birthday parties any more. I was mad at Dicky for this. If he could just see how his behaviour was damaging our relationship as a family and our friends and family"*.

Elsa wrote in her narrative: *"Through all of this, I have become withdrawn and have isolated myself and where possible I avoid socialising as I don't want William to embarrass me. I have tried to pretend that everything is alright and carry on as best I know how. I try to avoid confrontation and don't speak to William when he's had a drink"*.

Louna mentioned: *"Your dignity is affected; you are afraid that strangers may find out what is really going on in your house. In so doing, you and he eventually have no social life and no friends any more"*.

Cindy wrote: *"Soon I was estranged from everyone, disconnected and found peace in a separation from others. It was easier this way, less people to lie to, less revving*

myself up to pretend that everything was fine. I lost touch with every part of me and became a slave to being the caretaker. I lost friendships and family relationships were hard”.

Linda’s account sketched the scenario how she withdrew from Conrad physically and emotionally: *“...he revolts me when he is drinking...I then don’t want any physical contact from his side. And as the years went by he struggles to get and keep an erection. And then we would rather avoid these situations...But clearly, I do not want any physical contact when he had been drinking and he knows it...this also became a point of dispute...he wants to and I don’t want to so this created even more problems...In a marriage one should be there for each other, but we are not...if one link in the chain is broken, there is no proper chain”.* Later she said: *“...together with avoiding physical contact I also withdrew emotionally...”*

Withdrawing, physically and emotionally from the partner with a SUD during the progression of the substance abuse problem, is not uncommon (Klostermann & O’Farrell, 2013:235). Hussaarts et al. (2011:44) postulate that partners’ SUD in actual fact side-line the CSOs. The partner’s substance addictive resultant behaviour ignites the CSO-partner’s withdrawal (McCann et al., 2017:2). Orford et al. (2007:34) emphasise that this coping strategy of withdrawal can become the steppingstone that could lead to independence. Distancing oneself from the substance abusing partner creates the time and space to start focusing on self needs.

3.3.4.8 Subtheme 4.8: Taking control, managing home-life in an attempt to keep the family together as a coping strategy

The CSO-partner caught up in the micro-system of a partner’s SUD is soon forced to take control and manage or organise events and situations at home to keep the family together. Peled and Sacks (2008:395) confirm this coping strategy when they wrote: “Seeking to achieve a “normal” life, Rona [one of their participants] and the other women made great efforts to create a secure environment for themselves and their children and to hide the problem of addiction, which they perceived as the main

reason for feeling different". Lander et al. (2013:196) express the opinion that becoming emotionally enmeshed in a partner's SUD and taking control of events, as a way of "adaptation" contributes to a state of equilibrium in the family but inadvertently sustains the SUD. In addition CSOs become burdened with the responsibility of taking care of the addicted partner (Craig, 2004:179). This "care-taking" role may continue even when the partner with a SUD is sober. If the CSO-partner, even after their partner with the SUD is sober, is still hurt or unaware of what drives her behaviour and the problems inherent in SUDs, they might elicit feelings of rebellion or inadequacy inadvertently resulting in the eventual relapse of their partner (Mackintosh & Knight, 2012:1095). If the CSOs do not themselves receive assistance, they may unintentionally continue to place the dysfunctional relationship above their own needs (Adedoyin et al., 2014:592).

Louna, Olga, Felicity and Paul's accounts gave rise to this subtheme, which also resonates with the viewpoints found in the sourced literature.

Louna mentioned the following in her written narrative: *"I also had to gradually start doing everything; finance, children... At that time, we stayed on a smallholding outside Pretoria, where all those responsibilities also became mine. He just drank!"*

Olga's account served as testimony as to how she had to take the lead to support and care for her children: *"...I have my children, I am not allowed to sit in that corner... I have to look after them; I have to be strong for them. ... my kids ... they look up to me as a role model ...they see you work hard and you get money for it and you can buy nice things. The way I work is to create my own salary...I cannot sit and think when I will break down, I sit and think how I can make my children's life better...It is a luxury I am not allowed to have - that's it!"*

Felicity explained how she tried to cope by fighting to keep her family together but later realised this was not possible: *"I started to put money away for the day I need to, I can go. I already had the house and I told the guy who rented there that he must be prepared should I go...In the beginning I was holding on for the family...I was*

trying to fight to keep everything together...I did not grow up in a broken home and he also always was against a broken home as he grew up in a broken home...he said it was not nice. So, the fight was to keep the family together...but at a point I just couldn't anymore...I realised I was not able to manage two kids on my own".

Paul also tried to keep the family together mainly for the sake of his children: *"The thing is that at that stage we had three kids...my fear was mostly about their well-being...you see, I had to keep them safe and then also make them believe we are one big happy family ..."*

This coping strategy of taking control, managing home-life and keeping the family together as displayed by these CSO-participants must be seen as a strength. It resonates with Peled and Sacks (2008:396) when they state that a CSO's ability to function simultaneously on many planes in a reality that is fraught with difficulties and emotional distress is a true testimony of strength and tenacity.

However, on the contrary, O'Doherty et al. (2016:236) and Jesuraj (2012:38) found, all attempts to try and preserve any kind of meaningful family life with a SUD present in the home eventually does not work out. Their supporting evidence showed further deterioration and more problems when such a coping strategy of taking managed control was attempted and adopted. By implication, the solution is that help is required as indicated in the next subtheme.

3.3.4.9 Subtheme 4.9: Reached out for professional help to manage and cope with the partner's SUD as a coping strategy

Reaching out for help, described by some practitioners as help-seeking, is a coping strategy to address a person's psycho-emotional discomfort (Rickwood & Braithwaite in Best, Manktelow & Taylor, 2016:260). Generally, the non-substance abusing partner would be the first to reach out for help for their partner with a SUD (Jason, Stevens & Light, 2016:335; Toner & Velleman, 2014:147). In this regard, Wilson et al. (2017:58) suggest that CSOs would seek advice on how to encourage their

partners to seek help; advice on how to cope with partner's substance abuse, and to talk to someone about the emotional stress and problems they experience (see Kinney, 2012:211; Lewis et al., 2011:173). Copello et al. (2005:371) point out that between 30 and 50% of calls to alcohol advice centres in the UK for help with substance addiction concerns came from partners and family.

Cindy, Linda, Louna, Elsa and Felicity were the only participants in my study who mentioned that they reached out to professionals in the meso-system for help as a means of assisting them in coping with their partner's SUD.

Cindy, after she left her husband, decided to join a recovery programme. This decision was mentioned in her narrative: *"A mutual friend told me about Mighty Wings and the dynamic recovery program for supporters [CSOs]. Even though I moved out of the house, I still felt broken and wrecked and I knew I needed help. Coming to Mighty Wings was my saving grace. So, I decided to give myself fully to the programme and welcome the pain and suffering that goes along with change".*

Linda indicated that she joined her partner in going for professional help, as at times they both felt they needed it. This, however, did not help her, as Conrad's drinking never stopped. She stated: *"For many years we have attended psychology sessions ... we went for marriage counselling ... we did go and see people with whom we have discussed our circumstances ... alcohol was regarded as a factor, but may not have been regarded as the most important one ... but we did go and discuss this with professionals ..."*

Louna reached out for advice from her pastor, but admits the advice given was not helpful. *"You have to understand that his drinking reached the stage where I sued him for a divorce. Prior to this I spoke to our pastor and his response was that I had to pray about it. But I have prayed even many years before this. And then I reached the stage where I stopped praying because it felt as if God was not listening to me. I don't mean to say that one should not pray, it is the right thing to do ... but we have to be clear that once the situation becomes desperate, you need practical guidance*

... and then you become angry with the whole world because he is not stopping ... and it creates tremendous conflict in me as a person and between the two of us“.

Elsa explained her reaching out for professional help as follows: *“I have in the past weeks found my voice and said what I wanted to say to William. I am also seeing a counselling psychologist at this stage. I need to as I will not be able to get through this on my own. I have asked William to go for counselling, but he has refused. I asked him, ‘I would go for therapy and they also want to talk to you, would you go? He did not agree that I go into therapy, so I left it. It turned out however that we both are going to see a psychologist. Whether he goes or not, I will go... Although problems were still there [it] helped me find better solutions”.*

Felicity shared that she reached out for help just after the birth of her daughter: *“It reached such a stage that I had to go to the doctor ... and I said to the doctor I don’t know if I am going mad but I need somebody to evaluate me and they booked me in at a clinic to see a psychologist as I also was on an anti-depressant ... but they thought I had baby-blues. The psychologist said that he did not think I had baby-blues, there is nothing wrong with you, what are you doing here? ... I asked him to just keep me there as I needed some rest. He kept me there for three days”.* Not admitting her husband’s SUD as motivation for reaching out for help, underscores the viewpoint that it should be identified professionally as a primary concern. Should this not be done, it is likely that the patient is at risk to not be placed on the treatment programme (Cox et al., 2013:160; Kinney, 2012:211).

The outreach for professional help is emphasised by Saunders, McLeman, McGovern, Xie, Lambert-Harris and Meier (2016:237) who state that there are strong links between substance use, social problems and CSOs’ post-traumatic stress disorder (PTSD) (Ventura et al., 2015:140). Adding to this, Gupta et al. (2014:82), include a higher than average incidence of depression, psychosomatic, mood and anxiety disorders among CSOs living with a partner with a SUD. This should motivate them to seek professional help, as the participants in my study did. The decision to reach out for help is determined by a variety of factors, including the

emotional attachment to the partner, pregnancy, the children, attitudes and behaviour of family or friends as well as their self-esteem and the professional appraisal of the situation (O'Doherty et al., 2016:226).

When casting the coping strategies employed by the CSO-participants to mitigate and manage the experiences and challenges related to living with a partner with a SUD against the theoretical frameworks, the strength-based perspective and the resilience and eco-systems theories adopted for the study emerged as useful. The CSOs were identified as being part of a micro-system and enlisting the professional help on the meso-system level helped for seeking professional help and for obtaining protection orders and the help of the police as coping strategies. The coping strategies employed tie in with the coping strategy of “standing up” as mentioned by McCann et al. (2107:02). The CSO-participants’ “standing up” by a threatening to leave their partners, and temporarily leaving and filing for divorce, taking over all responsibility in an effort to keep the family together testify to the their strength and resiliency. It disclosed their ability to “bouncing back” (Galea in Green, 2014:944), or the trait to recover from or adjust to misfortune or change (Windle et al., 2008:285). However, some of the CSOs’ attempts to cover up the partner’s emerging or existing SUD in fear of embarrassment and other consequences and taking over all responsibilities, and joining in with the partner’s substance addiction are in the substance addiction literature seen as “enabling behaviours” (Hawkins & Hawkins in McNeece & DiNitto, 2012:263; Perkinson, 2008:244; Craig, 2004:176).

To conclude this subtheme on coping, Papalia et al. (2007:425) are of the view that the coping strategies employed to mitigate and manage life’s stressors can be adaptive or maladaptive. These authors refer to three ways of coping to deal with and manage stressful events, which include striking at others, indulging oneself as non-constructive way of coping and constructive coping (Papalia et al., 2007:425). The subthemes on the CSOs’ coping strategies can be fitted under the latter two mentioned ways of coping. The subthemes on the CSOs’ coping strategies are fitted under the latter two mentioned ways of coping. However, some of the coping strategies can be regarded as both constructive and non-constructive, because they

help the CSOs to cope, but does not resolve the partner's substance abuse problem nor does it prohibit the enabling behaviour. These are presented in Table 3.6 below.

Table 3.6: Participants' coping strategies according to Papalia et al's (2007:425) ways of coping identified

Striking at others as way of non-constructive coping	Indulging oneself as way of coping of non-constructive coping – which can also be interpreted as enabling behaviours	Constructive coping
	Covering up the partner's substance addiction as a coping strategy	
	Adopting the philosophy of "if you can't beat them, join them as a coping strategy employed	
		Threatening to leave or divorce, or requesting the partner to leave as coping strategies employed
	Blocking out thoughts and feelings	Blocking out thoughts and feelings; focusing on work and keeping busy as coping strategies employed
		Obtaining a protection order and enlisting the help of the police as coping strategies
	Avoiding or withdrawal from the partner and from social life, friends and family to spare embarrassment as coping strategies	
	Taking control, managing home-life	Taking control, managing home-life in an attempt to keep the family together as a coping strategy
		Reached out for professional help to manage and cope with the partner's substance addiction as a coping strategy

3.3.5 THEME FIVE: CSOs' ACCOUNTS OF WHAT MOTIVATED THEIR PARTNERS TO ENTER TREATMENT

In introducing this theme focusing on what motivated partners to go for treatment, Sterk, Ellison and Theall (2000:845) focusing on women and drug treatment and after interviewing 48 mother/daughter dyads of whom two-thirds were cocaine users, in Atlanta Georgia, found that that both external and internal factors led them to seek drug treatment. Under the external motivators mentioned were court-ordered drug treatment in lieu of incarceration, interventions by social and health service providers, encouragement or pressures from relatives and friends, and threats from other drug users and sellers. These factors are confirmed by Gruszczynska, Kaczmarek & Chodkiewicz (2016:351) when indicating that it creates a "heightened personal crisis" which contributes to their decision to enter treatment. Internal factors motivating them to go for treatment included physiological and psychological problems, pregnancy, and "burn out" from the drug lifestyle, including having "hit rock bottom." These external and internal motivators were also confirmed by Stokes (2017:106) in her study focusing on the sustained recovery. Her participants identified the following as internal factors sources motivating them for treatment, namely: physical problems, problems with appearance and becoming unacceptable for self, life becoming unmanageable, feeling isolated and lonely. In all these cases a strong undertone of depression was present. Resorting under the external motivators, and in addition to the factors mentioned by Sterk et al. (2000:845), the following were mentioned namely, threat of divorce or losing their family and loss of the ability to manage their circumstances due to their drugging (Stokes, 2017:107). Adherence to and agreeing to enter treatment is significantly higher in "coerced population of addicts" as external motivation, with a more positive treatment outcome and decrease in criminal activity and drug use (Oreskovic, Bodor, Mimica, Milovac & Glavina, 2013:107).

Against these remarks six of the subthemes related to this theme (depicted in the Table 3.7) can be regarded to be more external motivators that encouraged/forced

the CSOs' partners with the SUDs into treatment, while the seventh subtheme reflects a deliberate decision and the motivation is therefore more internal.

Table 3.7: Overview of subthemes related to the theme on CSOs' accounts of what motivated their partners to enter treatment

THEME FIVE	SUBTHEMES
CSOs' accounts of what motivated their partners to enter treatment	<p>5.1 Partners entered treatment following being hospitalised for SUD-related incidences</p> <p>5.2 Husband's affair coming into the open triggered his decision to go for treatment</p> <p>5.3 A participant's decision to leave her husband and obtaining a protection order served as external source of motivation for the partner to enter into treatment</p> <p>5.4 Filing for a divorce as external motivator for partner to go for treatment</p> <p>5.5 Gave the partner an ultimatum (external motivator) to go for treatment or the relationship will end</p> <p>5.6 Obtaining a court order, an external source, to force partners to enter treatment</p> <p>5.7 Partners decided on their own to go for treatment after being motivated by their CSOs</p>

3.3.5.1 Subtheme 5.1: Partners entered treatment following being hospitalised for SUD-related incidences

Paul and Anne's accounts gave rise to this subtheme. **Paul** recorded the following in his narrative: *"On the day I came to the final realisation that it [referring to Grace's alcohol and Khat use] was over, Grace collapsed in her aunt's kitchen leading to a cracked skull and vertebrae. For the weeks in hospital I dutifully visited but knowing there was no going back. When it came time for discharge the decision was made by myself and Grace's dad for her to go into long term rehab at Healing Wings. This was a tricky nine months for me emotionally. I was able to speak to Grace for 10 minutes every Thursday evening. For the first while these generally did not go well,*

but as time went on I started to hear a change in Grace. Her old self was struggling its way to the surface”.

Anne, in her narrative, gave a detailed account of how Dicky’s hospitalisation triggered the decision to go for treatment: *“...I said to him that his addiction is totally out of control and he must please leave the house.... My friend arrived and took me and the kids to their house. I phoned Dicky’s mother and I asked her to please come to Centurion as Dicky has lost his mind. She did arrive at 02:30 the morning and informed me that Dicky attempted to commit suicide by drinking sleeping tablets. We took him to the hospital. Standing next to his hospital bed in the emergency room, I knew the Doctor is going to ask questions. And I decided to answer them truthfully, as this is the opportunity God gave me to turn this whole situation around... I said to her that he’s been in denial for a very long time and that she must run any possible tox screen [screening test to determine if legal or illegal substances are present in the blood or urine]. The results came back positive. I asked my mother-in-law to be present when she discussed the results with us in order for her to hear that Dick has a problem and that I indeed did not have an affair. I anticipated this day for so long that I already had all my plans in place. I had to make a lot of decisions, but one I made is that 13 January 2010 [fictitious date to preserve anonymity] will be the turning point in our house. There will be no rock bottom or relapse again. I will ensure that this experience is the worst experience of his life and he will never think of using again. I requested that Dicky be transferred to Steve Biko Hospital. He did not know where he was when he woke up and I only visited him Sunday 14:30 for the first time. He was very emotional. We spoke for 3 hours, cried a lot and at last he submitted to go to rehab... The moment he submitted to go rehab I went to the social worker at Steve Biko and obtained a list of all rehabs in South Africa...”*

3.3.5.2 Subtheme 5.2: Husband’s affair coming into the open triggered his decision to go for treatment

This subtheme emerged from **Elsa’s description** on how after William’s affair with another woman came into the open, which could be regarded as an external source

of motivation, he decided to enter treatment: "... the bottom of my world dropped out [when she learned about the affair]. I was on my way to hospital for surgery on my wrist...on our way to the hospital the security guard [at the gate of the complex where they stayed] phoned William's phone and said there was somebody there. William informed him that we had already left. They then phoned on my phone saying there is somebody who wants to see me. He told me who he was and asked me if I knew that William has been having an affair with his wife...he shouted and screamed and went on without stopping. I looked at William who was driving and asked him if this [referring to the affair] was serious. I told this person that I was on my way to hospital and will phone him back". After Elsa's operation she met the man and they went and talked in the coffee shop: "He asked a lot of questions that I could not answer. I asked William to go outside and smoke so that I can determine from this guy what is going on... I requested him some time to process all of this. He then walked out, and William returned. I told him that we had to discuss this situation. The guy returned and said he wanted us to go to a place less public. I warned William to be careful and that this guy may kill us... We followed him to the highway when I phoned him that she (the man's wife) should also be involved. So, we went to her home. With all of us there he wanted to know everything in the finest detail. I did not want to know this. When he got the answers he wanted... William took me home. A few days later he phoned and spoke a long time. My trust in William was totally broken; they had different versions of what happened, and I needed to deal with it in my own way. Three days later we got a lawyer's letter suing William for adultery and loss of income". Elsa concluded: "...the only reason William came for help is because the affair came out. And that is why we are here...otherwise I would have been on my own for ever and a day, being none the wiser". (In this situation, the trigger for William to go for treatment remains an external motivator)

3.3.5.3 Subtheme 5.3: A participant's decision to leave her husband and obtaining a protection order served as external source of motivation for the partner to enter into treatment

By deciding to leave Mike due to his abuse resulting from his addiction, was also noted as one of **Cindy's** coping strategies (see Subtheme 3.1), this decision informed his going for treatment. Cindy explained: *"...I just could not take one more beating and I could not care whether we are not together anymore...I lost all sense of care, even for myself...I called his mother and told her that I am going to move out. Please come home with me and get my clothes and my car. So his mother helped me" ... I remember that morning when I decided to do this, I approached a colleague who helps people with protection orders ...he went with me to court to get a protection order. One day he came to my work and I was not there and became insulting and swearing, almost as if he was psychotic ...he was making a big scene...that is what triggered me to get [implement] the protection order... For me this was the only way out. I had to protect myself ...I also was very scared ... what helped me is that I knew one of the facilitators [volunteer working at MWLC]. So, I could ask her a lot of questions and she guided me a lot ...the programme involved my husband as recovering addict".* Cindy's decision to stand up (indicated as coping strategy by McCann et al., 2017:2) and by leaving him and by involving the judicial system and getting a protection order became the external motivation force motivating Mike's entry into treatment.

3.3.5.4 Subtheme 5.4: Filing for a divorce as external motivator for partner to go for treatment

Louna got to the stage when she filed for divorce and this made Stefan go for treatment: *"A divorce was the only outcome I saw, and I told him that. The only answer I got was you're crazy! I went to see a lawyer. The day the court order was delivered at his work, it was war!! He went into another series of quarrels before he realised I'm serious. He then agreed to go for help. I cancelled the divorce".*

3.3.5.5 Subtheme 5.5: Gave the partner an ultimatum (external motivator) to go for treatment or the relationship will end

Through this measure Andries and Jane forced their partners to go for treatment. **Andries** explained: *"She did not confess [referring to Ida]. When I confronted her, she said that there was more than one occasion that she did want to confess it. She wanted help...she knew that she needed my help, but she was too afraid to acknowledge that to me as she thought that I would just leave her. Instead she made it worse by continuously hiding [referring to her addiction] ... that is what made it worse".* Continuing, Andries revealed: *"...and then there was this incident ...where she just wanted to get out of the house...at night...and she gave the wrong excuse [stating that she had to go and meet her aunt about a matter regarding their child] ... I phoned her aunt, actually to say that she just told me that she is meeting you for this reason and I feel that it is not the case and she said but she is not meeting with me...The lies made me suspicious. I spoke to her aunt who one day called me and said she was concerned and was having nightmares...and about drug abuse. I said it is interesting that you phoned as I saw this message on the cell phone, you know...so we put all the information together and she [referring to the aunt] said we must find evidence and I looked in her cupboard and found little black bags, not many of them. I tested them...I took some of the powder that remained behind and took a urine tester and tested that and I could see that this was drugs. On the Friday I asked someone to come with me as I did not want to confront her on my own, so someone can see I am not unreasonable, or whatever, so that is how it came to light...The day that I confronted her I gave her a choice. I said you need to get help or I am going to end the relationship and I will look after our child".*

Jane also reached the point where was so enraged with Honey that she wanted to physically assault her. However, she constrained herself, and gave Honey an ultimatum that made her decide to go for treatment. *"...at one stage I grabbed her in front of the chest and was about to hit her with my fist, but I realised that this is not who I am before I hit. That was how angry I was, but then this is not who I am. Instead I told her to pack her bags and go. But then I realised that I promised before*

God I will not forsake her...that is why I made the ultimatum, she had to choose between coming here for treatment, or go. The fact that she decided to come here, gave me a little bit of hope”.

3.3.5.6 Subtheme 5.6: Obtaining a court order, an external source, to force partners to enter treatment

Going to the extreme of obtaining a court order was for Olga and Queen the only way out to get their partner to go for treatment.

Olga explained: *“It was one of those weekends again [referring to Danny abusing alcohol with his friends]. He and I had an arrangement. He signed an agreement that he is not going to drink and not bring alcohol into my house. Then the Friday I got home...a bit later than he does, and he was drunk as a lord. So obviously when I saw this it was nails out and I lost it. He fled... he went to his mom’s place. The Saturday morning, I had training at work got a call from my mother that he is at home with a bunch of guys and he wants to take the children out. So, I lose it. When it comes to my children I lose it. I immediately went to my trainer and requested to leave. I had enough. I just had enough. I had a protection order against him to not come to my house, drink and make problems. He may live there but not make problems. So I called the police and enforced it. So my mother... said he assaulted her. I doubt it, as she exaggerates, but she made a case against him... But that Monday he did not come back. On Tuesday she got a message to me that he is in prison. On Thursday he went to court. My mom and I discussed it and she admitted that she exaggerated so we went and withdrew the case. But the prosecutor was not available, so only the following Monday we went to see him [the prosecutor] and he said that he could see what was going on and not withdraw the case but rather seek a solution to the problem. He then enforced a court order [forcing him to go for treatment]. ...I was actually very happy about it. I firmly believe prison is not a solution...you come out ten times worse. I was very happy with that decision...”*

It was **Queen**'s parents-in-law who arranged a court order for Tom to go for treatment, as she explained: *"I left Tom for a week and stayed with my mother... My parents-in-law booked him in [at a treatment centre] so that I can go back home... they may not have necessarily dealt with it in the right way, [implying that her parents-in-law may have gone about getting Tom into treatment in a different way] but at that point they did put court orders in place for example, they emphasised me leaving him and such things, but not how we will correct the problems [indicating they tried different ways to force him to stop using drugs]... It was very difficult..."*

Obtaining a court order resonates with McCann et al.'s (2017:2) coping strategy of "standing up" by challenging the partner with the SUD's behaviour and by soliciting the assistance from law enforcement and judicial agencies, CSOs motivate the partners with SUDs to go for treatment.

3.3.5.7 Subtheme 5.7: Partners decided on their own to go for treatment after being motivated by their CSOs

Kate and Felicity mentioned this as a route for their partners to begin treatment. **Kate** recalled: *"After having spoken to him on a number of occasions to get help, he agreed to get help at that point. Slowly but surely, I managed to motivate him and eventually convinced him to go. It felt awkward...I constantly worried that the same things [referring to his recurring use of Khat] will start happening again. I actually was not too sure how to handle the situation. I had to adapt all over again. Gradually I realised that I could start talking to him again. But it does take time. I still feel unsure most of the time... I told him to come [to Mighty Wings]...Because he is not yet recovered...he is not himself yet...He did improve but is still not fine..."* Later Kate added: *"Let me tell you... I just patiently spoke over and over in an understanding way until he went to the rehab".*

Felicity shared the following in substantiation of this subtheme: *"From the beginning of last year all this crazy stuff started...the one day I told somebody at work what was going on and that I have no idea what this is all about. The colleague hinted that*

maybe he is using drugs... So I contacted the marriage counsellor and asked him if he thought my husband was using drugs responded the only way to know is to ask him yourself...so I asked him the evening if he was using drugs. He said no. Later that night he said he had something to confess... he had been using Khat, but only on some occasions. I asked why he used it as he knew I was against drugs. He said he only used it a few times, but it made him feel sick... After a few weeks his behaviour changed again, and he pushed me so hard that I wanted to beat the crap out of him...I started to speak to one of our friends, but they agreed with him that I was the mad one. He would again confess that he has used. We end up in a fight and he would say he is sorry. We spoke to a friend of ours who worked at a rehab (ARK). One night I got home and there were a lot of cars and he called me to the room and admitted that he had been using drugs for two years and booked himself into the rehab the next day..." However, Felicity added that she had threatened to divorce Zane: "I said to him that I no longer am prepared to do this, and I am filing for a divorce. And I said to him that if you are doing drugs, you will never see your kids as I am the only stable person. That was all I could threaten him with ... I was using the kids by saying I am filing for a divorce and you will never see your kids".

In reflecting on this theme, specifically the measures employed by the participants to convince their partners to go for treatment by standing up threatening to leave, filing for divorce, giving ultimatums (as external sources motivating to partner to go for treatment) signifies the strength and resiliency displayed by the participants.

3.3.6 THEME SIX: CSOs' VIEWS ON THE FUTURE PROSPECTS OF THEIR RELATIONSHIP WITH THE PARTNER WITH A SUD

As indicated by Denning (2010:165), the CSOs often find themselves in conflict when remaining loyal to their partner with a SUD or closing their relationship. As is the case with contemplating seeking help, the CSOs' decision about the future depends on a number of factors. These include the emotional attachment to the partner, having children, support from family or friends, and believe in self and consideration of their circumstances (O'Doherty et al., 2016:226). The decision to

remain in this relationship or leave it is closely related to the repertoire of coping strategies and a partner's willingness to go for treatment and commit to sobriety.

The participants in their accounts provided a forecast of their future relationship prospects with their partners with the SUD. Their responses were grouped around the subthemes (depicted in Table 3.8 below) to be presented afterwards.

Table 3.8: Overview of the subthemes related to the CSOs' views on the future relationship prospects with the partner with a SUD

THEME SIX	SUBTHEMES
CSOs' views on the future relationship prospects with the partner with a SUD	<p>6.1 Participants undertook to remain committed to their relationships with their partners and will not give up on them</p> <p>6.2 Participants' future relationship forecast with their partner conditional – if they relapse, they leave</p> <p>6.3 Participants' prospects for their future relationships with their partners with the SUDs, uncertain and no guarantees</p>

3.3.6.1 Subtheme 6.1: Participants undertook to remain committed to their relationships with their partners and will not give up on them

Kate and Linda's accounts gave rise to this subtheme, but I also had to include Louna's testimony speaking of the life with her partner in sobriety.

Kate described how she will not leave her partner with a SUD: *"Well then one starts all over again [referring to the possibility of Barry relapsing] ...you pick up the pieces...even if it is for somebody else...you carry on until you eventually get there...you cannot just leave it... He may perhaps require other assistance... go to a rehab again...you have to get him back...you have to get the other person back. You cannot just leave him...because then what? He may end up in an accident, commit suicide, get worse or whatever... at least if you try and help him and address the situation differently or whatever, you will eventually get there..."*

Linda was adamant about not giving up: *I don't want to surrender...I would rather fight to get things to be in order. Fight may not be the right word, but I don't want to sit back, and things get out of hand. To accept my situation is like giving up. It is not even about accepting, more a matter of complacency... We are together for 28 years and I have not given up...It is by far the biggest issue in my life. If I think back on everything that has happened in our lives, and the role alcohol played in this...if there was no drinking everything would have been much better. But then I am not one for giving up... I think before I give up I will rather divorce him. But I don't want to as he actually is a good man...He will destroy himself...I am his brakes...I prevent him drinking himself to death. Even if he may lose his work or become ill, I refuse to give up".*

Felicity wrote to her husband (as part of her narrative) stating she will try to support him but it depends on him: *"You can take this letter any way you wanted but if you care about this family you better get yourself rite and it would take time to win our trust and faith in you back. This is make or break of this family depends on you now to prove that you a man and not a wimp. You have disappointed our families and our friends. Words at this point cannot express how I feel the anger, hurt, disappointment and trust all gone. The fact that we almost lost something that was so good because of your stupid mistake makes me so agree that our kids would have grown up in a broken home. I really hope that this time you will pull yourself together and be an example to your kids and not a disappointment. As for me I will get over it I love you dearly and I'm very proud of you for taking the step to become a better husband and most importantly the father your kids deserve. I will support you and will take total control of everything. All I'm asking is for you to be honest with yourself and your family. I love and looking forward to a drug free live together. Your friends and family are all willing to support you as long as you honest to us".*

Olga's reflection also disclosed something about her commitment and support when she wrote: *"The one thing I ask myself, is why did I not let go at some point, and the answer is I don't know, maybe it is the hope that he can leave demon that turns him inside out, because he is actually a good guy if alcohol is removed. At this point I am*

in a total roller coaster, it's as if I am also leaving the substance all the habits everything is out of the, this is the only life I have known, and now he and I have to break down all the old and learn all over again. I have made my fair share of mistakes as well. But I am prepared to fix that".

Louna admitted that to trust her husband again took time, but after accepting his effort to remain sober the prospects for their relationship was looking bright: *"...for a long time I could not trust him at all, always being suspicious of when he finally stopped drinking it took a very long time before I could trust him. It was very long before I could unconditionally accept that he is remaining sober. And once this happened, everything changed for good; going to the theatre, having friends over, visiting others, no more excuses were required, no longer being ashamed for others".*

3.3.6.2 Subtheme 6.2: Participants' future relationship forecast with their partner conditional – if they relapse, they leave

Cindy, Anne, Elsa and Jane were very clear that should their partners relapse in future they would leave them. This forecast is not far-fetched when literature pointed out that a partner's continued substance addiction will eventually result in divorce (Dethier et al., 2011:151; Schonbrun, Strong, Wetle & Stewart, 2011:400; Homish, Leonard & Cornelius, 2008:281).

Although **Cindy** stated the relationship was now better, she also stated that if her husband relapsed, she would leave him. *"...if he relapses I have to move on with my life...I really can't do it again. It will be hard. I think what helps me is to think about the month we were apart...it was the happiest time of my life; I can do things I like... it is my time...it may sound selfish, but it felt so good to do things for me. I felt so free and happy... I started to feel a whole person again".*

Anne openly stated that if Dicky would relapse: *"I will divorce him. My stepsister's husband relapsed on eight occasions... she was with me at the hospital with Dicky*

and said to me, *'If he relapses once after this, leave him. He will relapse again and again'*."

Elsa reflected: *"I believe hasty decisions now will be regrets later. I will try and support William regarding his drinking. But he has to prove himself regarding his drinking. I won't stay if he drinks again"*.

Jane stated the following if her partner relapses: *"I am giving her a second chance ... I will first hear her out, like if she comes and tells me first admitting to what she had done, but if she did not and was dishonest about it, I will go"*.

3.3.6.3 Subtheme 6.3: Participants' prospects for their future relationships with their partners with the SUDs, uncertain and no guarantees

This uncertainty is fuelled by the distrust caused as result of the partners' substance addiction and the resultant behaviour and the fact that there are no guarantees that they will return to their old ways.

Andries wrote about how there is still a certain amount of distrust, even if Ida is sober: *"One more challenge for me to accept is that there is no instant solution to the problem. The effects of distrust for instance will live on forever (it feels), e.g. when something is missing in the house, the first thought which comes to mind is that it was pawned or sold for drug money. The programme has not necessarily improved the communication between me and my partner either and she is still making decisions on her own without knowing me in them. I feel that after all I have sacrificed and my willingness to support her I deserve some respect"*.

Olga also spoke of the difficulty of trusting: *"For me it is actually too good to be true. He is almost too positive, and I don't trust it...I am waiting for it to fail. I don't know if it just me or whether I am meant to think this way, but I am waiting for the bomb to go off, I am waiting for the bang"*. She added that she did not see herself separating completely from Danny: *"I don't think we can completely separate. Although it may*

be like a prison sentence, until my children have grown up and become independent things will not disappear”.

Queen stated that there are no guarantees: “...and also scared for what lies ahead as there are no guarantees how things will turn out...”

Cindy admitted the possibility of Mike relapsing cast their future relationship in uncertainty: “[Relapsing] is in the back of my mind the whole time. And I think part of why this week has been a difficult one way I started to feels because I saw signs of where he was edgy ... he was talking to an old friend who also used. So, he relapsing remains in the back of my mind”.

Paul explained how life has changed but also indicated that there are basically no guarantees. “Well, as is taught here, and I agree with it 100%, Grace will always be a recovering addict. I don’t think it is ever going to be over...I mean our life has changed so considerably from this ...our social life is dwarfed tremendously...we never have alcohol in the house, I only drink when I go out ...I never drink at home...our whole relationship with alcohol has changed...considering I was quite a heavy social drinker...and that just doesn’t happen anymore...so we are actually actively keeping the addiction at bay...we are smarter in our choices on a day to day level...so I don’t see at as she is cured from addiction, that this addiction is finished, it is not. We are actively keeping at bay...it required a mind shift and I think that mind has shifted. It does get frustrating to me now and then.

Concluding this theme, it becomes evident three participants (Kate, Linda and Louna) will stay with their partners with a SUD, irrespective of whether they use substances again or not, three CSOs (Cindy, Anne and Elsa) will leave them if they start using again and five (Andries, Felicity, Queen, Paul and Olga) were not clear what they would do, while Jane’s decision will depend on her partner’s handling of the problem.

3.4 CHAPTER SUMMARY

In this chapter, the reader had been exposed to the biographical information of 12 CSOs of partners with a SUD as well as a discussion of the findings of six themes and their subthemes obtained during data collection.

In Table 3.1 a summary was provided of the participant profile; they were mostly female and white and between the ages of 23 and 61 years. Except for one participant they were all at least matriculated and employed and had been in a relationship with their current partner between three and 35 years. Nine of the participants had children. Of the 12 partners with a SUD, one was still using and two relapsed at the time of the research while the others were sober for a period of between two and 36 months. Three participants had themselves used substances earlier on but had stopped. Five participants had tried to get help once and twice prior to the research.

In Figure 3.1 an overview was given of the six themes after which each theme was discussed individually and casted against existing literature.

The first theme provided a reflection of the experiences of CSOs while living with a partner with a SUD. Six subthemes emerged namely: CSOs living with a partner with a SUD experience their relationship as stressful; they experience their partner as distrustful; their partners' substance abuse turned them into unfamiliar persons by taking on different personalities; they experience emotional enmeshment and feelings of ambivalence; they experience isolation and feel being trapped; and a participant's initial, but short-lived relief experienced when coming to know the reason for his partner's erratic behaviour.

The second theme conveyed to the reader the CSOs' feelings and emotional reactions to their partners' SUD. These included seven subthemes: feelings of anger and frustration experienced in relation to partner's SUD; feeling trapped and lonely as result of their partners' SUD; feelings of sadness; embarrassment; shame,

humiliation; despair, and hopelessness experienced as result of partners' SUD; feelings of fear experienced in relation to partner's SUD; feeling inferior and blaming themselves for the partner's SUD; feelings of hurt and shame experienced as result of the partner's SUD; and the CSOs' experienced emotional detachment from their substance dependant partners.

In theme three, I discussed the challenges experienced regarding partners' SUD related behaviours. The subthemes included: CSOs cited poor communication; arguments and accusations; even intimate partner violence as challenges experienced; that the partner with a SUD did not take responsibility; their erratic and reckless behaviour was a challenge experienced by the CSO-participants; manipulation of the CSOs by the partner with the SUD; the effect of the partner's SUD on the children; and the partner's possible relapse was a challenge experienced by the CSOs.

In the fourth theme the reader was informed of the coping strategies employed to mitigate and manage the experience and related challenges of living with a partner with a SUD. Eight subthemes were identified, namely, covering up the partner's SUD; adopting the philosophy of "if you can't beat them, join them"; blocking out thoughts and feelings; focusing on work and keeping busy; threatening to leave or divorce; or requesting the partner to leave; obtaining a protection order and enlisting the help of the police; avoiding or withdrawal from the partner and from social life and friends and family, to spare embarrassment; taking control; managing home-life in an attempt to keep the family together; and reaching out for help to manage and cope with the partner's SUD.

Theme five gave a reflection of CSOs' accounts of what motivated their partners to enter treatment, together with seven subthemes, namely, that their partner's entered treatment following being hospitalised for SUD-related incidences; a husband's affair coming into the open triggered his decision to go for treatment; a participant's decision to leave her husband and obtaining a protection order served as external source of motivation for the partner to enter into treatment; filing for a divorce as an

external motivator for a partner to go for treatment; giving the partner an ultimatum as an external motivator, to go for treatment or the relationship would end; obtaining a court order as an external source, to force partners to enter treatment; and that some partners decided on their own to go for treatment after being motivated by their CSOs.

In the sixth theme a reflection was made on CSOs' views on the future prospects of their relationship with the partner with a SUD. Three subthemes were identified: that three participants undertook to remain committed to their relationships with their partners, and would not give up on them, five participants' future relationship forecasted that their partnership would be conditional – if they relapsed, they would leave, and some participants' prospects for their future relationships with their partners with the SUDs, would be uncertain and no guarantees.

In the following chapter the second part of the research findings will be presented. Specific attention will be given to the suggestions for social work support to CSOs living with a partner with a SUD as put forward by both the CSOs and the partners with the SUD.

CHAPTER FOUR

RESEARCH FINDINGS (PART TWO): SUGGESTIONS FOR SOCIAL WORKERS SUPPORT TO CSOs OF A PARTNER WITH SUD - CSOs AND THEIR PARTNER WITH THE SUDS' SUGGESTIONS

4.1 INTRODUCTION

In the previous chapter of this thesis the research finding portraying the experiences, challenges and coping strategies of CSOs in relation to living with a partner with a SUD were reported. These mentioned aspects were presented after the biographical information on the participants was given as backdrop to, and context for the thematically presented findings. The main themes were presented under various subthemes, supported by data from the narratives and the interviews conducted with the participant sample groups and subjected to a literature control.

In this chapter the focus will be on presenting suggestions on how social workers can support CSOs with the experience and challenges in their relationship with a person with a SUD, from the perspectives of both the CSOs as well as their partners with the SUD. These suggestions will become the foundation and inform the guidelines for social work intervention to support CSOs that I will proffer as recommendations in the next chapter of the thesis.

This topic of how CSOs would like to be supported by social workers in respect of their experiences and related challenges in living with partner with SUD, were as stated in Chapter Two (see sub-section 2.6.3), the focus of the second follow-up in-depth interview I conducted with the respective CSOs sampled. As far as the partners with the SUD were concerned, I engaged in an in-depth interview with them to glean their perspectives on how, and with what social workers could support their partners living with them in this quagmire of their SUD. The data obtained from these interviews were, as was the case with all the other data collected, thematically analysed, by an independent coder and myself. The themes that resulted were

presented as subthemes and, in some instances as categories and then consolidated during a consensus discussion facilitated by the study's supervisor.

This chapter continues to give the biographical information about the partners with the SUD and will start by providing the pseudonyms for each of the participating CSOs and the person to whom they are related. The discussion will then proceed by describing the themes that are dealt with as subthemes that relate to each theme or, where necessary, as categories. These pertain to the suggestions for social work support as gathered from the perspectives from the two sample groups.

4.2 BIOGRAPHICAL INFORMATION

The biographical information on the CSO-sample group living with a partner with a SUD was introduced in the previous chapter with reference to their age, gender, race, qualifications, employment; the length of their relationship with the partner with a SUD; the number of children in the relationship they were taking care of and how long the partner had been sober at the time of the research. Responses to whether they as CSOs had used substances themselves and had gone for professional help to deal with the circumstances caused by the SUDs were also given. The content in Table 4.1 on the following page, concerns the biographical information about the partners of the SUDs with reference to the aspects of age, gender, race, qualification and their field of employment. For the purpose clarity and continuation, in the first table of the column the CSOs' pseudonyms are presented after which the pseudonyms of their partners with SUD were recorded, together with biographical aspects related to this sample group.

Table 4.1: Biographical information on the sample of partners with a SUD

	Partner with a SUD					
CSO (pseudonym)	(Pseudonym)	Age	Gender	Race	Qualification	Employment
Andries	Ida	32	Female	W	Grade 12	Receptionist
Linda	Conrad	48	Male	W	Grade 12	Auto technician for car dealer
Cindy	Mike	36	Male	C	Grade 12	Assistant to Mechanical Engineer
Louna	Stefan	64	Male	W	Grade 12	Pension – previously bookkeeper
Felicity	Zane	42	Male	W	Grade 12	Electronic equipment installer
Paul	Grace	42	Female	W	Grade 12	Administrative clerk at NGO
Queen	Tom	33	Male	W	Grade 12	Light fitting installer
Olga	Danny	32	Male	C	Grade 10	Marketer
Elsa	William	60	Male	W	Grade 12	Clerical, HR
Kate	Barry	22	Male	C	Grade 10	Air-conditioner installer
Jane	Honey	23	Female	W	Grade 12	Administrative clerk at security firm
Anne	Dicky	39	Male	W	B. Econ.	Auditor in the construction sector

4.2.1 The age distribution of the partners with a SUD

Gathering from the ages of the partners with the SUD, seven fit into Stage 6 titled Intimacy versus Isolation or young adulthood taken from Erikson's psychosocial developmental stage life-cycle (Linerós & Fincher, 2014:41), as introduced in Chapter Three. Five of the partners with the SUD were in Stage 7, Generativity versus Stagnation, or middle adulthood. Eleven of the couples were in the same stages of their lifecycle, with one couple, Elsa in the young adulthood and William in the middle adulthood stages of the developmental life-cycle respectively.

4.2.2 The race distribution of the CSO and their partners with a SUD

As listed in Table 4.1, nine of the partners with a SUD were from the White racial group and three from the Coloured racial grouping. When comparing the partners with the SUDs with the racial classification of their respective partners, none of the couples were in mixed-raced partnerships. One couple, Jane and Honey was at the time of the fieldwork in a same-sex marriage, known as a civil union.

4.2.3 The educational level (highest qualification) and current employ of the partners with a SUD

One of the partners with a SUD has a tertiary qualification having completed a degree in Economics. Nine of the partners with a SUD had completed Grade 12 with two of the partners with a SUD with Grade 10 as their highest qualification. As was the case with the CSOs, all of their partners with a SUD were gainfully *employed* at the time of the fieldwork.

The *qualifications* of the CSOs and that of their partners with a SUD were generally similar. One couple, Anne and Dicky were both graduates. Seven couples, namely: Linda and Conrad, Louna and Stefan, Felicity and Zane, Pauls and Grace, Queen and Tom, Elsa and William, as well as Jane and Honey have all completed Grade 12

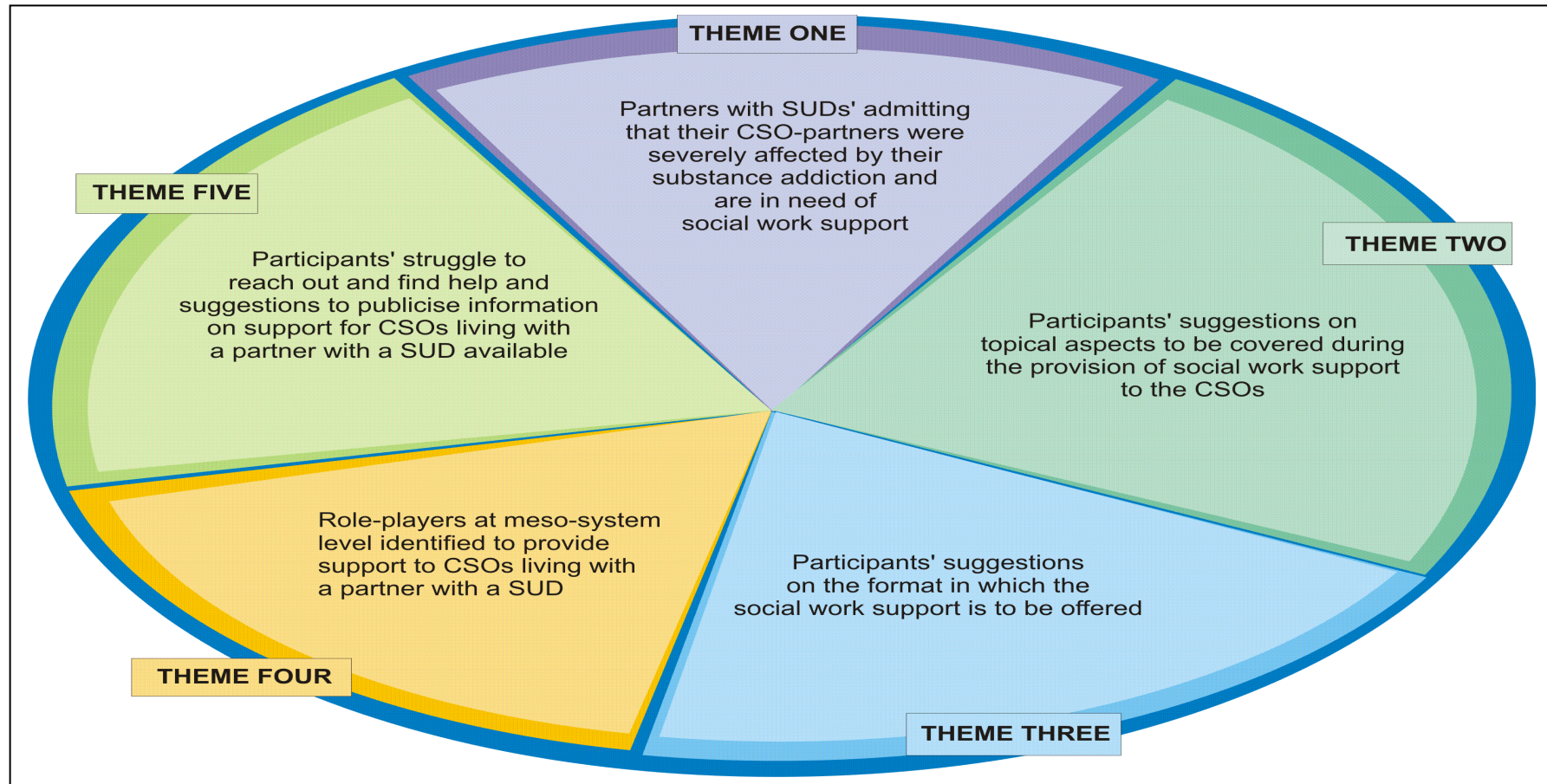
as their highest qualification. One couple, namely Kate and Barry have both completed Grade 10 as their highest qualification.

With three of the couples, the CSOs were qualified higher than their partners with a SUD. With two couples the CSOs had degrees (Andries – B. Comm. and Cindy – M.A. Social Work) while their partners with a SUD, Ida and Mike respectively had Grade 12 as highest qualification. Olga completed Grade 12 while her fiancé Danny's highest qualification was Grade 10.

4.3 PRESENTATION OF THEMES AND SUBTHEMES: PARTICIPANTS' SUGGESTIONS FOR SOCIAL WORKERS SUPPORT TO CSOs LIVING WITH A PARTNER WITH A SUD

In Figure 4.1 (see next page) an overview is given of the five themes and their related subthemes as relevant. The graphic was created using the information gathered from the interviews with the participants in the specified respective sampled groups. When I met with them during the individual in-depth interviews I conducted with them, they were requested to forward suggestions on the topic of how social workers could support CSOs living with a partner with a SUD. This information was thematically analysed. Direct quotations from the participants' transcribed interviews will be provided to underscore and substantiate the identified themes and the related subthemes. Literature extracts and related ideas were added to either/or confirm, contrast and elaborate on the participants accounts and/or comment on a theme or subtheme.

Figure 4.1 Themes suggested for social work assistance of the CSO of a partner with a SUD¹⁵



¹⁵ The Subthemes and categories (where applicable) related to each of the themes will be presented in table form and deliberated in detail with the discussion of each theme

4.3.1 THEME ONE: PARTNERS WITH SUDs' ADMITTING THAT THEIR CSO-PARTNERS WERE SEVERELY AFFECTED BY THEIR SUBSTANCE ADDICTION AND ARE IN NEED OF SOCIAL WORK SUPPORT

This theme emerged from the following question put to partners of the CSOs: How would you describe the effect that living with a person with a SUD has on a partner?

All participants, some more reluctantly than others, admitted that their respective substance addictions had affected the partners and their relationships negatively.

When framing the aspect of CSOs being severely affected by their partners' substance addiction against the backdrop of the ecological systems theory adopted as one of the theoretical perspectives, the following notion rings true. Systemically speaking, an individual person operates as a complex biological, spiritual and psychological system and interrelates and connects directly with at least, all the other functioning micro- and meso-level system components. In this dynamic exchange the individual's behaviour and actions exert an influence on the mentioned systems and their dynamics in turn has an influence on the individual. (Sherwood, 2009:335). When making this applicable to the couple-system, one can postulate that one partner's or sub-system's SUD, or addicted behaviour, will affect the other part of the sub-system and the couple-system as a whole (Weiss, Coll, Mayeda, Mascarenas, Lawlor & Debraber, 2012:148).

Various scholars maintain that being in an intimate partner-relationship with a person with a SUD exerts stress and tension in the relationship, which results in negative relationship experiences with SUDs being regarded as a third reason with incompatibility and fidelity too being reasons for divorce (Cox et al., 2013:161-162; Amato & Previti, 2013:161; O'Farrell & Clements, 2012:123). A spouse's substance addiction has a deleterious effect on marriage with both the abusing and the non-abusing spouses facing physical, emotional, social and economic difficulties that also impact negatively on marital satisfaction (Nooripour, Bass & Apsche, 2013:26; Cranford et al., 2011:211). Lea, one of the participants in Peled and Sack's (2008:395) study with 10 Jewish Israeli women, aiming to explore more about the

self-perception of women who live with alcohol addicted partners, admitted that “living with an alcohol addicted husband or family members is extremely difficult”.

Against these introductory remarks and in substantiating this theme all the participating partners with a SUD admitted, as shared from their accounts, that their CSO-partners had been adversely affected by their substance abuse and addiction. They even stated that their partners do need and could benefit from social work support. This theme ties in with the view of Fals-Stewart et al. (2009:118) as well as Arkin et al. (1990:125-126) maintaining that as the spousal sub-system, in the context of the troubled alcoholic family, plays a major role in the development and continuation of the alcohol problems, they must also play an equal role towards its resolution. Further on, and in pointing to the need for professional support, or in this case the suggestions for social work support to the CSOs of a partners with a SUDs, Peled and Sacks (2008:390) state: “Life with an addicted partner is demanding and difficult and often requires professional support”.

Ida explained how her drug abuse affected her fiancée, Andries and especially how it had eroded their former trust that had been part of their relationship. Andries also mentioned this aspect of trust in Subtheme 1.2 “CSOs living with a partner with a SUD experience their partner as distrustful (see sub-section 3.3.1.2 in Chapter Three. She shared in this way: *“First of all looking at the [drug] addiction side, it affected him very badly... and also our relationship... There was no trust after he found out about my addiction... he was very disappointed, not just in me, but also the situation... I didn’t turn to him for help... or discussed my problem with him. It also affected our household because of the decisions he had to make after he found out about the addiction; first of all he did not trust me after everything I had done. I have stolen from him, I lied to him. Most of the time he had to hide everything away or lock everything up... I was very ashamed when he found out. About everything. I am his partner and I think it must be heart-breaking for him ...”*

Danny summarised how his drug abuse affected Olga: *“I was never home... we had regular arguments... I have given her a lot of drama... I have really given her much drama ...”* Olga also mentioned the aspect of arguments under the Subtheme 1.1

“CSOs living with a partner with a SUD experience their relationship as stressful” (sub-section 3.3.1.1 in Chapter Three) focusing on the fact that living with a partner with a SUD is stressful.

Zane articulated how his partner, Felicity, who admitted that she became like a detective (see Subtheme 1.2, sub-section 3.3.1.2: Chapter Three) due to his substance addiction had been affected negatively by his drug use: *“I would say very negatively... her trust in me is gone... emotionally she shuts off now [indicating the current state of their relationship]... when she is feeling sad, she tries to block it... always portrays strong and hard...”*

William admitted: *“[because of my drinking] ...there is a lot of pain, heart sore and heartbreak and I understand there is a lot they have gone through...”* When asked whether Elsa, his partner needed support, William replied: *“As much as the addict needs help...”* He continued: *“I suppose she no longer is the person she would want to be [implying his drinking has changed her to become somebody she cannot be happy with]... leading an almost false type of life... like to portray positive...”* In her account under, Subtheme 1.5 (see sub-section 3.3.1.5 in Chapter Three) Elsa has confirmed William’s account where she stated that his addictive behaviour caused her to isolate herself and withdraw from company.

Tom described what his partner Queen went through: *“Because it [referring to his addiction] is taking her to hell and back... with our [referring to everyone with a SUD including himself] addiction... and it is that they [CSOs] who have to accommodate us with the state we have been in, with the issues we have been up to [referring in general to those with a SUD]... it is not easy I suppose... but I cannot answer really because of my addiction [acknowledging that he does not fully comprehend how his own behaviour affected Queen, rationalising about it and at times minimising its severity], but what I have done to my wife, she also needs a break... she needs a bit of recovery as well... to understand us better and clear their frame of mind... This is the longest I have been clean in my life. She must have thought ‘what type of a relationship is this?’ [Referring to him taking drugs as essential to his usual behaviour]... it must have been tough... I have been arrogant I suppose, and I was*

selfish... self-centred... it has affected her... I have not been there for her... we were like showboats in the sea passing each other... we have constantly been negative towards each other... We are working on it [their relationship] but still it will take time”.

Stefan referred to the impact of his drinking on Louna’s self-image and their family life: *“I think it [his alcohol abuse and subsequent behaviour] must have had a tremendous impact on her self-image... she constantly tried to protect me against the outside world, having to come up with excuses and other rationalisations about my drinking. She would tell lies so that people don’t visit us, or we don’t have to go anywhere... I believe that the first thing affected was her self-image... we would not visit friends anymore as she was ashamed of me, for others to see me in that condition... I could not care less what happened [when he was intoxicated] and only afterwards [when he was sober] did I realise that I must have caused a lot of damage. But then I would just drink again to forget it... Clearly, she was not happy... She refused to talk one word to me, however much I tried. She went through deep waters... through dark times in her life because of my dependency... She can’t go through that dark time again...”* Stefan’s assertion confirmed that his alcohol addiction had a damaging effect on Louna’s self-image. Dethier et al. (2011:152) state that being in the position of an alcoholic’s wife, it can be expected that she would be prone to developing a sense of low self-esteem.

Stefan’s reference to the aspect of Louna’s shame experienced in relation to his alcohol addiction is confirmed by the, all female, participants in Peled and Sack’s (2008:395) study, who after comparing their relationships with their peers and the family of origin came to realise that their husbands’ addictions brought them to an anomalous situation in which they wanted to hide from everyone as they felt ashamed. Stefan, admitting to the effect of addiction on their marriage said: *“I made peace with the fact that I have messed up... I cannot change this... and I know that it damaged our marriage...”*

Grace described the effect of her addiction and behaviour on her husband Paul, in this way: *“I completely changed [referring to the consequences of her alcohol and*

drug abuse] *I became extremely abusive, verbally and mentally. I blamed everything on him, it was all his fault... also I would just leave [to go and drink and visit men afterwards] to only come back the next morning.*" Paul's accounts (see Subtheme 3.1 under sub-section 3.3.3.1, and Subtheme 3.4 under sub-section 3.3.3.4 in Chapter Three) confirm Grace's accounts that her addiction made her abusive, argumentative and manipulative.

Grace continued, detailing many recollections: *"I can believe that Paul, besides the hurt and pain I put him through... and the abuse I put him through because I attacked him in every possible way... and this also brought out a very ugly side of Paul as he retaliated... he became physical [hitting and shoving her]... I made him go straight against his moral beliefs... Paul chose to kick me out on three occasions [he demanded that she left as she was under the influence of alcohol and became unmanageable]. I was not allowed to see the children at one stage... I was horrible... I was not safe to be around, I could not be trusted... my behaviour was erratic [referring to the times of her intoxication] ... I think he must have felt complete and utter frustration... desperation and hurt... I can only look back now and THINK what I put him through. Because when I was in addiction, I did not give a shit... I didn't, rarely I didn't. It is only when one is clean for a certain amount of time that one can think bigger and not only about yourself... and I wanted him to feel the pain that I was [projecting her feelings of humiliation and anger at herself due to her loss of control over her drinking] so I made sure that I got him to feel something like that".* Grace's account resonates with Homish et al. (2008:281) citing Quigley and Leonard, who found that SUDs was related to a notable likelihood of aggression in marriage. Hussaarts et al. (2011:38) agree when they refer to the effect of the partner with a SUD's unpredictable and destructive behaviour contributing to the relationship breakdown.

Barry focused on how his partner, Kate's self-image had been harmed and the hurt he had caused: *"...most of the harm that we did [referring generally to the behaviour of persons with a SUD while using substances] was emotional... our words and that... also physical harm... that was done... we broke them [the CSO] down... said stuff that was hurtful... we made them feel inferior... everything was wrong... any*

excuse to cause a fight would do..." Barry's account is confirmed in the literature as Dethier, et al. (2011:152) state that CSOs who are frequently criticised and insulted by their partners with a SUD are exposed to verbal abuse and report developing a low self-esteem. This low self-esteem is described by Karamat and Ahmed (2015:70) as a negative self-perception, with the CSOs doubting their ability to make any positive contribution to the relationship.

Honey described her actions towards Jane as follows: *"It [referring to her use of Khat and cocaine] must have totally broken down her trust in me... I don't think it [restoring trust and the harm caused by her substance abuse] can happen overnight, but to help her deal with it... she must build the trust and not harp on the same negative things all the time..."*

Mike explained how his wife Cindy had been badly affected and needed support: *"...firstly it [his substance abuse and subsequent destructive behaviour] brought up lots of insecurities; how she sees herself as a wife, the fear of me being arrested as most of the times I went to the drug dealer, I took her with me. Also, the fear of getting a phone call informing her that I died in a car accident or something... She knows that I would go out and get high [on crystal meths and Khat as his drugs of choice] and then come home driving. There also was financial insecurity; I would use drugs before going to work, and again leave the office over lunch time and the do it again... she must have been afraid that I can be losing my job and then she will have had to carry us through on her salary... I don't think she had any joy... We just got married, and six months later I was in addiction. In a lady's mind they want to get married and will be thinking we want to put things together and we will build this and that... and that wasn't happening as I was using most of that time... that would become a big argument".* Mike's account reflects how his drugging behaviour impacted on their marriage and caused his wife Cindy to be stressed and disappointed. Homish et al. (2008:289) found that marital satisfaction was higher in the beginning of the marriage (note that Mike shared he started using drugs six months after they got married), compared to the satisfaction experienced later on in marriage. This is confirmed in Cindy's account (see Chapter Three: sub-section 3.3.1.5, Subtheme 1.5) where Cindy described her marriage further on as one in

which she felt entrapped and isolated negative towards her future, feeling ashamed and humiliated, blaming herself for what was happening (see Chapter Three: sub-section: 3.3.2.5, Subtheme 2.5).

Dicky (who during his interview showed much resistance towards currently being involved in treatment) abruptly referred to the damage he had done to his partner, Anne: *“There was damage done and I know it needs healing”*.

Conrad said: *“Yes... look I have often wondered how it [my drinking] can have affected her. The most I think she had been affected by my drinking is being ashamed [he is very tentative and minimising due to a probable lack of insight] ... not that I have abused her or anything... I would rather withdraw myself if I had been drinking as I don’t then want to share things or discuss matters with her... she expected more from me... she expected me to behave better than I actually did... she did not want others to think badly of me... And also, she can be associated with me and this makes her to feel ashamed”*.

Considering the accounts given above of how their substance addiction and resultant behaviours affected the CSOs, Ida, Mike and Conrad acknowledged that their partners needed to attend a support or treatment programme as reflected in the following accounts.

Ida explained: *“In the beginning he [referring to Andries] did not know anything about drugs... If I can refer to the programme of Mighty Wings, the supporter¹⁶ programme’s [referring to group sessions for family members (CSOs) of persons with a SUD] are very important where partners also come in for group sessions. In our situation it is a bit difficult with our two-year-old daughter... but if he could attend it would be good for him... Because I know how I feel attending a programme and what it did for me, especially sharing about your problem and get it into the open [sharing during group discussions] ... even if you do journaling or something [writing*

¹⁶ CSOs are generally referred to as “supporters” at many treatment facilities, faith-based and community-based organisations.

up about your feelings and behaviour] ... *I think for him to share in a programme where there are others sharing about the same problem would help him*".

Mike explained: *"Ja, the first time it hit me that she needed help was at the empowered seminar [information group for both significant others and the partners with a SUD] where you do the exercise about feelings... and I saw that she had almost the same feelings that I had. I could numb my feelings [by using drugs] but she not"*.

Conrad agreed that the CSOs need assistance, but qualified it in that the CSO must be motivated to attend the programme: *"She must be there [receiving assistance] because she wants to be there... she must not attend her programme to try and stop you [referring to the partner with the SUD's drinking]... or to try and change you or things like that... She must be there because she wants to be there..."*

Dicky, a partner with a SUD, spoke about how CSOs need support to understand the person with a SUD: *"... it is better for me that she [his spouse Anne] attends this programme [referring to assistance of CSOs]... It can help her to at least in part understand what happened to me. She usually does not understand... because of the fact that she can share what happened with others... We are both very private and do not talk... we bottle up everything... in her programme we will allow the opportunity for her to share with others in the same situation... because if me and her talk we always end up in a fight..."* He continued, indicating her need to learn how to cope: *"Look things were very difficult at home and... she began drinking a lot much more than usual. I am honest... I think she did not know how to deal with the situation... she had nobody that she could talk to... as private persons we do not talk easily. So this became her way of coping..."*

In confirming this need for social work support, literature appears to be increasing about the need for marital and family-type interventions to help couples and families deal with and how to treat a partner or family member's SUD (Saunders et al., 2016: 237-243; Kinney, 2012:301-339; Orford et al., 2009:379-408; Peled & Sacks, 2008:390; Freeman 2001:236-261; Arkin et al., 1990:125-126). The suggestion for

social work support to CSOs living with a partner with a SUD is implied in some of the participants' narratives presented in this first theme. They disclosed something of their belief in the CSO-partners' ability to bounce back from the adversity these partners experienced as result of their SUD. It also unveils the acknowledgment of and confidence in the implied obligation as partners with the SUDs to recover and develop the strength to do so. This accentuates one of the tenancies of the strength-based perspective which is outlined by Saleebey (2006:16-20) and summarised by Sherwood (2009:333) that within every client system there are strengths or internal and external capacities. These, in themselves, are internal and external resources, enabling them to grow in, and from painful experiences.

4.3.2 THEME TWO: PARTICIPANTS' SUGGESTIONS ON TOPICAL ASPECTS TO BE COVERED DURING THE PROVISION OF SOCIAL WORK SUPPORT TO THE CSOs

In the second follow-up interview held with the CSOs, against the backdrop of the information obtained in the first follow-up interview, the focus was to get suggestions on what topical aspects they thought should be covered in social work support focussed on their recovery and how such initiative should be packaged or presented format-wise. (This latter part will be presented as Theme Three under various subthemes.) After the interview with the CSOs, a one-on-one interview was held with the respective sampled partners with a SUD. They were prompted to suggest topical-aspects to be included in a social work intervention to support CSOs living with a partner with a SUD, as well as its format. I need to point out that the suggestions of both the CSOs and their partners with the SUD's suggestions were experience-based treatment programmes they had either already had or were currently attending during the time allocated for fieldwork. As some of the suggestions forwarded by respective sample groups pointed to the same topical aspects, others were only mentioned by either the CSOs or the partners with a SUD, I decided to divide data into three subthemes and categories (depicted in Table 4.2 on the following page).

Table 4.2: Overview of the theme and its related subthemes of participants' suggestions on topical aspects to be covered during the provision of social work support to the CSOs

THEME TWO: Participants' suggestions on topical aspects to be covered during the provision of social work support to the CSOs
SUBTHEME 2.1: Topical aspects suggested by both the CSOs and partners with a SUD
<p>SUBTHEME 2.1: CATEGORIES -</p> <ul style="list-style-type: none"> • Category 2.1.1: Information on the topic of drugs and its effects • Category 2.1.2: Setting of personal and relationship boundaries as a topical aspect • Category 2.1.3: Communication skills for effective partner interaction • Category 2.1.4: Acquiring anger management skills • Category 2.1.5: Rebuilding self-esteem • Category 2.1.6: Aspects related to parenting • Category 2.1.7: Relapse and how to manage it
SUBTHEME 2.2: Topical aspects suggested by the CSOs only
<p>SUBTHEME 2.2: CATEGORIES –</p> <ul style="list-style-type: none"> • Category 2.2.1: Information on how the CSOs can support partners with SUDs • Category 2.2.2: Life skills and decision-making skills • Category 2.2.3 Regaining self-confidence and independency
SUBTHEME 2.3: Re-establishing trust in the relationship as topical aspect suggested by the partner with a SUD only

4.3.2.1 Subtheme 2.1: Topical aspects suggested by both the CSOs and partners with a SUD

Seven topical aspect suggestions were deduced from both the CSOs and their partners with the SUDs' accounts. These will be presented under categories to this subtheme.

- Category 2.1.1: Information on the topic of drugs and its effects

Andries, Elsa, Jane, Paul, and Cindy, participants from the CSO sample group, admitted to the fact that if they were informed about the drugs their partners were addicted to and how they were affected by them, they would, in the first instance, been able to understand the partners' behaviour. Secondly, they would have been in the position to manage the situation differently. Similarly, Ida, Zane, Barry, Grace and Honey as the partners with the SUD, were also of the opinion that the CSOs needed to be informed about substances and their effects. Moreover, they suggested that this information be included as a topical aspect for social work support to the CSOs living with partners with a SUD.

After Ida abruptly stopped attending the recovery programme, her fiancée **Andries** strongly felt the need for a better understanding about addiction and recovery, as “... *it would have helped me as supporter to manage the situation* [pointing to the fact of Ida taking responsibility for her behaviour]”. **Ida**, Andries' partner also suggested the need for information on the topic of drugs and its effects, when stating: “...*this* [indicating to professional help] *is where you get information about drugs and also about the addict ... and for him* [referring to Andries] *to understand about being a supporter and that it is okay for him to feel the way he feels... In his case he* [Andries] *did not know ANYTHING about drugs and warning signs and addictive behaviour and to know what to look out for... and to know when there is a problem... like when I am using drugs again... warning signs that lead up to a relapse...*”

Elsa, as CSO-participant, also pointed to the aspect of more information about SUDs and related consequences, when stating: “...*first of all let me say I wish I had more knowledge about addiction, and if I can say the consequences and the effects. I don't think I know enough... sometimes here* [referring to the support programme she was attending] *they talk, and I go 'wow I didn't realise that, I didn't know that' and you know you live with that* [referring to Williams alcohol abuse] *and you don't actually realise what goes on... And the effects it has on the brain ... for me I wish I had more knowledge of the problem of addiction and the drugs itself...*” Her partner William did not refer to the need for information in his interview.

Jane, (a CSO-participant) suggested that more information on SUDs was important for CSOs: “... *I believed I understood it [referring to information about her partner’s SUD], but now realise that I don’t. We need to include more information on this in the programme. The information is important*”. **Honey**, her civil union partner agreed that CSOs need to know more about SUDs and said: “...*they [CSOs] need to be explained to about drugs... not that I really know myself why I used... to get a professional person who is knowledgeable on this topic, to explain to both of us why we do these things and how we feel... to go into more depth about how they [CSOs] can relate to us instead of focusing all the time on what we do wrong...*”

Paul, (a CSO-participant) although not specifically suggesting more information on drugs and its effects, pointed out how he became more knowledgeable after starting to attend the support groups of MWLC. He disclosed: “Yes, *the information we received at the awareness group... I was learning about things I never knew before; I was learning about addiction, I was learning about specific drugs...*” **Grace**, Paul’s wife, shared how her behaviour was driven by her SUD and noted that CSOs need information in this regard to be able to understand their partners: “*Another thing that I think can help supporters is to understand what drugs do to the brain... the person’s sense of reality is completely screwed up... I don’t think supporters understand this... the majority of stuff that is spewed out of the addict’s mouth is chemically related... And the pursuit of that chemical sort of overrides everything... Understanding that it is purely the chemicals that are talking... and the supporter can’t talk to me...*”

Cindy, as CSO-participant, also pointed to the need for information about drugs and its effects as a means to support the partner with the SUD. She explained: “*I think it is very important that people know this [referring to information on SUDs] because at that stage [referring to the time of Mike, her husband’s addiction] I was still in a lot of denial about what was really going on... I knew my husband needed help, but I thought it was going to be quick... a quick fix you know? And when they showed at the empowered seminar [information session on substances for families at MWLC] the effects on your body and brain by the different type of drugs, I could relate what my husband was going through. I could see it more clearly. He has been like this*

[referring to his addictive behaviour] *but I never saw it... the explanation helped me to see it very clearly*" ... *It* [referring to the information shared at the seminar] *put me at ease because it is in understanding the effect of the drugs that would determine the direction we can be going into...*". Mike, her husband with a SUD did not refer to the importance of information in his interview.

Zane, as partner with a SUD, in referring to the programme they, as a couple, were attending (during the time of the fieldwork) confirmed the suggestion for including information on the topic of drugs and its effect in social work support to CSOs as a way of assisting them: *"I think a lot of the time the partners [CSOs] don't realise what addiction entails and the effect of the chemical you get addicted to... they think it just happens... Compared to what I have learnt in Step work* [referring to the Twelve Step programme of AA], *it was beneficial to me as it covered a lot of things I did not know... both in my everyday life as well as my addiction... I don't think they* [referring to the CSOs] *understand that if they don't learn about it."* Felicity, his spouse did not have a suggestion to this effect.

Barry, also a partner with a SUD was more tentative: *"Probably they [CSOs] need to know about the effects of drugs... and then maybe warning signs and stuff... Different warning signs, relapse signs, behaviour warning signs... all of that... usually relapse in behaviour goes before relapse in use"*. Kate, Barry's partner, did not include this topic as a suggestion in the follow-up interview I had with her.

Some of the content of these narratives would fit in with the evidence Orford et al. (2009:379-408) retrieved in their British study, they measured the success of involving family members at two treatment facilities for the treatment of persons with a SUD with a focus on drug addiction and its effects. Here, where a "stress-strain-coping-support model"¹⁷ was implemented over two years. These researchers pointed out that including family members in the treatment plan empowered them

¹⁷ The "stress-strain-coping-support" (SSCS) model is an assessment and intervention tool developed by Orford et al based on documentation indicating that family members are exposed to *stress*, that they were under *strain* of physical and psychological harm, they were confronted with the predicament of trying to *cope* with their circumstances and received limited *social support* due the partners' SUD.

information-wise. Family members became better informed; acquired a greater understanding of SUDs and relapse, as well as developed a more realistic view on the expected outcome of treatment (Orford et al., 2009:391). Including information on SUDs forms an essential part of Behaviour Couples Therapy (BCT) in view of a better understanding of the dynamics of addictions and its progressive nature (Sherrell & Gutierrez, 2014:27), eventually leading to “positive transformations in family life” (Orford et al., 2007:34, 36).

In addition, the literature highlights that providing information through education on SUD’s aetiology, its ecological systemic positioning and the effect it has does not only reduces humiliation and prejudices, but also addresses co-occurring labels and feelings that CSOs have to grapple with (Haskell, Graham, Bernards, Flynn & Wells, 2016:11; McNeece & DiNitto, 2012:151; Craig, 2004:177-178). Labels such as being a “contributor” and “enabler” and “co-dependent” are frequently attributed to CSOs (Boylin & Anderson, 2005:3; Harkness & Cortell, 1997:473, 474). The CSO partner and the family are blamed, mostly by the person with the addiction, as the cause of their own addiction. With taking on the partner’s responsibilities, falling into the roles of caretaker and rescuer, while negating and denying their own needs their own needs, they are blamed for “enabling” the addictive partner to remain additive. Thus they maintain the addiction and become and stay co-dependent. This concept as explained by Spann and Fischer, as cited in Cullen & Carr (1999:506), refers to “a pattern of relating to others characterised by an extreme belief in personal powerlessness and the powerfulness of others, a lack of open expression of feelings, and excessive attempts to derive a sense of purpose through engaging in personally distressing care taking relationships which involve high levels of denial, rigidity, and attempts to control the relationship”.

To sum up: The familiar saying of “information is power” rings true in this situation. CSOs become more informed; resourceful and gain new perspectives through the information provided by professionals and laypersons, in their engagements with at the meso-system-level talking about the topic of SUDs, drugs and its effect. This in turn CSOs, at micro-system level, to become strong and gain the courage to grow in and from painful experiences and how to understand, respond and cope with this

challenges resulting from a partner's SUD (Sherwood, 2009:333). They start to bounce back from adversity. Providing information on SUDs and related behaviours and issues expands the CSO's perspectives on recovery and increases their repertoire of responses on a personal within a micro-level context. The support from individuals and systems on the meso-system level interface contributes positively to the recovery of a family caught up in SUDs (Jason et al. 2016:340; Bradshaw et al., 2015:327).

- Category 2.1.2: Setting of personal and relationship boundaries as a topical aspect suggested

Andries, a CSO-participant, and Grace as a partner with a SUD suggested the topic of boundary-setting to be included in the provision of social support to CSOs living with a partner with a SUD.

Andries suggested: *"... setting own boundaries for your own interest ...something I believe could be very valuable for supporters to understand fairly early in the process. You should not lose yourself and forget that you also have needs, whether it is in terms of time you spend with your family or whatever, and that shouldn't be neglected."*

As an example of setting boundaries, **Grace** as partner with a SUD said: *"Yes. I think he [referring to the CSO] needs to learn about boundaries, healthy boundaries for helping a person who comes from addiction... and how to treat them [partners with a SUD] in recovery". In this way, the supporter protects himself from the crap [erratic behaviour while under the influence including arguments and accusations] that is going to come"*.

This subtheme of boundary-setting must be read in conjunction with emotional enmeshment, described in Chapter Three (see Subtheme 1.4 under sub-section 3.3.1.4) and the subtheme on setting boundaries and self-care as coping strategy employed by CSOs (see Chapter Three, Subtheme 4.3 under sub-section 3.3.4.3). Emotional enmeshment refers to a state where a person has difficulty in separating

self from others and is boundary-wise diffused (Askian et al., 2016:277; Perkinson, 2008:244) - a condition that is rife in dysfunctional co-dependant addictive relationships (Craig, 2004:174). Fischer et al. (cited in Harkness & Cortell, 1997:473, 474) explain that emotional enmeshment and co-dependency are characterised by an extreme focus outside oneself, an inability to openly express feelings, and an effort to derive a sense of meaning exclusively through relationships with others. Setting boundaries requires from CSOs a certain sense of strength and the tenacity to disentangle themselves from this web of predicament caused by the partner's substance addiction and create an emotional distance imperative for gaining a perspective into their own needs and recovery (Galea in Green, 2014:944; Orford et al., 2007:34; Paquin, 2006:128).

- Category 2.1.3: Communication skills for effective partner interaction as a suggested topic

This topical suggestion was mentioned by some of the CSO-participants, as well as the partners with the SUD, as can be deduced from the storylines below:

Queen, a CSO-participant, referred to the aspects to be covered when focusing on the topic of communication: *“How to communicate... expressing yourself... How to deal with emotions ... also how to react to your partner [with a SUD], how you approach him and communicate with him”*.

In providing social work support to CSO of partners with a SUD, **Olga**, a CSO-participant, suggested *“communication skills... that covers everything, being able to express yourself and all of that...”* Her fiancée, Danny did not refer to this topic in his interview.)

Anne, a CSO-participant, briefly suggested the topic of communication skills when stating: *“... we [referring to her and Dicky] need to include it... communication skills, but also what can and what cannot be said...”* Her husband, **Dicky**, also underscored the topic of effective communication, by pointing out that *“it [referring to communication skills] can help... it is more than merely communication only...”* His

motivation for suggesting this topic was based on how his addiction had affected the communication in their relationship. This he worded as follows: *“Our relationship with each other... we stopped communicating and when we did it ended up in an argument”*.

Jane, (a CSO-participant) referring to communication between her partner and herself, admitted that it was not effective and implied that assistance was needed: *“Because I always trusted her, I accepted everything and never confronted any issues... I never took the time to actually really listen and respond to it.”* **Honey**, Jane’s civil union partner also emphasised communication in her interview, reflecting on its difficulty: *“Communication... we will have to become more open and honest with each other. It isn’t easy as there are things she does not know, things that happened very long ago in my life... I still do not know how to discuss it with her... not constantly invading my space with lots of questions and remarks... trying to control all I say and do... but she does not listen...”*. O’Farrell and Schein’s (2011:204) description that effective communication can be blocked by various factors relates to the point that both the CSOs and their partner with a SUDs need to acquire both “listening” and “speaking” skills.

Kate, a CSO-participant, in relation to the topic of communication reflected that the focus should be on how *“... to refrain from negative talking and insults, running down the other person... one can learn how to say certain things differently to come out in another way... don’t be harsh...”* Despite referring to the fact that *“in the time of addiction every time she [referring to his partner Kate] would open up it would end in an argument”*. **Barry**, her husband, proposed *“...communication skills... opening up and sharing. Not being scared to open up...”*

Support to this subtheme, is found in Weiss and Heyman’s (cited in Kelly et al., 2002:269) assertion that good communication is a prerequisite for effective conflict management and is essential for sustaining a satisfying couple relationship. Various scholars declare, that it is an established fact that in couple relationships where there is substance abuse and addiction, poor and destructive communication, poor problem-solving, destructive ways of conflict-resolution, arguing, physical and verbal

aggression are rife. These manifestations work as corrosive elements eventually leading to the breakdown of the marital relationship (Fals-Stewart et al., 2009:117-118; Egeci & Gencoz, 2006:383; Kelly et al., 2002:269). This deadlock in the communication experienced by partners caught up in a family member's SUD, according to Perkinson (2008:245) can partly be contributed to fearing disaster or the retaliation from the partners with the SUD if their spouses openly share what they think and feel. Placing another damper on the couple's communication is the lack of trust due to broken promises. This inadvertently leads to the development of a negative attitude towards each other with a matching communication style resulting in misinterpreting what is said and recriminations (Kinney, 2012:308). Where the couple communication is tarnished by a partner's substance addiction and its associated behaviour, trust must be regained, the communication channels must be cleared, and a safe space created where the both partners experience that they are being heard. (Toner & Velleman, 2014:153; Orford et al., 2009:391; Perkinson, 2008:245). Failure to establish this, according to Hagedorn and Hirshhorn (2009:48), will cause the couple to fall back into denial and defensiveness. Egeci and Gencoz (2006:390) pointed out that for unhappy partners the dynamics to explore and mend impaired communication, especially when one or both partners insist on their own specific point of view, indicates an unwillingness to listen to the views or opinions of others.

For these reasons and in support of this subtheme, Nooripour et al. (2013:26) recommend the idea of "training interventions". Fals-Stewart et al. (2009:119) propose developing a strategy that would create "relationship-focused interventions" to increase positive feelings, shared activities and constructive communication to enhance marital satisfaction.

- Category 2.1.4: Acquiring anger management skills as a suggested topic

Anger management, as deduced from the participants' accounts was another topic suggested to be included in the menu of social support of CSOs of partners with a SUD. This subtheme ties in with two of the subthemes presented in Chapter Three (see Subtheme 1.1 and Subtheme 2.1). The first touched on the aspect that living

with a partner with a SUD is stressful because, when they are under the influence under the influence, they were aggressive. The second focused on the fact that the CSOs responded with anger to their partners' substance addiction and resultant behaviour.

Speaking from personal experience, **Olga**, a CSO-participant, emphasised the need for anger management, by stating: *"... more specifically the need for including anger management... one is angry most of the time [referring to herself] and needs to get rid of it... I think it is definitely something to be included"* [in a programme to assist CSOs].

Anne, a CSO-participant, also brought up the topic of anger management, when mentioning: *"... definitely anger management... especially because there are many frustrations ... we have to include anger management... working through our feelings and coming to terms with them"*.

Tom, one of the partners with the SUD suggested anger management for CSOs as *"...there is no anger management for them out there..."*

SUDs and SUD-related behaviours can for some addicted partners and their non-addicted CSOs, metaphorically speaking be the fuel to the fire of anger in that they lash out to each other. (Zarshenas, Baneshi, Sharif & Sarani 2017:375). Kelly et al. (2002:269) has observed that where one partner in a couple relationship is inextricably involved in a SUD, amongst other things, their relationship be characterised by poor communication and destructive conflict. Persons struggling with SUDs, particularly their CSOs, often struggle with high stress levels and anxiety that can be exhibited as suspicious and paranoid behaviour (Raheb, Khalegi, Moghanibashi-Mnasourieh, Farhoudian & Teymouri, 2016:309). Generally, the partners with the SUDs also tend to have a blinkered view of themselves, which makes them especially susceptible to overreact to environmental prompts, something that helps to explain why they can be easily triggered to become involved in fights when they are intoxicated (Gottdiener, 2013:39). Such outbursts of anger, according to Papalia et al. (2007:425), is regarded as a maladaptive coping strategy,

something that needs to be addressed with treatment of the SUD (Meyer, 2016:80; McCollum, Stith, Miller & Ratcliffe, 2011:227, 228).

In offering anger-management as a relationship enhancing focussed intervention, Lloyd, Ramon, Vakalopoulou, Videmsek, Meffan, Roszczynska-Michta and Rolle (2017:480), propose a strength-based approach. Such an approach can provide for a nuanced understanding, especially of women's' responses, coping and recovery experiences to anger, aggression and violence. The strengths-based perspective acknowledges both hurt and growth, admitting that while circumstances have been painful and destructive they can become an opportunity for dealing more constructively with adversity. Resulting from their multi-focused research project on women's experiences of domestic violence and mental health problems the work of Lloyd et al. (2017) was consulted. The perspectives of women and service providers in five European countries (Greece, Italy, Poland, Slovenia and the UK), were investigated in terms of how abused women can be supported through an intervention in the form of a training programme offered to them. They developed a training programme, embedded in a strength-based and empowering approach that included strategies to promote becoming more assertive and safe-guarding oneself, by identifying and sharing strengths, relaxation and anger-management techniques. Following the implementation of this programme they concluded that the service providers felt more confident and competent in assisting women who had been subjected to abuse, while the participating women felt more empowered; and reported higher levels of self-esteem; and no longer accepted responsibility for being abused. A tendency is to blame themselves and feel guilty about what was happening is generally found amongst CSOs living with partners with a SUD (Lloyd et al., 2017:484). Lloyd et al.'s (2017) descriptions of how the meso-level system involvement and intervention can be applied to the contexts of CSOs living with partners with a SUD was significant in that they could become more tenacious by bonding with others in the same situation (Ungar, 2013:255; Saleebey, 2006:8). Through empowerment and education, CSOs can be rid of denial and disclose the abuse by committing to and building on cultural values that allow for positive narratives indicating hope (Wortham, 2014:60).

- Category 2.1.5: Rebuilding self-esteem as a topic suggested

In turning to the literature to find support for this category, Dethier et al. (2011:152) confirm that the stress of living with an alcoholic partner affects a CSO's self-esteem in a negative way. The frequent exposure to substance abuser's repeated verbal abuse appearing as blaming, insulting, swearing, yelling, ridiculing and humiliating, in the long run, is a negative influence. Loss of self-esteem can leave the non-abusing partner feeling tired, burdened, useless, worthless and self-blaming (Stanley in Dethier et al., 2011:152; Campbell in Dethier et al., 2011:152; Perkinson, 2008:410).

Stefan, a participant with a SUD in his account, does not only support the literature quoted, but suggests that CSOs through social work support could be assisted to rebuild their self-esteem. He stated: *"...to give an example, the friends we had who saw me under the influence. It was a huge embarrassment for her [referring to his wife, Louna]. It in fact contributed to destroying her self-image... it affected her terribly. And before this is not healed she will struggle to be herself again. ...The longer I maintained my sobriety, the more I became aware of the damage I caused. ...the spouse's self-image is destroyed, they have lost all faith in you, they also became dishonest and defensive...all of this has to be put right...but many spouses do not come to terms with this. Sharing in support groups will help them to ventilate as well as get a better perspective..."*

Louna, Stefan's wife (quoted above) acknowledged the fact a partner's addiction can impact negatively on a person's self-esteem, and that when you *"...have a low self-image your morals and spiritual values also suffer ... you lose interest and become careless; you no longer care how you dress or what you look like, you no longer care what your house looks like, you no longer worry what happens at your place of work ... this is where your self-image goes down. So, if you can get guidance how to counter this, and it can take effort, but just do it ... making deliberate efforts to take care of yourself"*.

Olga, a CSO-participant, also suggested the re-building of the self-esteem and acknowledged the aspect of spiritual healing as well, when she said: *"...the next*

point, building self-esteem... number one is spiritual... we know that there is a Higher Power out there. There is no other way that you [referring in general to CSO of a partner with a SUD] could have survived without somebody looking over you. We need to go deeper into that - also very important, especially for females, the physical is broken down a lot... small simple things to help females look after themselves again. ...so, it can just be something like body armour almost... you need to respect yourself... everyone should respect themselves”.

Felicity also suggested that “as a person [referring to the CSO-partner] *needs to be built up spiritually and psychologically else you act out of hurt and anger...*”

Olga and Felicity’s’ suggested references to spiritual healing and linking it with self-esteem rebuilding, seems not to be so out of place given Pardini, Plante, Sherman and Stump’s (2000:347) assertion that spirituality, religious faith and the belief in a Higher power, can be associated with higher levels of self-esteem, life satisfaction, and personal adjustment in the context of substance abuse and recovery. In addition, Black and Lobo (in Adedoyin et al., 2014:591) postulate that religion makes provision for a “built-in mechanism” to overcome hardship, tying in which the notion of resiliency as one of the theoretical frameworks adopted for this study.

- Category 2.1.6: Aspects related to parenting as a suggested topic

When reflecting on the aspects on the topic of parenting suggested, I noticed that the participants’ recommendations were based and informed on their own needs.

As, CSO-participant, **Olga**, expressed the need for “*parenting skills*” as a preventative measure to ensure that a child will not, after growing up “*one day can come home having used alcohol or drugs, not particularly because of what happened at home [referring to Danny’s addiction], but because something was not handled properly or sorted out... or it can just happen... But as a parent one wants to make provision for these things*”.

Queen, a CSO-participant, explained her suggestion for including parenting skills as a means of social worker support as: *"I think, for me the children are more important, how they can help, but also how to help THEM deal with the situation. For instance, it is very difficult to explain to a six-year-old, why his dad [in this case Tom] going to rehab... I have two children... I am not too concerned about the one of two years old... it is more the older one everything still plays off in his mind... whatever this all entails... he is perhaps not at such an intense stage yet... he knows his dad is in treatment because he witnessed what happened..."*

For **Anne** (one of the CSO-participants) her need was for information on how to support her children. She spoke about it as follows: *"For me primarily, is the support towards the children. That is where there is a gap for me which I have not managed to address... I need to be able to explain to the children what happened [with reference to Dicky's substance addiction situation] and how to explain it as they have also been through all of this. Our children have not yet spoken to us about it... I know they are seeing a counsellor at school, but I need more support in this regard... as I think the children are struggling..."*

Queen and Anne's need and suggestions for information assisting them and other non-abusing and non-addictive partners, in how to explain a partner's SUD to the children. Protecting and supporting their children is endorsed by Hudson et al. (2002:172) emphasising that the social support provided by other adults in homes where a parent engages in alcohol or drug abuse too can have a profound effect on the developmental outcomes such children experience. In addition, Lander et al. (2013:201) point out that children in families with SUDs witness the convergence of destructive interaction between their parents, as something which can often lead to violence. They could then be required to hide this from family and public view, or lie about it to others in the extended family, their peers and those with whom they interact at meso-system level. These circumstances that children are exposed to have been closely associated with substance abuse during adolescent years (Best, Wilson, Maclean, Savic, Reed, Bruun & Lubman, 2014:115). As CSOs not using drugs, Queen and Anne (as per the quotations above) were aware and concerned about the effect of SUDs on their children.

Barry, as partner with a SUD, did not suggest any aspects related to the topic of parenting, but instead focused on his challenges in this sphere when he remarked: expressing his insight and concern about his behaviour affecting the children, explained: *“In our situation the children are still quite small... the boy is four and a half... the other one is only 8 months this month. When I was at the in-patient centre we said to them that I went away for work... I did not really know what to say to him... He further acknowledged: “Later on in life I need to open up but don’t know what I should say to him [his boy] about the problem...”*

- Category 2.1.7: Relapse and how to manage it as topic suggested

Relapse, a term used in the field of SUDs refers to returning to addictive behaviour after a period of abstinence (Witkiewitz et al., 2013:351). It is a common occurrence in SUDs and as pointed out by both Kinney (2012:279) and Geyer (2010:80), relapses are a normal part on the road to recovery and sobriety. However, Hsu and Marlatt (2012:106) point out that although this should be regarded as part of the recovery process, it is actually perceived to be a separate and disconnected event. The possibility of relapse and its predominantly negative effect on an already strained and vulnerable partnership relationship must be clearly understood by all parties concerned (Kinney, 2012:263). Adedoyin et al. (2014:594) point out that if the CSOs are not actively involved in their partners with a SUDs’ recovery, there is an increased likelihood of regression in terms of their circumstances. Even under Subthemes 3.6 (see Chapter Three, sub-section 3.3.3.6) the topic of relapses as a challenge experienced by the CSOs was described.

Felicity, although not suggesting this as a topic to be covered in providing social work support to CSOs, does acknowledge the possibility of it happening. Her husband with the SUD, **Zane**, regarded this topic as essential – *“I think it is important, how to deal with that [relapse], the consequences and how to enforce them, how to deal with your emotional state at that time [when the relapses happened], maybe you reach a point of enough is enough... They [referring to the CSOs] obviously are going to need help to deal with their emotional state... If I relapse I am back to learn what I have to learn...”*

Paul, one of the CSO-participants, suggested the topic of relapse and how to manage it should be included in the provision of social worker support to CSOs. He referred to it as: *“Although it is a very depressing thing to think about relapse, especially if the spouse is clean for a long period, but it happens... So we [as CSOs] need to know how to manage that to get through the situation”*. Although Paul’s wife Grace had relapsed on a previous occasion he stated that he was not able to, off-hand, describe how he would handle it if it happened again – *“I don’t know... I will have to be in the situation to know how to deal with it...”*

Grace, Paul’s wife, in the following account did not only suggest this to be included as a topic to assist CSOs, but also provided a glimpse on the topic on relapsing from the perspective from the person with a SUD: *“It is a tough one... to set yourself up for a relapse. The addict goes through the programme with the aim never to relapse... so now you are almost preparing yourself for failure. That is how a person who has not been through a relapse with an addict will feel. Yet it is almost inevitable; you don’t want to tell them that ... and for the addict it can become a free pass [an excuse for using again]... it is tough... And I think supporters also need to understand that there will always be a relapse in a recovering alcoholic. That is just the way it is, even for me who is more than three and a half years clean... there is always a relapse in me. I cannot just say it is in the past... and is always a matter of choice... I think it is information that they should have for themselves... and this is for my own journey, I mean, and Paul knows about it, I have gone back on Antabuse [medication that gives an aversive reaction when taken and alcohol is consumed within the following 12-18 hours] and regular testing because I am scared of relapsing as I am scared I can lose everything... Most recovering addicts do not have this sense, so for them... But then relapse is not the end of the world... it is a mistake as it is part of addiction. At the end of the day supporters and recovering addicts need to know that it is the recovering addict’s choice... They need to understand that. If you are in a relationship with a recovering addict, whether a mother or father or spouse, that there is always that chance. Supporters really do need to understand this. Being clean does not mean that you are 100% free”*.

Andries, a CSO-participant's account below does not speak to the topic suggested, but rather featured the importance of knowing about the possibility that a partner could relapse and how to manage it. He shared the following: *"I attended the information seminar [referring to the information provided for families by MWLC]... But if I had known that there are setbacks [relapses] and that Mighty Wings has seen this many times before, I would not have lost faith in this process of moving forward [Andries thought that after Ida relapsed she would be dismissed from the programme]... Andries' ignorance about the aspect of relapse also became evident as he saw the treatment programme as "the solution", and when the Ida's setback happened, and because of his ignorance "I didn't know how to handle it"*

William as participant with a SUD's account by implication pointed to the fact that a support programme for CSOs would help him and others in a similar position to deal with setbacks or relapses. He explained: *"I believe... and I did not even know from my side... that this programme [referring to the support programme for CSOs] was needed... now that we are into the programme to learn how to deal with it [the problem of SUDs] we also should be able to learn how to handle the recovery part of the addiction, including setbacks ..."*

An aspect to be emphasised from the accounts provided above is the fact that a partner's relapse into addiction, if repetitive and destructive in nature, evokes negative emotions; encourages conflict; taxes the CSO's strength and resilience, and it endangers the future prospect of the relationship (Ferrari et al., 2014:856; Farabee, McCann, Brecht, Cousins, Antonini, Lee, Hemberg, Karno & Rawson, 2013:206). This accentuates the importance of furnishing CSOs with information on relapse in the context of substance addiction as a normal occurrence in regaining sobriety and keeping it remaining so. Encourage them to take a different view on the matter. To recover from addiction and staying sober is a lifestyle change, which for many, does not happen the first time around. Change, in this context takes place gradually with many setbacks (Denning, 2010:167).

Considering relapse and recovering from it from a strength-based perspective and in the context of resiliency means that in supporting a partner with the SUD, CSOs

testify to their partner's strength to bounce back from drinking or using drugs when it occurs and show confidence in their belief to do so. This then concludes the presentation of the respective subthemes related to topical aspects suggested by both the CSO and their partner with SUD. The following subthemes will focus on topical aspects suggested by the CSOs only.

4.3.2.2 Subtheme 2.2: Topical aspects suggested by the CSOs only

The three topical aspects that emerged from the CSOs only are presented now as categories of this subtheme.

- Category 2.2.1: Information on how the CSOs can support partners with SUDs

From the storylines presented below it becomes clear that this topical suggestion is not at the same level as requiring information about the SUD and its effect (presented as category 2.1.1 under the previous subtheme). However, it refers to the nuts-and-bolts, by way of speaking of how to support a partner with a SUD.

Andries, as Ida's supporter expressed a need for more information to be better equipped for this task. He explained: *"...if I know as a supporter that I am doing [referring to supporting Ida] what is expected of me, I can just be more effective in doing what I am doing... I cannot know what to do as I don't have the answer [referring to his current situation in which his fiancée Ida is still on the programme during the time of the fieldwork], but if I have sufficient information it can be better... I could perhaps have acted quicker [Ida relapsed about two weeks earlier] ... and could have been more effective".*

Queen, as CSO-participant verbalised the need for guidance on how to manage a partner with a SUD as well as how to deal with their own emotions: *"How to deal with emotions... also how to react to your partner, how you approach him and communicate with him. But now the problem is that you can do everything right and they still rebel against it... and sometimes they do the opposite of what you were taught. Then you become scared doing things..."*

Louna needed information on how to manage Stefan, her husband's drinking habits. She stated: "... *how do I manage his drinking? At first, I tried to understand it from a social perspective... but then the social drinking became worse... he started drinking at home now... and there is a justification for every time he wanted to drink. And then it struck me that this no longer is social drinking, it has become a habit. Then I felt I have no idea what to do... I wasn't even aware of the danger signs to assist me, but even if I knew, I did not understand and not know what to do...*"

Cindy implied she needed to be equipped how to handle a partner with a SUD even when he stopped using drugs: "...*In the beginning I just thought I was merely here [at the support facility] for him. I did not realise I had a problem until about a month into the programme... I saw my behaviour was still the same, but he is changing. So, we clashed a lot... as supporters, how do you go about it, how do you feel, how do you cope?*"

Other than being informed about SUDs and its effects on the user, the family and society, but especially the CSOs often seemed to require practical advice about making informed decisions about of their behaviour and how to deal with day-to-day issues created by their partner's SUD (Rhodes, Rance, Fraser & Treloar, 2017:126; Haskell et al., 2016:1; Toner & Velleman, 2014:147; Arkin et al., 1990:126). The CSOs' need for assistance with practical issues in the field of substance abuse applies to situations where the partner with a SUD might still be abusing drugs or had stopped using it. It must be understood that the decision to stop using the substance does not imply *immediate responsible behaviour* from the person with a SUD (Hawkins & Hawkins in McNeece & DiNitto, 2012; Kinney, 2012; Steinglass, 2009; Freeman, 2001).

- Category 2.2.2: Life skills and decision-making skills as a topic suggested

Closely linked to the previous suggestion of how to practically support the partner with a SUD, Olga, Queen, Jane and Paul (all four, CSO-participants) proposed the inclusion of life skills, especially decision-making skills, to be included in the provision of social work support to CSOs living with a partner with a SUD.

Olga proposed: “... we need to get stronger skills, life skills... how to deal with situations more constructively”. Building trust [referring to regaining faith in her partner] is very difficult, especially ... decision-making... that is trusting yourself... ‘Am I making the right decision’? And that depends on the life skills ... where you put it down on paper... this is how you are going to do it... I call my strategy [referring to the decisions she had to take to deal with her fiancée, Danny] always a ‘battle plan’... so a day’s battle-plan, a week’s battle plan... teaching yourself to make decisions and not doubt yourself... it is a matter of trusting yourself... because it is very difficult... I actually feel guilty to try and fix my life... but I think eventually my skills will help them [referring to Danny and their two children]...”

Queen included under life skills managing feelings, conflict and decision making: “Well they [referring to the partner with a SUD] don’t feel or consider our feelings ... We need life skills... to make a barrier to protect ourselves [but it is] extremely difficult... not to worry about him and if he relapses... he is a person who is responsible for his own choices... and if he makes a mistake, it is HIS responsibility, it cannot be MY responsibility...”

Jane’s account also seemed to look for guidance on how to make better decisions when admitting: “... I am inclined to end up in situations I do not want to be in... I am married to Honey and will always take her side and always submit to what she wants to do, often against my will. I do not stick to my own judgments. I need to allow myself to make better decisions after considering all the consequences. When she acknowledged her problem [referring to Honey’s addiction], my first reaction was to divorce her. I did not think of all the consequences for both of us...”

Paul aptly summed up the motivation for the suggestion why he and other CSOs living with partners with SUDs need life skills: “... we don’t have the problem of being with an addict, but we have a problem of trying to construct a life WITH an addict. So that in itself is a huge problem ...”

Although more broadly stated, the need for life skills by CSOs of a partner with a SUD can be linked with managing circumstances caused by the person with a SUD,

but also trusting their own ability to do make appropriate decisions in general as their self-confidence and self-esteem has been eroded by the behaviour and reactions of the person with a SUD (Rodriguez et al., 2014:299; Denning, 2010:166; Peled & Sacks, 2008:400). Taking decisions and sticking with them in the context of living with a partner with a SUD, according to Perkinson (2008:245) remains a challenge as the erratic and reckless behaviour infused by the substances of addiction tend to collude with decisions taken and plans made causing it more than often to fail.

- Category 2.2.3: Regaining self-confidence and independency as a suggested topic

Two of the CSO-participants, Olga and Felicity, owing to the fact of having lost faith in themselves and lost their self-confidence due to partners' SUDs suggested social work support in this area.

Regarding self-confidence, **Olga** explained: *"Then also very important if this [the treatment is completed] is done, is for a female [CSO] to gain her independence again... even if you are sharing now [referring to shared responsibilities and income], you still have to become independent... make a decision, gain self-control and gain freedom if I can say that... some individuals are stuck [in living with a partner with a SUD] and cannot move out of that situation, and become dependent... or scared or have no self-confidence".*

Felicity also referred to the importance of self-confidence: *"... he [referring to her husband Zane] will say to me I am always over-sensitive, to which I respond that 'yes, I am sensitive because you are always breaking me down'... so yes, I also need to feel happy in what we are going through... need to be built up again... the treatment facility must directly or indirectly cater for that... definitely... there were times I felt I just was not good enough, I did not look good, being down, being not worthy...it will be good to have seminars about this."*

4.3.2.3 Subtheme 2.3: Re-establishing trust in the relationship as topical aspect suggested by the partner with a SUD only

The issue of trust and the need to rebuild trust between the CSO-partner and the spouse with the SUD was pertinently suggested by Mike, as being necessary to include in the programme for CSOs.

Mike said: *“Yes, we need to get the trust back. In our case we openly discuss things; we need to learn to trust. I must realise to answer truthfully. Also trust in God... also to make provision for husbands that have been unfaithful [during the time they abuse drugs]. In my mind when you use, sexual impurity becomes a problem. So, I think that this must be added in a programme... in terms of support they [the CSOs] need to understand it ...”*

Mike’s suggestion is not out of line for the fact that a partner’s SUD often manifests in erratic behaviour; promises being broken, and on-going deliberate and compulsive dishonesty being displayed as the SUD progresses. This together with a history and episodes of relapsing all erodes the pillars of trust that must uphold relationships (Fletcher, 2013:327; Hussaarts et al., 2011:38; Nastasic, 2011:94).

This then concludes the presentation of the theme focusing on CSOs and their partners with SUDs’ suggestions on topical aspects to be covered during the provision of social work support to the CSO partner.

4.3.3 THEME THREE: PARTICIPANTS’ SUGGESTIONS ON THE FORMAT IN WHICH THE SOCIAL WORK SUPPORT IS TO BE OFFERED

Both CSOs and the partners with a SUD were asked to give their opinions and suggestions about the nature and format of the social work support they as CSOs and partners with a SUD, would find helpful. From the responses provided by the participants (both the CSOs and their partners with the SUD) the suggestions were at times directed to the CSOs and in other situations at both parties in the couple relationship. This is to be expected as the negative effects of a SUD impacts on the

family as a whole; as a family unit develops emotionally and socially in terms of its roles and responsibilities, it both impacts on the community and is influenced by its surroundings (Lander et al., 2013:194). Families with a SUD, as pointed out by Mercado (2000:270) have a common belief system on substance use which, with time influences the families' identity with rules and roles governing family members' thoughts, feelings and behaviour.

When socially healthy couples are compared with those affected by SUDs, the latter groups reflect far-reaching relationship problems and significant levels of psychological suffering. All these issues also negatively impact on the relationship with, and the development of their children (Fals-Stewart et al., 2009:117). It is for these reasons that Copello et al. (2005:369) emphasise that family members need to be part of the recovery which merits help for family members as persons in their own right. Table 4.3 reflect the suggestions made by both CSOs and partners with a SUD and they will be discussed as Subtheme 3.1. The additional suggestions which were derived from the CSO only, are discussed as a separate subtheme (see Subtheme 3.2 below).

Table 4.3 Overview of the subthemes related to Theme Three - Participants' suggestions on the format in which the social work support is to be offered

THEMES	SUBTHEME 3.1	SUBTHEME 3.2
Participants' suggestions on the format in which the social work support is to be offered	<p>Suggestions from both CSOs and their partners with a SUD on the format in which social work support is to be offered:</p> <ul style="list-style-type: none"> • Category 3.1.1: Couple or marriage counselling • Category 3.1.2: Support group sessions • Category 3.1.3: Own-programme tailor-made for CSOs and programme stipulations 	<p>CSOs' suggestions only on the format in which social work support should be offered:</p> <ul style="list-style-type: none"> • Category 3.2.1: One-on-one sessions for those who do not want to be in groups • Category 3.2.2: Family sessions as a way for providing social work support

4.3.3.1 Subtheme 3.1: Suggestions from both CSOs and their partners with a SUD on the format in which social work support is to be offered

This subtheme branched into suggestions for couple/marriage counselling, support groups, and an own-programme tailor-made for CSOs as the formats through which social work support is to be offered. These are presented next as categories.

- Category 3.1.1: Couple or marriage counselling

Given the accounts presented under Theme 1 in this Chapter, by the partners with the SUD on how the latter's addictions have impacted on the CSOs and their partnership relationships, the need for improving their relationships were suggested. Some of the participants in both sample groups suggested marriage and couple counselling as a means to realise this.

Danny, as partner with a SUD admitted: “...*our relationship* [referring to the relationship with his fiancée Olga] *needs to improve... from my side it is difficult to say... she must say what she needs...*’

Conrad said: “We [generally referring to the partners with a SUD] *must learn to see how we can take care of ourselves... We must also have the will-power to make the relationship work. This is the anchor, and then everything else follows on to this... But it is the drinking that keeps us apart... we must become closer again ...*”

Barry admitted that he and Kate [his CSO-partner] needed assistance “*To build the relationship. So, you [referring to himself in the second person] are not just feeling your way around... I don't know where I go right or wrong...*”

Ida's, contribution aptly sums up that both partners need help, when she stated: “*The changes for the addict is more deliberate [he **needs** help] while the change for the supporter is more voluntary [implying that they might not have to go for help]... But you have to acknowledge the fact that if you want to achieve the goal which was*

set [implying sobriety and restored family relationships], *as the addict puts things in place to change, so the supporter has to change... both need help.*"

Anne, Cindy and Paul, as CSO-participants, and Zane, as partner with a SUD, directly suggested couple or marriage counselling to improve their relationships and also referred to its value.

Anne, suggested "... *maybe a simple course in marriage guidance... something like that. To get back to the way things were before... I know it must be very difficult to do it at the beginning of a programme [Anne felt that marriage counselling makes up part of a bigger treatment programme] ... and if it can be later in the programme, it can be better*".

Cindy, with reference to the need for marriage counselling for CSOs and their partners with a SUD responded with an affirming "*Yes! Absolutely..., that is why my partner and I went to see a social worker [after they entered the support programme]... it was not offered in-house, but I think because one cannot afford this every week it must be part of the programme [treatment or support programme for SUDs]...we also have to learn to live together as a man and a wife you know. More of that can help, together with the boundary setting*".

Paul pointed out the value that attending a marriage counselling couples group, he and Grace attended later but that was not part of Grace's treatment. He mentioned "...*we did attend a couples group. It ran over ten to twelve weeks and this was very good. Not that it was specifically related to addiction but still very helpful... obviously our relationship was bruised and battered... I did come under duress [referring to the couples counselling] ... Grace had to really make an effort to convince me to come... I think it is a male thing... but yes, once I was there I enjoyed the sessions. It was presented by a psychologist and it gave insight in how you interact as a couple...and how to improve your interaction as a couple...it was very helpful*". Paul was asked whether a couples group should be included in the programme for partners: "*Definitely. And then I am looking at it purely from a spouse frame of reference*". Paul continued: "*I mean our marriage could not be perfect... no marriage can be perfect,*

but it deteriorated to such a level, I mean when drugs are involved, and addiction is involved...”

Zane (as participant from the SUD-sample group) spoke of a combined session for the CSO and partner with a SUD when stating: *“I am not much of a talker, I never have been and I don’t know if it’s because of the things I have gone through [he grew up in a family where his father was addicted to alcohol and was a violent person], but then I am one that deals with things by myself. If I need money, I will make a plan. I don’t ask people for things. Asking me how my day was, I will merely say it was okay and then keep quiet. This is just who I am. So, a combined session can help her [referring to Felicity and probably CSOs in general] if you ask her. You see if you have a combined session with a mediator [professional counsellor], there is always one who does more of the talking and wanting to be right... she is one who always wants to be right so I respond “okay”. That is why a mediator can definitely help [indicating to assist him also in contributing to the conversation].”*

Various authors (Wesley, 2016:90; Fletcher, 2013:337, O’Farrell & Clements, 2012:127; Arkin et al., 1990:127) agree that there were three primary aims of couple counselling in the context of substance addiction treatment. These are alcohol/drug focused intervention, which is aimed at supporting the substance abuser to quit the addictive behaviour; interventions aimed at improving the quality of marital and family relationships; and relapse prevention strategies. Behavioral Couples Therapy (BCT) and Alcohol-focused Behavioral Couples Therapy (ABCT), stand out in research literature as the most efficient treatment modalities for assisting CSOs and their partners with SUD (McCrady et al., 2016:443-459; Wesley, 2016:89-92; Fletcher, 2013:327-352; Klostermann & O’Farrell, 2013:234-247; O’Farrell & Clements, 2012:122-144; Sprenkle, 2012:3-29; Fals-Stewart, et al., 2009:115-125; McCollum, Lewis, Nelson, Trepper & Wetchler, 2003:1-19). The focus of this therapy includes alcohol and drug-focused treatment¹⁸, seeing the CSO-partner and spouse with a SUD conjointly, to support abstinence as well as focuses on relationships to

¹⁸ Alcohol and drug-focused treatment for the person with a SUD includes focusing on abstinence, dealing with dysfunctional lifestyle and behaviours, stress management, psychological and related matters and addressing physical problems caused by substance abuse (Kinney, 2012:274).

enhance caring and communication skills (Klostermann & O'Farrell, 2013:239). SUDs-focused treatment, as described by Fals-Stewart et al., (2009:119) emphasises abstinence that involves a series of commitments. First, drafting a recovery contract, attending self-help/support meetings, drug-screening tests, and daily discussions on the experience of their recovery with the CSO. Then dealing with the relationship directed at behaviours which can constitute triggers for relapse, as well as assisting the partner with a SUD to avoid events that can cause a relapse.

In addition, Arkin et al. (1990:127) stress that in marital therapy with couples in an alcohol affected marriage, interventions should also focus on aspects such as the history of resentments, breaches of trust and broken promises. BCT, according to McCrady et al. (2016:444), can also be applied addressing Post Traumatic Stress Disorder (PTSD) and domestic violence, as intimate partner violence seems to be a common occurrence in a relationship where one of the partners (or even both) are addicted to substances (Choenni et al., 2017:38; Alexandercikova et al., 2013:271). BCT incorporates the strength-based perspective by not concentrating on past negative feelings and interactions caused by substance abuse, but shifting the focus to positive behavioural exchanges between partners, including communication and activities to identify good qualities in each other encouraging positive feedback (Klostermann et al., 2011:1503; O'Farrell & Schein, 2011:203). BCT furthermore aligns itself with the elements of the eco-systems theory with an emphasis on the micro-system level, the couple-system, as it reduces social costs and domestic violence as well as the emotional impact it has on the children (O'Farrell & Schein, 2011:194). It also acknowledges that caring and support is the primary protective factor against relapse, as well as encouraging the building and strengthening of support from the meso-system level environment (Roberts et al., 2002:58)

- Category 3.1.2 Support group sessions

Group treatment refers to those actions that address the socio-emotional needs of group members (Qalinge in Mbedzi et al., 2015:136) where, through group work encounters, the objectives of support, education, therapy, growth and socialisation are pursued (Toseland & Rivas, 2009:21). McNeece and DiNitto (2012:135) refer to

group treatment as the treatment “of choice” for treating SUDs. This is confirmed by Yalom (in Kinney, 2012:298), a founder in therapeutic group work, who on the topic of the value of groups for alcoholics found that group membership counters the alcoholic’s prevailing pressure to drink; provide support; offer role-models, and harness the power of peer pressure. By the same token, McNeece and DiNitto (2012:136) aver that both therapeutic and support groups with CSOs of partners with a SUD hold the prospects for members to obtain information on SUDs; assist them to deal with their feelings caused by the SUD, and to receive understanding and support from each other (Perkinson, 2009:248). Gitterman and Knight (2016:451) assert that the sharing of common experiences in groups creates opportunities for group members to advise and develop insight into matters being discussed, which enhance self-efficacy and promote more effective coping. Group therapy lends itself to incorporating a strength-based approach as it provides group members more opportunities for identifying and developing their strengths and, in doing so facilitate group cohesion (Harris, Brazeau, Clarkson, Brownlee & Rawana, 2012:345). Developing group cohesion enhances positive outcomes including abstinence from drug use and overall improved interactions (Harris et al., 2012:344).

From the accounts of some of the participants in the respective sample groups, two aspects emerged in relation to topic of support groups. These relate to -

- **the value of attending support groups, for both CSOs and the partner with the SUD were highlighted**, suggesting that this mode of intervention be provided to couples affected by a partner’s SUD.
- **suggestions on the composition of the support groups.**

From the accounts of Andries, Kate and Louna (as CSO-participants) and Ida, Stefan, Conrad and Zane, (partners with a SUD), it becomes clear that **support groups are valuable and provide opportunities for mutual sharing and learning**. These are the types of benefits support groups offer as highlighted in the literature consulted (Young & Timko, 2015:66; Kinney, 2012:316; McNeece & DiNitto, 2012:136).

Andries: *“...group sessions are probably better because you can reach more than one person, but not discounting one-on-one sessions in any way... what is also good about a group session is that you can interact with other supporters [CSOs]...the understanding from somebody else experiencing the same challenges puts you in a different space where you understand that your problem is not unique... and together find different solutions from their experiences... we learn lessons from these different experiences”.*

Ida, Andries' fiancée, in a separate interview, shared similar sentiments when stating: *“If I can refer to the programme of Mighty Wings, the supporter programme [support groups for CSOs with a SUD] is very important where partners also come in for group sessions...it would be good for him... Because I know how I feel after attending a programme and what it did for me... I think for him to share in a programme where there are others sharing about the same problem would help him”. She continued: “They [the CSO of a partner with a SUD] will feel better sharing in groups in that they will feel that they are not alone and that there is hope. When you hear other people's stories it gives hope, you see that there is light at the end of the tunnel”.*

Louna shared the following about CSOs attending groups: *“It [referring the support group she and Stefan (her husband) attending regularly] does have great value. We go regularly and find this very meaningful. I as partner [CSO] receive so much empathy and realise how many of us are going through the same difficulties... the discussions make us [as CSOs of a partner with a SUD] reflect a lot on ourselves and what is happening... This information must be conveyed to the partners when the addicts are admitted [when persons with a SUD are admitted for in-patient treatment]... not allowing for this [including CSOs in the treatment process] leaves the partner vulnerable as they have no idea what to do”.*

Stefan, Louna's husband with a SUD, stated the following in this regard: *“...whatever an addict [person with a SUD] has done, the end result is that the spouse's self-image is destroyed, they [referring in general to CSOs, including Louna] have lost all faith in you [referring to partners with a SUD in general including*

himself], *they also became dishonest and defensive ... all of this has to be put right ... but many spouses do not come to terms with this. Sharing in support groups helps them to ventilate as well as get a better perspective. It is not simplistic to help her [Louna]... you [referring to the partner with the SUD] must help create the right attitude in her; help her trust and share her feelings... and in joining a support group*".

Kate, a CSO-participant, briefly referred to attending groups as follows: "*... you learn a lot from what others share, their experiences and how they deal with situations*".

Dicky, Anne's husband, emphasised the need for CSOs to share similar experiences: "*Yes, and sharing this [indicating the thoughts and feelings of the CSO partners] with others as part of her programme should help as the others most probably went through the same situations...*"

Conrad, Linda's husband with a SUD, referred to attending groups in a similar vein: "*They [CSOs] must learn to practically apply different things... and share things in groups and give each other feedback...*"

Zane, Felicity's husband with a SUD was more detailed in his contribution: "*...maybe when you get admitted [referring to the partner with a SUD entering in-patient treatment], if you want to call it that... expose them [CSOs] to one or two [group] meetings in the form of an induction... and join you [partner with a SUD] for a couple of meetings so that they can understand what it is all about. Many of them can think 'you are the addict, so go and get yourself right, we will be on the outside waiting for you'. So make them come in for a couple of [group] sessions and make it compulsory and educate them in a couple of lessons*". Zane's spouse, Felicity, in a separate interview, echoed this: "*...it [attending group sessions] will be beneficiary especially in the beginning... I think we can first have some combined sessions [indicating joint groups for CSOs and their partners with a SUD] and later separate sessions [when CSOs and partners with a SUD attend different groups]...*"

Acquiring life and decision-making skills, lacking in the arsenal of coping mechanisms of the CSOs of a partner with a SUD, Hagedorn and Hirshhorn (2009:43 - 67) recommend including experiential learning with group activities in the context of group work. Citing Moreno, these authors (Hagedorn & Hirshhorn 2009:47) qualify the use of experiential exercises as they allow for self-expression exceeding that which is found in so-called “talk-therapies”. These activities or exercises, amongst others music therapy and psychodrama, are usually implemented in group sessions as they provide opportunities for members to interact in new ways. This allows for personal growth in receiving direct feedback from group members and the facilitator, building inter-personal skills and learning more constructive and applicable emotional expressions (Hagedorn & Hirshhorn, 2009:48). Striving towards reaching these objectives is enabled by the CSO of a partner with a SUD to build upon their strengths, something which assists as powerful energy for change.

Concerning the aspect of the **composition of the support groups** the participants suggested the following:

Elsa, a CSO-participant, suggested that CSOs living with partners abusing alcohol should be different in their own group, separated from CSOs with partners addicted to and abusing other substances. She explained: “...*I don't mind the group* [referring to being in a group] *and I am not saying do away with it... It is more a matter that it is about having groups with partners married to an alcoholic* [only] *...I go into a general group* [where both CSOs of partners with a drug problem and CSOs of partners with an alcohol problem are grouped together]... *but I can't relate to them because I am in a different situation*”.

Paul, a CSO-participant, suggested group composition based on similarity by putting CSOs' partners with a SUD in one group and parents with a child with a SUD in their own group. He explained: “...*the groups must be structured carefully though with members as similar as possible... they should be selected according to as I said... last week I was in the wives and girlfriends group... I noticed at that time that there were lots of parents with children* [with a SUD]... *and parents and children cannot*

relate to how a spouse [of a partner with a SUD] feels... so I got stuck in a parents group and I know there are similarities... but the spouse group I found to be most helpful."

Cindy, a CSO-participant, also referred to the group composition on similarity, when stating: *"When I am thinking about it... what also helped me [referring to her entering the programme] was when they separated all the wives from the people who come there because of their children or girlfriends or other type of partners... and separated the wives and husbands into one group and I think it helped, because for me being in recovery is different from someone who is here with a child. The dynamics is different, and I think with boundaries it is also different".*

Kate, a CSO-participant, also suggested support groups ... *"otherwise they won't learn... they have to learn from others and apply it in their own lives"*, but also acknowledged... *"Those then who are in groups but still struggle can get individual help, extra help"*.

As Toseland and Rivas (2014:13) point out a group's purpose reflects the reasons why members come together. In this case, based on the accounts of the CSOs commonality shared of being partnered with a person with a SUD, it seems that the purpose here is finding support from others caught up in similar situations and learning from other members' experiences, which help them to understand and manage their own circumstances. Considering that the group serves as an opportunity to attend to members' personal needs through self-disclosed and open sharing of common problems and concerns, the group becomes a treatment group (Toseland & Rivas, 2014:14). The composition of the group is based on the selection of group members according to both their similarities or homogeneous characteristics, concerns and issues and their differences or heterogeneous characteristics. These are represented by their individual backgrounds, age, and level of education, life-experiences and other relevant factors pertaining to the selected group. The advantage of having a more homogenous group is that communication and cohesion between members will improve. It also helps group members to identify and relate to each other's situations. A more heterogeneous

group allows for more options and alternatives, assisting members to learn from each other as they consider and then are more likely to make different and possibly better choices (Toseland and Rivas, 2014:76). Support groups are best served with a combination of homogeneous and heterogeneous elements.

Support groups are established when people with similar needs and concerns get together. Treatment groups (including support groups) in the field of SUDs, according to Kinney (2012:300) as well as Hagedorn and Hirshhorn (2009:470) are able to provide group members with opportunities for personal growth. The primary emphasis in support groups is on promoting greater self-awareness (Kinney, 2012:300) while belonging to a support group brings with it an acceptable new social identity of being in *recovery* instead of being stuck in *addiction* (Buckingham, Frings & Albery, 2013:1132). Giving and receiving feedback from each other on pressing issues; acquiring constructive interpersonal skills and learning how to appropriately express their feelings, and expanding their repertoire of coping strategies to address the SUD-related challenges, by discussing and role-modelling it in a safe support group environment, promotes recovery.

Considering the feedback from the CSOs, there seems to be a need for more homogeneity in the group composition by paring of parents with children with SUDs, partners with spouses with SUDs, and children of parents with SUDs in separate groups. Some will focus and relate to either a relative's alcohol or drug addiction. Factors such as age, race, gender, life experiences and educational level were not mentioned as factors of concern for group composition.

The accounts presented thus far focused on suggestions for couple or marriage counselling and support groups, and its value as suggested by CSOs and their partners with the SUD. In the next section quotations are presented that gave rise to another category suggested by both CSOs and their partners with the SUDs that specifically focus on the aspect of an own-programme tailor-made for CSOs and programme stipulations related to such programme.

- Category 3.1.3: Own-programme tailor-made for CSOs and programme stipulations

As described in Chapter One of this report (see paragraph 1.1.1) the CSOs of partners with a SUD are severely affected by their condition. In their research, both Bradshaw et al. (2015:314) and Orford et al. (2009:380) found that the need and benefits for assisting these family members (the CSOs) in terms of their personal recovery is limited. These findings are supported by Wilson et al. (2017:57) who stated that more research is required into the help-seeking needs of CSOs of partners with a SUD as their involvement has traditionally been perceived as “adjunct treatment” for persons with a SUD. In addition, recent indications are that involving family members in the treatment of SUDs is coming under threat with a stronger emphasis on individualising addictions treatment due to restricted state funding (Selbekk & Sagvaag, 2016:1058), further underlining the need for support of CSOs as persons in their own right (Orford et al., 2009:380). The accounts below underscore the need for a tailor-made programme for CSOs of partners with a SUD.

Louna, as CSO-participant, suggested that all treatment centres should have a **programme separate** from that of the partner with the SUD, **catering specifically for the CSO living with a person with a SUD**: “...*They can include this [referring to assistance to CSOs of partners with a SUD] as a course, as part of their treatment programme. When the partner [CSO of the partner with a SUD] arrives [at the treatment facility] he/she can be introduced to the programme running separate from the programme of the addict. They don't have to stay over in the facility, but can attend weekly groups, for instance*”.

Ida, as partner with SUD, felt strongly that Andries, her fiancé, should attend support groups as part of the programme: “*Because I know how I feel attending a programme and what it did for me, especially sharing about your problem and get it [referring to their experiences living with someone with a SUD] into the open even if you do journaling or something ... I think for him to share in a programme where there are others sharing about the same problem would help him... They [referring to CSOs in general including Andries] will feel better sharing in groups in that they will*

feel that they are not alone and that there is hope... when you hear other people's stories it gives hope ... you see that there is light at the end of the tunnel."

Zane and Grace (two of the partners with a SUD) not only supported the idea of a **separate programme for CSOs**, but even suggested that the **attendance of such programme should be made compulsory** for the CSOs of partners with SUDs.

Zane suggested compulsory attendance as follows: *"Many of them can think 'you are the addict, so go and get yourself right, we will be on the outside waiting for you'. So, make them come in for a couple of sessions and make it compulsory and educate them in a couple of lessons"*.

Grace, said: *"I also think ... and I know it is 'our programme' [pointing to the partner with the SUD's treatment]... they [referring to the CSOs] have nothing to lose to have their own programme... [but]... they also need to sign a contract or agreement that prevents them to stop halfway..."* Grace further elaborated on the idea of an own programme for the CSO: *"...the partners [CSOs] who come here [indicating the treatment facility] only do so because the addict partner with a SUD] is here. Some partners will come regardless of the addict. So give them their own programme, run in their own time so that they don't have in the back of their mind that 'the only reason I am here is because of the addict'"*.

Grace emphasised the necessity for **CSOs to buy into the programme**: *"You know the thing is you need to get the supporters [CSOs] to buy into it. And that is the tricky bit. They need to buy into it to believe that first of all they have got issues that need to be worked on... once you get the buy-in that they are here to improve themselves, it becomes a lot easier. I think people, especially people in distress as we have touched on, see that they need to work on themselves... and it is almost a good crutch for them to say 'I am here to support my addict'. And that's fine, as long as you get them in here and once they grasp what is being shown to them, and feeling the togetherness and support in the group, that's what I went through. A few weeks down the line I look forward to coming to the group"*.

Paul, Grace's husband and a CSO-participant, in an earlier interview, agreed with having a **separate programme** and reflected on the **length of the programme** for CSOs in this way. *"I think the person on the programme must decide this. They will know when they have gone through each different lesson [indicating that there must be specific lessons on SUDs]... they have to complete the process. But I will not kick them off once they have done all the lessons... they can still attend groups for as long as they need to... But not too short, say a minimum of three months to go through all the lessons... but after that don't run away. If you need to stay, please continue"*.

Andries, a CSO-participant, also suggested that there should be a person who could be contacted by CSOs as part of **aftercare**: *"For me personally it will be good to know that there is a person available who could listen... I think I would be able to manage that"*. This account resonates with Wilson et al. (2017:56) when they endorse that "distance-based" services, such as telephone and online services provide readily available access to professional assistance.

To enable CSOs and partners with SUDs to **attend treatment and support interventions**, Olga suggested **providing child care for children**. This suggestion by the participants, resonates with Schonbrun et al. (2011:405) who found that making provision for child care while parents are in sessions is a practical way of removing possible obstacles that can prevent them from entering treatment. Wilson et al. (2017:56) too supported the idea that the aspect of child care was a barrier to the help-seeking of CSOs.

Olga, a CSO-participant, explained and suggested this: *"Also speaking from a mommy point of view, the programme must also be child friendly. Some parents have young children and they need looking after... I don't know how to say this, not all moms can trust others to leave their children with them. So maybe if there is a little child department, someone at the programme who can assist, where the children can be looked after while mommy is trying to sort herself out... I am one of those paranoid parents who don't believe in babysitters. I will not leave my children with my neighbours"*.

Andries suggested an **interactive web-based site** as alternative option running alongside the existing own programme as avenue to support CSOs. He motivated this suggestion along the following lines: *"I did not have the freedom to attend Thursday and Sunday meetings [referring to the days on which the support groups met]... if there is some form of technological advancement one can make... even just an e-mail address, so that I can, instead of always wondering how I find time to attend a meeting or whatever, I can simply pose a question on e-mail... It can be better to go online, which is something which can also be monitored and accessed during the night [of the group session] for feedback the next morning... and that could be helpful for a supporter [CSO] if that could be published on a website somewhere where it can simply be accessed. Even things like the results of research like this or different topics... it can all become a knowledge base for supporters to find answers for their questions"*. Regarding this account, we are informed by Wolf-Branigin (2009:340) that there are several studies that describe the application of internet technologies with the regard to the phenomenon of SUDs and related issues, including internet-based recovery and other web-based interventions replacing personal face to face social service interventions. Chuang and Yang (2014:39) further informs that information on alcohol (also other drugs) can additionally be found on Question and Answer websites or online support groups. None of these programmes however make provision for information which is CSO-specific.

This concludes the subtheme focusing on the subtheme of suggestions on the format in which social work support is to be offered to both CSOs and their partners with a SUD. The next subtheme will focus on the CSO' suggestions on the format in which social work support is to be offered.

4.3.3.2 Subtheme 3.2: CSOs' suggestions only on the format in which social work support should be offered

This subtheme branched in two categories which now becomes the focus of the discussion

- Category 3.2.1: One-on-one sessions for those who do not want to be in groups

Elsa, Olga and Anne, all CSO-participants, to the aspect of one-on-one sessions as a format for providing social work support to CSOs.

Elsa said: *"...maybe if the programme [for assisting the CSOs of a partner with a SUD] is more one-on-one. As a supporter and a partner, I am coming in here [referring to a treatment facility] and I know about the anonymity and... I am put into a group [as the programme is a group support programme, no individual sessions are provided] where I don't know anybody's circumstances... you don't know their [fellow group members'] backgrounds and... I don't feel comfortable... I have a trust issue at the best of times... And you [with reference to herself and other CSOs in general] are placed into a group... so for me personally I prefer one-on-one time. My circumstances are different to theirs [at the time Elsa joined the programme the majority CSOs were partners of drug abusers while she was in a relationship with a partner with a drinking problem]... and when I hear them talking about the problems they are going through I can't understand that because it is something I hadn't been through... like the husband taking stuff and stealing stuff and I don't know about that..."*

Based on **Olga's** own experience when she first came onto the programme [referring to the service offered to CSOs of partners with a SUD], she suggested one-on-one sessions as orientation for new persons coming on the programme: *"The one-on-one sessions allows to break the ice... in the beginning already you are scared when you walk into a situation... to walk into a group is very, very intimidating. So, speaking to somebody on a one-on-one first, it can explain how the programme works... it is like an introduction. It will break the ice so that you can be a little more open to for instance speak in a group"*.

Anne also suggested one-one-one sessions, stating: *"Groups are fine, but I would want to see it [referring to providing social work support to CSOs] implemented on an individual basis... maybe once a month as there are things one is not comfortable with sharing in a group... sometimes one feels emotional and you don't always want*

to cry in front of the others... also be a platform where both parties learn to understand what happened during addiction..."

- Category 3.2.2: Family sessions as a way for providing social work support

The negative effects of a SUD on individual family members and the family as a whole (Bradshaw et al., 2015:22), and more specifically the interaction between family members implies that interventions which provide for the person with a SUD are only excluding the other family members would "be less optimal" (Fals-Stewart et al., 2009:118). Olga and Anne (as CSO-participants) in their accounts presented below, attest to the suggestion that family sessions are a way for providing social work support.

Olga stated: *"First there are the individual sessions, then the groups and thirdly family intervention... What I mean by that is that we are living with my family...Then there is Danny and the two children. I am here I am getting myself fixed, but what about the other parties? We live in one household and I thought that this can also be important because all of us need help in one way or the other... I have two children aged five and seven and they seem fine on the outside, but I don't know how it has affected them".*

Anne also referred to the programme including the children at some stage: *"For me primarily, is the support towards the children. That is where there is a gap for me which I have not managed to address... I need to be able to explain to the children what happened and how to explain it as they have also been through all of this. Our children have not yet spoken to us about it. I know they are seeing a counsellor at school, but I need more support in this regard. Maybe we need to include an information section, maybe in the form of a seminar, where it can be explained on their level, what happens in addiction...?"*

These suggestions for family therapy as a format for social work intervention are supported by some documented literature. Lander et al. (2013:194) as well as Fals-Stewart (2009:194), point out that it is an established fact that the conditions created

by a SUD negatively affect the family as a whole. In the process of addiction, the person with a SUD develops and sustains interactions with family members by forming emotional patterns and rules (Nastasic, 2011:96). These contribute to the family members going into a survival mode (Mercado, 2000:70) as they attempt to cope with the accompanying stress. Winek et al. (2010:47) point out, it is the function of family therapy to proactively intervene to alter these dysfunctional patterns from a strength-based perspective, and then reinforce these structures once they are established. Historically, three models of family intervention stand out, namely the family disease approach, the family systems approach and behavioural approaches, the latter of which has proven to be the most successful (Klostermann & O'Farrell, 2013:236; Sprenkle, 2012:24; Fals-Stewart et al., 2009:116). Both Olga and Anne (quoted above) reflect on how they, as an entire family had been affected, and that they, as CSOs and also as parents of their children who had been affected, and they all require assistance to understand and contextualise these experiences.

4.3.4 THEME FOUR: ROLE-PLAYERS AT MESO-SYSTEM LEVEL IDENTIFIED TO PROVIDE SUPPORT TO CSOs LIVING WITH A PARTNER WITH A SUD

Orford et al. (in Wilson et al., 2017:56) felt that research to date has found that CSOs generally experienced professionals (not specified) as not being supportive as they lacked knowledge and understanding of the needs of family members caught up in SUDs. These findings resonated with the experiences of many of the CSO-participants in this study. Both CSOs and the partners with a SUD were asked to identify role-players whom they think need to have the knowledge and/or skills to assist the CSOs, Role-players, such as health and welfare professionals, lawyers and teachers are micro-system level individuals interfacing on meso-level system in the ecological-systems theory (Brakenhof & Slesnick, 2015:224-226). The support from these role-players and the interdisciplinary cooperation between such professionals and service providers, according to Daley and Feit (2013:614) is vital for referral in medical, psychiatric, psychological, social work. Similar principles would apply to combined treatments for CSOs and partners with SUDs. In Table 4.4 an exposition of the participants from the respective sample groups gave of role-

players who should be equipped to provide support to CSOs living with a partner with a SUD is provided.

Table 4.4: Overview of the role-players at meso-system level identified to provide support to CSOs living with a partner with a SUD

THEMES	SUBTHEMES
Role-players at meso-system level identified to provide support to CSOs living with a partner with a SUD	<ul style="list-style-type: none"> • 4.1 The court officials as role-players identified to provide support to CSOs • 4.2 Health and welfare professionals and ministers of religion identified as role-players to provide support • 4.3 Recovered CSO-volunteers identified as role-players to provide support

4.3.4.1 Subtheme 4.1: The court officials as role-players identified to provide support to CSOs

Only one person, namely **Elsa** suggested that the courts should be equipped to assist CSOs and the partners with a SUD: *“Well if you have somebody referred by the court to a rehab or treatment centre they [referring to the court officials] need to know where you need to go”*.

The Prevention and Treatment of Substance Abuse Act 70 of 2008 (South Africa, Chapter 8), makes provision for the courts to intervene in SUD and related matters. Questions can be asked whether the officials of the courts are sufficiently informed about the options, and also whether there are enough resources to provide for the services stipulated in the Act.

4.3.4.2 Subtheme 4.2: Health and welfare professionals and ministers of religion identified as role-players to provide support

CSOs and partners identified professionals with reference to medical practitioners, psychologists, social workers and ministers of religion to be equipped with the knowledge required to assist CSOs, as they are the main professionals CSOs first reach out to for help. These professionals exclude those who specialise in addiction or are employed at treatment facilities. After interrogating the data speaking to this subtheme, I came to the realisation that the medical doctors were the suggested professionals CSOs should reach out to as point of entry for treating SUDs and related issues.

William, a partner with a SUD suggested: *“Maybe one can educate them [referring to medical and welfare practitioners] in terms of resources that are available so if they don’t know what to do they can refer you somewhere. This should pertain to all doctors and certain sectors of other helpers”.*

Stefan, a partner with a SUD, was of the opinion that professionals including ministers of religion and social workers should be equipped with more knowledge: *“...inform professionals so that they can be equipped to assist addicts and their families more constructively. We must move on while the opportunity is there to support our spouses”.*

Louna (one of the CSO-participants) felt disappointed by the reaction of her pastor when she, as a last resort before leaving her husband, Stefan, approached him for assistance about her Stefan’s drinking problem. The pastor’s reaction implies that if he had been more knowledgeable he would have been able to assist: *You have to understand that his drinking reached the stage where I sued him [Stefan] for a divorce. Prior to this I spoke to our pastor and his response was that I had to pray about it...”*

Paul, a CSO-participant, suggested: *“It would be nice if GPs could be trained on recognising the problem in an addict, something I don’t think they are...Grace was a*

patient of our GP for a long time, for years, and he did not pick up on it...they would have to know of places, places like Mighty Wings, places like the one in Boksburg, Horizon... they should know that places like this exist”.

Anne, a CSO-participant, also recommended of doctors being better equipped about SUDs: *“GPs especially. I cannot recollect even one GP I have come across in all this time that knew about substance abuse or even noted it with Dicky [her husband]. Not that they looked out for it.”* When asked whether her doctor would know how to assist her, Ann responded: *“She probably would have prescribed something”.* **Dicky** stated that all the helping professions need to be better equipped: *“I don’t believe so... unless they themselves are directly affected by substance abuse. In general, they can’t know enough...they would have to be able to identify the problem and know how to address it... doctors and psychiatrists take the easy way out and prescribe something instead of referring on”.*

Jane, a CSO-participant, explained how she was unable to get assistance from professionals such as medical practitioners and ministers of religion: *“I have made numerous calls and the only answers I got was to take Honey to a rehab ...but nobody really offered any solution... all caregivers [she approached medical staff where Honey, her civil union partner was hospitalised, as well as the pastor at her church for assistance] should know where to refer her to, but also where I can find help”.* By implication it can be concluded that she did not get the assistance she wanted from them.

Kate, a CSO-participant, who worked for a doctor stated: *“He did receive some kind of training... he does not know about drugs very specifically. I am not sure that enough doctors know about it though...They [general practitioners] must be trained ... so that they know what to do and what works, and they will know where to refer one to”.*

Pertaining the meso-system level involvement, in SUDs and related interventions, Leahy, Schaffalitzky, Armstrong, Latham, McNicholas, Meagher, Nathan, O’Connor, O’Keane, Ryan, Smyth, Swan and Cullen (2015:122) in referring to the work of

Bronfenbrenner (1989, 2005), accentuate the importance of involving the extended family network, the local community and wider society. In this regard, specific reference is made to enhancing the capacity of health care professionals (Leahy et al., 2015:124), as well as ministers of religion and social workers who assist families crippled by substance addiction (Adedoyin et al., 2014:594). The need for further training resonates with the needs from those caught up in a SUD such as the CSO-participants in this study, referring to their accounts reflected in the previous paragraphs. In a UK-study by Orford et al. (2007:29-47) assessing a 5-step intervention programme in primary care for families caught up in a SUD, the majority of the 143 family participants strongly valued the contact to discuss their situation being exposed to a family member's SUD with a health care professional who was caring, informed and understanding towards their circumstances (Orford et al., 2007:42). Although these health-care professionals involved in the research were linked to a treatment facility, it verifies the need for their participation and therefor confirms a need for equipping these professionals as indicated by the participants. This need was further confirmed by a New Zealand study where 109 persons affected by a SUD, who attended an outpatient programme were asked what they expect from such a programme, to which 71% of the participants declared that they wanted to talk to a professional person with specialist knowledge of SUDs) to obtain practical advice to deal with their SUD (Pulford, Adams & Sheridan, 2011:224).

4.3.4.3 Subtheme 4.3: Recovered CSO-volunteers identified as role-players to provide support

Olga and Paul (both CSOs) suggested that partners who have been through the recovery programme could work as volunteers, either educating others or facilitating groups of CSOs.

Olga said: *"Then very last as well is that when you are strong enough to give back, working as a volunteer with wellness talks and all of that...and I think it is important educating youngsters. Educate them before there are any problems".* (I would educate them on) *the effects of drugs ... we have seen a lot of the effects of drugs,*

but I have never seen one picture of the effects on the supporter ... or something that says "the supporter goes through this".

Paul also mentioned that CSOs could do volunteer work: *"Yes, I think it will help...I don't see any negative side to it. They [CSOs] can stay on to facilitate groups".*

In supporting this category and the participants accounts presented, the following information is provided: As confirmed that by Viola, Ferrari, Davis and Jason (2009:111), the high rate of continued sobriety amongst persons with a SUD can be attributed to the fact they find purpose in becoming lay counsellors to fellow addicts. By helping others; through sharing experiences; suggesting alternative conduct and providing practical assistance that contribute to promote psychological well-being of the recovering person with a SUD through an improved self-esteem and increased faith in own ability to address problems (Smith et al., 2016:319), while assisting them to keep on the straight and narrow. I am of the view that this can also ring true for CSOs and that through what they have experienced, learned can be paid forward to support others in a similar position.

4.3.5 THEME FIVE: PARTICIPANTS' STRUGGLE TO REACH OUT AND FIND HELP AND SUGGESTIONS ON WAYS TO PUBLICISE INFORMATION ON SUPPORT TO CSOS LIVING WITH A PARTNER WITH A SUD AVAILABLE

Participants from both sample groups admitted how challenging it was to reach out for help and/or to request help and thus forwarded suggestions on ways in which information on support to CSOs living with a partner with a SUD could be made available (advertised or publicised). Their responses were divided into two subthemes with the second subthemes further branched into categories as depicted in the Table 4.5 on the following page.

Table 4.5: Overview of the theme, subthemes and categories related to Theme Five

THEMES	SUBTHEME 5.1	SUBTHEME 5.2
Participants' struggle to reach out for help and suggestions to publicise information on support to CSOs living with a partner with a SUD available	Participants' struggle to reach out for help – not knowing that help was available or where to find help	<p>Ways to publicise information available to support CSOs living with a partner with a SUD:</p> <ul style="list-style-type: none"> • Category 5.2.1: Print and public media as way to publicise information available to support CSOs living with a partner with a SUD • Category 5.2.2: Electronic media as way to publicise information available to support CSOs living with a partner with a SUD • Category 5.2.3: Social media as way to publicise information available to support CSOs living with a partner with a SUD • Category 5.2.4: Billboards and posters as way to publicise information available to support CSOs living with a partner with a SUD • Category 5.2.5: The workplace as an avenue to publicise information available to support CSOs living with a partner with a SUD

The subthemes reflected in the table above are presented next.

4.3.5.1 Subtheme 5.1: Participants' struggle to reach out for help – not knowing that help was available or where to find help

In respect of asking for help, one of the CSOs, namely **Linda** (a CSO-participant) was the exception as she was the only one who said she did not find it difficult to ask for help: *“I personally have never found it difficult to reach out for help. If I became aware that I need help, I would go and ask for it. I have always been open for help”*.

However, seven participants (see the accounts below) emphasised the struggle experienced in finding help and/or asking for help either as CSOs living with a partner with a SUD or being a person with a SUD.

Felicity, a CSO-participant, said: *“When I was confronted with this situation I did not even know what was wrong until he booked himself in at a rehab. At first he would say that he used occasionally but he never said he had a problem... so most people won’t know, until they are booked in for treatment, then that centre should have the skills to also accommodate rehab for the spouse...you are confused...you don’t know what to look for...that is what I experienced. Every time I would phone to find something out I did not really get answers.”*

Queen, as CSO-participant explained: *“I would most probably not have come for help... not enough is known about places that can offer help”*. She also later admitted how difficult it was to reach out for help with her partners’ addiction: *“... I could not speak with other people”*.

Tom, a partner with a SUD also stated: *“I did not even know about any place to go to myself until a friend of mine who was here [referring to MWLC] told me about Mighty Wings...”* [Tom continued] *...I know about another place in Benoni, which I drive past nearly every day... so that is the only one I know of... The programmes all only deal with the rehabilitator” (person with a SUD).*

Louna, a CSO-participant lamented the lack of information on assistance for partners: *“Well, firstly, there is no information available for partners such as myself in terms of what we are to do... no articles in magazines or books... and those that do refer to partners actually do so very superficially. There is nothing available in terms of guidelines to assist us with what to do; how can we protect ourselves, because if you don’t do it, it will destroy you... your self-worth is compromised... A lot of conflict surfaces when substances are abused something which inadvertently leads to verbal and physical abuse. But one is too scared to go and speak to somebody... So, if this was known more broadly in the media, the prejudice will decline, especially with reference to the partner [CSO]... We need this type of information”*. This account is

supported by Wilson et al. (2017:56) and Woodward, Misis & Griffin, (2014:939), when they draw attention to the fact that a CSOs' shame and concerns about the labelling and humiliation attached to SUDs (see Subtheme 2.3 under sub-section 3.3.2.3 in Chapter Three) is a specific issue for wives of problem alcohol user (also drug users), which makes it difficult for CSOs to seek for help.

Cindy, as a person with a SUD could not find help as she explained: *"I could not find any [help]. When I came here [referring to MWLC], my needs were not met so... maybe because I was in a very emotional state. But what did help I did keep in touch with one of the facilitators on this programme... If I was totally drained or felt I was losing my mind I would just pick up a phone and cry on the phone or talk".*

Paul, as CSO-participant, was also ignorant about any assistance: *"the fact is that at that stage [referring to the time he was urgently seeking help] I did not even know a place like Mighty Wings existed. I can't even remember how we came across it. You know, at that point all hope was just draining rapidly... the more people are stuck in the situation thinking that there is no way out, they need to know that there is".*

Olga, a CSO-participant stated: *"The first thing I wrote down [referring to her written narrative] is that a programme should be known. It must be marketed and easily accessible. I never even knew that programmes for us [CSOs] even existed, including this programme at Mighty Wings".*

4.3.5.2 Subtheme 5.2: Ways to publicise information available to support CSOs living with a partner with a SUD

Having agreed that it is difficult to find information on the resources available for CSOs living with persons with a SUD, the participants suggested ways to market or advertise information available to support CSOs living with a partner with a SUD. Their suggestions are presented next as categories.

- Category 5.2.1: Print and public media as way to publicise information available to support CSOs living with a partner with a SUD

Printed media with reference to newspaper articles and pamphlets and the public media, best known as radio and television are common channels for advertising services. It was therefore not strange for participants to refer to these mediums when prompted about how CSOs can be informed about support available to them giving rise to this category. Paul, Linda, Queen, Olga and Kate referred to printed media and Zane, Tom, Queen and Louna referred to public media to inform CSOs about support services for them, and by implication for persons with SUDs.

Linda, a CSO-participant suggested using newspapers to advertise: *“I read our local newspaper back to front. I read everything and I have found people who work with addiction place advertisements there...”*

Queen, a CSO-participant suggested using newspapers: *“...in daily newspapers that are read often, and then there must be a big article or advertisement and not a small block that nobody can notice”.*

Olga, as one of the CSO-participants suggested pamphlets when stating: *“Just to say that there is help. No one really asks for help, you are either too shy or too embarrassed and you don’t want to be identified. For those that need help there can be pamphlets and people can call anonymously... It must be general but can include drugs and alcohol, it can include abuse, sexual abuse, anything one is just too afraid of to talk about, things one is ashamed of... they can just lay around there afterwards... or one can put them in bathrooms, any place where you can just take one without being observed”.*

Kate, a CSO-participant, also mentioned pamphlets: *“One can put information in a leaflet or an advertisement. At our church we get a pamphlet we can complete during the service...on these same pamphlets one can also advertise”.*

Paul, one of the CSO-participants, suggested using the TV and radio: *“...maybe if there was some sort of Ad campaign, be it TV or radio...it could be just ten second*

spots: 'while you are in this situation, we can help, phone this number'. Just so that people are aware that there is something there...If I was in this situation and I heard an advert like that I would respond; the second time I listen more carefully; the third time I take down the number and eventually get to phoning them. Or I can imagine myself doing that...that is what I meant with the mock TV Ad: 'Are you in this situation? Are you an addict? Are you in a situation where you are living with an addict?' Just to make people aware ..."

Zane, a partner with a SUD referred to television as a way to publicise information: *"If there was maybe a programme on TV and she (CSO), could identify certain behaviour patterns, she can see why he is acting like that. But even then, they can a lot of the time look past it. Just to bring my mom into this, she saw me in active addiction, but thought I was normal. I would act a certain way and get away with it".*

Tom, a partner with a SUD referred to television as way of publicising information about support to CSOs when stating: *"...I don't really watch it. But I am sure it can work yeah, because everybody has got a television... everybody watches TV".*

Queen, a CSO-participant mentioned using television: *"...if you for instance watch a gambling programme they only have a small line underneath the picture. And in a soapie where you have a scene portraying abuse, they can place information for help afterwards..."*

Louna, as CSO-participant, advised that CSOs need to speak to someone and this message needs to be broadcasted: *"...go and speak to somebody. So, if we can bring this across more strongly in the media, for instance talks on the radio which usually covers a broad spectrum of topics, but never talks about partners... There is nowhere I could go to. We have to focus on the media. I have said earlier that they have a huge role to play. All of us watch TV or listen to the radio, at home or in the car..."*

Although an affinity was expressed for print and public media to advertise support services to CSOs (as deduced from the participants accounts provided), it is

interesting to note that none of the five CSO-participants referred to having accessed these types of media when they sought help for their situations (Chapter Three, paragraph 3.2.6). Also noteworthy is that accessing information this way is limited and not always readily available. With electronic advancement over the past two to three decades, a shift in obtaining and presenting information has allowed its distribution to be more interactive than presenting a brochure-like information page (Link, Hefner, Ford & Heurta, 2016:664). This coincides with what Best et al. (2016:257) refers to as a “generational shift in help-seeking” giving greater preference to electronic media.

- Category 5.2.2: Electronic media as way to publicise information available to support CSOs living with a partner with a SUD

Various authors refer to the fact that CSOs as well as their partners with the SUDs turn to the world-wide web for help in the quagmire of SUD (Wilson et al., 2017:60; Chuang & Yang, 2014; Woodward et al., 2014:939). This according to Wilson et al. (2017:60) is because many families with persons with a SUD perceive professionals as lacking an understanding of their plight when reaching out for help and support. Additionally, the shame; concerns about the prejudice, labelling and stigma attached to SUDs is a particular issue among wives and partners of persons with a SUD, something that makes it difficult for them to seek for help and inadvertently encourages them to access electronic media (Wilson et al., 2017:60; Chuang & Yang, 2014; Woodward et al., 2014:939). The use of electronic media in seeking help has many obvious benefits. It is more readily accessible to provide information by service users such as CSOs and it is available “anytime, anywhere, are affordable or freely available, and provide anonymity” (Wilson et al., 2017:60).

Although not offered as a means of marketing, Cindy, a CSO-participant indicated that she found information about assisting family members of persons with a SUD on the website. Three CSO participants, Paul, Anne and Linda, reflected on the use of electronic media by means of their story-lines.

Paul, explained: “...if someone is desperate enough to get information, they can go on to Google... informing people about addiction”.

Anne, suggested using the internet: “I would be inclined to Google it... there are numerous programmes listed on Google. Too many almost.”

Linda, made reference to Google: “...I would say that Google is the best option. I have however not tried to Google for it [seeking help] myself yet. Also, for example treatment centres for addicts... they can have a website... That is how I managed to find CAD”.

Referring to the account of Linda about Treatment Centres placing their services on websites, Link et al., (2014:664) avert that the Internet is one of the best marketing tools that can be employed at the treatment centres, provided that it is user-friendly and applicable.

Although acknowledging the advantages of accessing the Internet for information on SUDs, smartphones is becoming more affordable, and people generally becoming more literate technologically, a large number of CSOs still do not have access to the Internet. Wolf-Branigin (2009:342), makes reference to this when right-fully pointing out that some CSOs will lack the know-how to access this type of technological information or lack financial means do to so. An additional problem area is that information found on the world-wide web is not always scientifically scrutinised for correctness and often presents misleading viewpoints, superficial solutions and negative or derogatory comments about persons with SUDs and CSOs (McNeece & Madsen in McNeece and DiNitto, 2012:197).

- Category 5.2.3: Social media as way to publicise information available to support CSOs living with a partner with a SUD

Social media was also identified as a way of making information available to CSO partners with a SUD. Although it can also be regarded as electronic media, it is placed under a different heading as it is used for different purposes. Social media

includes the use of social networks (online communities) where ideas, information and interests are shared with others and takes on an interactive form (Wolf-Branigin, 2009:340). There are a variety of formats this can take on such as Facebook, Twitter, WhatsApp-groups, news-blogs and SMS, with an emphasis on the social component it holds where information is shared with others in layman terms (Chuang & Yang, 2014:39). The information or conversations placed on blogs and online media is publicly accessible, yet persons generally feel freer to share here than in a private face-to-face atmosphere, as they can choose to remain anonymous and do not need to develop a personal relationship with other internet users (Woodward et al., 2014:939). The use of social media as a form of information-seeking and peer support by CSOs resembles the purposes of support groups such as Al-Anon. The same benefits and barriers apply here as discussed under electronic media in the previous sub-section.

Three CSO-participants drew attention to social media as an avenue for making information available to support CSOs as can be seen from the accounts below:

In **Olga's** words, reflecting her experience and perception of his media: *"The use of social media is very popular nowadays"*.

Felicity, also referred to: *"Social media... I see there is a lot now on Facebook, posting a lot of things on drug addiction and rehab etc. But it does not give much detail really... but ja, people will look at it"*.

Anne mentioned: *"I would consider using twitter... it gives pop-ups when you visit a specific site...I would place it as a pop-up... We have the church, google, twitter, even agents or people you can contact when needed"*.

- Category 5.2.4: Billboards and posters as way to publicise information available to support CSOs living with a partner with a SUD

Billboards and posters were also suggested as good means of marketing programmes for CSOs. Three CSO-participants referred to this form of marketing.

Tom suggested: *“So let’s be honest, in my opinion people won’t pick up and browse through a magazine, rather put it on a billboard or poster or something”.*

Jane proposed: *“Also they can put up information posters in malls, with information and hotlines for people such as me”.*

Elsa, recommended telemarketing by using TV-screens in doctors’ rooms and pharmacies to make information available to support CSOs: *“If you go to the doctor’s rooms, they have got those TV screens. I have seen that done...I recall sitting in the X-ray room looking at the screen and they have all sorts of adverts on there. You find it on screens when you wait for your prescription at Dischem¹⁹ they also have it up there”.*

- Category 5.2.5: The workplace as an avenue to publicise information available to support CSOs living with a partner with a SUD

Using the workplace as avenue where programmes CSOs could be marketed was suggested through employee-assistance programme initiative and talks.

Olga, a CSO-participant said: *“Workplace programmes where they do talks and so on, like at our place where they have programmes for female wellness”.*

Jane, a CSO-participant had this suggestion: *“There are many opportunities for companies to inform us all on a variety of matters, and substance abuse can also be highlighted. Life skills classes can also benefit all employees”.* **Honey** her partner also supported the use of EAPs: *“Yes, because as adult you take these things more seriously, you have more responsibilities ...it will have a bigger impact”.*

Kate, as CSO-participant recommended: *“...I would say about educating at workplaces... Talk about this and talk about that... they have AIDS awareness and*

¹⁹ Dischem is a pharmacy retail store that specialises, among other things in prescription and over-the-counter medication, beauty products, health food, sport supplements, health and well-being services

that... They come out to companies once a year and do awareness programmes and that would also be helpful”.

Felicity suggested that information for CSOs (like herself) should be built into health and safety in the workplace: *“Maybe make it a law, like health and safety. Like we have in companies; if somebody is intoxicated he can’t work, so maybe we can work it in there as health and safety training that employees have to go through? That could be a possibility as every company now by law has to provide for health and safety... somewhere, something can trigger something”.*

Many places of work are exposed to manifestation of SUDs amongst employees, and as pointed out by McNeece and Madsen (in McNeece and DiNitto, 2012:181), an employee affected by a SUD’s work-related performance can suffer. Workplace intervention, according to Kinney (2012:467) is widely regarded as the most efficient and cost-effective way of assisting the person with a SUD and family members. As pointed out by Burnhams and Parry (2015:10) the growing increase in SUDs in the workplace internationally, warrants a more health-orientated approach and, referring to the South African situation, it requires of employers to move away from the traditional approaches of addressing substance abuse and apply broader-based methods including all possible stake-holders including families, the medical profession, psychologists, cultural and religious interventions as well as support groups to provide an holistic approach and following effective international trends.

In summary, although several ways of marketing information about services for CSOs are offered by participants it seems clear that access to electronic and social media, due to its availability, anonymity and interactive nature is becoming the primary vehicle to do so. In support of this Link et al. (2014:665) pointed out that in 2011 more than 80% of adults reflected that they have accessed the internet for health care information which assisted them in their choice of service they wanted to follow. This can well be taken note of in making information and support services available on SUDs; its treatment and help offered to the help-seeking needs of CSOs.

4.4 CHAPTER SUMMARY

At the outset of this Chapter the biographical information on the 12 partners with the SUDs obtained as participant through using the network of their CSOs, was presented.

This was followed by providing an overview of the five themes mainly centred on the topic of suggestions for social work support to CSOs gleaned from the perspectives of both sample groups. The respective themes, their subthemes and categories were then presented.

The first theme focused on the partners with SUDs admitting that CSOs were severely affected by their substance addiction and needed social work support.

Theme Two emphasised the topics/aspects to be covered in providing social work support to the CSOs of partners with a SUD; a total of 11 different topics were mentioned, with the CSOs and their partners with a SUD suggesting seven similar topics respectively. These topical suggestions were: Information on the topic of drugs and its effects, setting of personal and relationship boundaries, communication skills for effective partner interaction, acquiring anger management skills, rebuilding of the self-esteem, aspects related to parenting and relapse and how to manage it. The CSOs only mentioned three additional topics, namely: requiring practical skills in assisting the partner with a SUD, general life skills and decision-making skills as well as regaining self-confidence and independency. The partners with a SUD only suggested the topic of re-establishing trust in the relationship.

Theme Three concentrated on suggestions related to the format the social work support should take. The CSOs and partners with a SUD agreed that support must be provided by way of couple or marriage counselling, group sessions and emphasised the need for a tailor-made programme to be developed focusing specifically on the CSOs and their needs. Additionally, the CSOs also suggested one-on-one sessions for those, who for various reasons do not want to be in a

support group; and family interventions to specifically pay attention to the effect of the SUD on the children, and how this should be dealt with.

Under theme four the meso-system level role-players that were recommended to provide support for the CSOs living with a partner with a SUD were identified and it was suggested that they be properly trained for the job at hand to assist the CSOs in a professional and efficient fashion. Court-officials were mentioned, as many persons with a SUD clash with the law, as well as professional persons, especially medical practitioners and ministers of religion. The suggestion for CSOs to assist fellow CSOs living with partners with SUDs was also forwarded.

With Theme Five the focus shifted to the participants' struggle to reach out for help and suggestions on how to support CSOs living with a partner with a SUD by providing appropriate and accurate information. Suggestions in this area included advertising support services to CSOs by using printed, public, electronic and social media, billboards and posters, as well as by means of workplace programmes.

In the following chapter, I will reflect on the conclusions derived from data collected, and recommendations will be forwarded.

CHAPTER FIVE

SUMMARIES, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter, entitled “Summaries, conclusions, limitations and recommendations” is the last chapter of this thesis. In Chapter One the reader was informed that, in the more than 30 years of my engagement in social work practice, I have consulted clients with substance use disorders (SUDs) and their spouses, partners, parents and children (commonly referred to as CSOs). I was particularly troubled by the intense hardships and challenges suffered and experienced by CSOs living with a family member with a SUD. This initiated in me a keen interest in going on a research journey to investigate the experiences, challenges and coping strategies of CSOs living with a partner with a SUD. However, before embarking on this research journey, I undertook a literature search to study and appraise the current state of the knowledge on this as a selected topic to investigate. Resulting from this I observed a trend, confirmed by various authors, that literature and research endeavours that focused on partners of persons with a SUD is small when comparing it to research and literature available on substance abuse, the treatment of a person with a SUD and the impact of SUDs on CSOs, and them being the focus of treatment on their own right (Wilson, 2017:57; Orford et al. 2009:380; Copello et al., 2005:376).

After due consideration, I decided to engage three individuals regarded by their peer practitioners as experts in the field of SUDs and its treatment, to take part in a preliminary pilot project. The aim was to get their views on whether treatment programmes, catering exclusively for the needs of CSOs of partners with a SUD were available in practice and whether such a treatment mode was needed or not. Their views affirmed that the existing treatment programmes and interventions available in practice are predominantly geared towards the person with the SUD and are insufficient to adequately address the primary treatment needs of CSO-partners

living with a partner with a SUD. They all indicated the need for a separate programme catering for the needs of CSO-partners. Expanding the small-scale pilot study to also obtain the views of CSOs with partners with a SUD, I randomly engaged five CSO-partners who, at the time attended a support programme together with the substance addictive partner, with the aim of finding out if they had received any professional help-seeking advice in their own right related to the fact of living with a partner with a SUD. I subsequently found out that none of them had received any SUD-specific professional help for dealing with their experiences in living with a partner with a SUD before joining the programme they were currently attending.

With these thoughts in mind, I set out to structure a research problem for this thesis. My own practice observations, the trends observed in the literature and the confirmation received from experts in the field and CSO-service users convinced me that a two-pronged research problem existed which Creswell (2016:88) refers to as “real-life” and “literature-related” problems, informing and underpinning this investigation:

- *First, living in an addictive home is like living in a whirlwind (Perkinson, 2008:242) as a family member’s SUD turns homes into sporadic unpredictable and out-of-control environment. The CSOs of the partner with the SUD become so preoccupied with the latter situation, sacrificing their own time, needs, energies and resources to manage this whirlwind, that they even begin to adopt maladaptive coping skills to survive (Perkinson, 2008:242; Orford et al., 2009:382, Cox et al., 2013:165). The people with SUDs who enter into treatment programmes dominate the treatment agenda with their CSOs playing second fiddle to their treatment regimes. The CSO partners are mainly instrumental, serving as an adjunct or a helper for the sake of the partner with the SUD involved in the treatment to help achieve an acceptable treatment outcome for them (Wilson, 2015:57; Copello et al., 2005:369). In most treatment programmes and initiatives available, the CSOs of partners with SUDs’ personal professional treatment needs go unattended unless they, in their own right, seldom receive specialised treatment to heal and recover from the many scars a whirlwind SUD causes (Wilson et al., 2017:57).*

- *Second, there is a lacuna in home-grown treatment and recovery programmes from the ambit of social work for the CSOs, per se, who live with a partner with a SUD.*

These identified research problems led to the formulation of three overarching-research questions (see Chapter 1: sub-section 1.3.1), guiding the process towards the realisation of the three goals formulated for this study which were to develop an in-depth understanding of how CSOs experience living with a partner with a SUD; the challenges they encounter in this regard; and their ways of coping amidst these circumstances. In addition, and by means of following a “bottoms-up” approach or obtaining an insider perspective (Mathani,2004:56), I aimed to establish how, and with what CSOs living with a partner with a SUD, would like social workers to support them. Ultimately, this information will be used to inform guidelines for social work intervention to be used in practice and to benefit and help other professionals and service organisations and support groups providing services to CSOs and their partners with SUDs as a recommendation, and as an outcome of this research.

As first step, in working towards fulfilling the stated aims of the study, a research plan was drafted and, when putting this report together, became part of Chapter One of this report. This research plan was submitted to the UNISA Social Work Department’s Research and Ethics Committee for scrutiny, approval, and for granting ethical clearance and permission to conduct the research. Once this Committee had granted permission for me to execute the research plan, I embarked on the journey of recruiting individual for participating in this study, according to the designated populations identified, and screened potential individuals eligibility for participation. I did all of this in an ethical and responsible fashion and prepared them for data collection which, once collected I analysed. The process of how the research plan was executed is placed on record in Chapter Two of this thesis.

The data collected had been thematically analysed for presentation as research findings in Chapters Three and Four of this report. In Chapter Three the themes, were further divided into subthemes focusing on the reported experiences, challenges and coping strategies of a CSO living with a partner with a SUD. In

Chapter Four the suggestions forwarded by both the CSOs and their partners with the SUD were presented as themes, subthemes and categories (where applicable) as they emerged from the processes of data analysis and the consensus discussion where the mentioned themes, subthemes and categories were finalised.

In this, the final chapter, a brief chapter summary will contain summaries and conclusions that concerned the salient aspects from each of the previous chapters, and cover the findings that emerged (specifically with reference to Chapters Three and Four). Leading to closing this chapter, discussions on the inherent limitations that emerged during this research endeavour; recommendations for further education and training; continuous professional development; and an agenda for future research will complete this work.

5.2 CHAPTER-WISE SUMMARY AND CONCLUSIONS

In the following sections I will provide a summarised overview of each of the chapters of the report together with related recommendations before stating the guidelines for social work support of the CSOs of a partners with SUDs.

5.2.1 Summary and conclusions: Chapter One - General introduction and orientation to the study

In employing the *BIS-principle*, Thomas (2017:4) proposes, I structured the general orientation and introduction to the study by providing *background* information to indicate the topic's situatedness in the scholarly literature surrounding it, highlighted the research problem or *issue* and motivated my intention on how to *solve* the identified problem.

5.2.1.1 The *background* to the topic

Under the sub-section focusing on background to, the historical overview, and the current state of the knowledge on the topic were mentioned. The ravaging impact of alcohol and substance abuse on families and communities and society at large were

noted, as well as how families were disintegrating because of the continuing damaging effects of a relative's problematic SUD-related behaviour, were indicated. The impact this has on the respective family members were highlighted pointing to feelings of anxiousness, low self-esteem, feelings of loneliness, rejection and worthlessness. Some even blame themselves for being responsible for a family member's substance abuse (Marinus et al., 2017; McCann et al., 2017; Askian et al., 2016; Wesley, 2016; South African National Drug Master Plan, 2013:1; Cox et al., 2013; Matsimbi 2012; Rowe, 2012; Munro & Allan, 2011; Gudzinskiene & Gedminiene, 2010; Hitzeroth & Kramer 2010; Orford et al., 2009; Perkinson 2008; Copello et al., 2005) This was followed by presenting a *historical overview* of society's and service provider's perceptions of substance addiction, how they perceive its causes and contributing factors and how treatment initiatives evolved was another point of interest mentioned. Initially, substance addiction was viewed from a (im)moral behavioural point of view (Moss, 2015:119; Clark, 2012:1750), thereafter regarded as a disease (Wiens & Walker, 2014:309; Gudzinskiene & Gedminiene, 2010:162). Currently it is viewed more holistically with SUDs being caused by an interplay of behavioural, disease and societal variables (Raheb et al., 2016:210; Adedoyin et al., 2014:594; Linley, Mendoza & Resko, 2014:643). The ways of treating the person with a SUD has also evolved from treating the affected individual only to treatment modalities involving the spouse and the family as focus of treatment. (Munro and Allan, 2011:174).

The discussion focus then shifted to *emphasising the role of CSOs* living with a person with a SUD and its development, dating from the 1930s. Initially CSOs were seen as perpetrators to the problem of SUDs in that they contributed to marital problems due to their own issues that which led to a partner's addiction and sustaining it and/or as a result of their behaviour (Klostermann et al., 2011:1502-1503; Tarter, 1976:741; Bullock & Mudd, 1958:526). This, in turn, brought the notion of CSOs being "co-dependent" into the equation (Kinney, 2012:214; Dear & Roberts, 2005:294; Boylin & Anderson, 2005:3). Currently, and after de-pathologising the CSO-partner's strain and reframing it as strain experienced resulting from the impact of living with a partner with a SUD (Wilson et al., 2017:57). CSOs are now seen as the "victims" and not the instigators to the problem. Their behaviour and actions are

attributed to that of a concerned significant other with the SUD (Rowe, 2012; Dear & Roberts, 2005; Beatty, 1992; Futterman 1953; Whalen, 1953; Jellinek, 1942; Peabody, 1936). The involvement of the CSOs of the partner with a SUD in treatment started in the 1970s in order to help motivate the person with a SUD to go for help and then help to sustain sobriety (Kinney, 2012:306; Klostermann, et al., 2011:1503; Copello et al., 2005:369; Meyers et al., 2002:286)

Four models (approaches) involving partners or family members into treatment were highlighted and discussed, namely: the Family Disease Model, the Community Reinforcement and Family Therapy Approach, the Systems Model and the Harm Reduction Approach (Sherrel & Gutierrez, 2014; Rowe, 2011; Denning, 2010; Gudzinskiene and Gedminiene, 2010; Loughran, 2006; Copello et al., 2005).

In the literature consulted, reference to the fact that CSOs as partners with a SUD, were traditionally conceptualised as an adjunct to the treatment of a partner with a SUD, or as an agent of change (Wilson et al., 2017:57; Peled & Sacks, 2008:400). CSOs, were not viewed as help-seekers in their own right (Orford et al. in Wilson et al., 2017:57; Wilson, 2017:57) acting to meet their own needs when looking for professional treatment *in an effort for them to heal from the many-varied scars sustained in living with a partner with a SUD.*

In Chapter One I also (as well as under the introduction to this Chapter) introduced the outcome of two small-scale pilot studies I undertook with three social work practitioners considered by their peers to be experts in the field of SUDs and treatment, and five CSOs at a community-based support centre for treatment of persons with SUDs to verify the lack of focus on CSOs as help-seekers in their own right and confirm the merit of the research project undertaken on the chosen topic.

Given the background to; the historical overview, and the current state of the knowledge on the topic provided, the research problem was indicated and articulated as a problem statement (see Chapter One: sub-section 1.1.2; Chapter Five: sub-section 5.1). Reflecting on all the information presented I arrived at the conclusion that CSOs living with a partner with a SUD are being exposed to adverse

circumstances (Nooripour et al., 2013:29; Hudson et al., 2002:171). The CSO-partners are at an increased risk for intimate partner or domestic violence, depression, stress, anxiety, financial stress, physical health problems, and relationship challenges (Wilson et al., 2017:56; Fals-Stewart, O'Farrell, & Lam, 2009:380; Copello et al., 2005:370). In this plot of living with a partner with the SUD the CSOs were previously depicted as the perpetrators by holding them responsible for the partner's substance addiction and/or maintaining it. After the consultation of the literature, I arrived at the conclusion that the CSO-partners are currently recognised as "help-seekers in their own right" (Orford et al., in Wilson, 2017:57; Wilson, 2017:57; Hudson et al., 2002:172)) and in need of professional help to deal and recover from the partner's SUD. I further concluded that such treatment programmes and initiatives tailor-made for and exclusively directed at treatment of CSOs of partners with SUD where to large extends lacking in practice, and no such programmes could be found in the ambit of the social work literature consulted.

The rationale or motivation for the study was presented in this Chapter and the envisaged contribution of this study highlighted. With reference to the latter I can conclude that through this research endeavour I made a three-pronged contribution. I managed to

- provide an example of how qualitative research can be applied in practice through the description of this presented in Chapter Two of this report.
- contribute to the body of knowledge specifically on the topic CSOs' experiences, challenges and coping strategies in relation to living with a partner with a SUD and their suggestion for social work support (see Chapter Three and Four).
- contribute to the field of social work practice, specifically the arena of SUD-treatment programmes through the recommended guidelines for social work intervention to support CSOs living with a partner with a SUD.

In the Chapter being summarised I also introduced the theoretical frameworks adopted to guide this study. Theoretical frameworks can fulfil many purposes in the context of research. It can serve as a spotlight highlighting a phenomenon (Fair in Green, 2014:34) or as tool to explain an issue or describe the problems and

adversities experienced by individuals and families. The constructs of a theory can even serve as coat hooks to hook the data on (Thomas, 2017:99; Maxwell, 2013:49-50; Ambrosino et al., 2012:46; Teater, 2010:1). The strength-based perspective, resiliency theory and ecological systems theory was selected for this purpose. The strength-based perspective, commonly referred to in social work theory and practice (Guo and Tsui, 2010:233; Lietz, 2004:29) accentuates service-users' self-determination and strengths. In working from a strength-based approach, social workers view the service-users as resourceful and resilient in the face of adversity (Munoz et al., 2017:102; Bottrell, 2009:323, Greene et al., 2003:76). This ties in with tenets of the resiliency theory which, in short, can be summarised as the strengths employed by people and systems enabling them to rise above and bounce back from adversity (McCleary & Figley, 2017:2; Greene, 2014:937; Hammel, 2008:8). The ecological systems theory situates the individual in relation to other ecosystems. It provides of a better understanding of service-users in their environments; how the interactions and transactions between various sub-systems and system levels reciprocally form, inform and influence each other and their contribution in the causation and maintenance of social problems (Joly, 2016:1254; Darling 2007:204). In addition, the ecological systems theory also highlights the strengths and resources inherently present at the various system-levels, micro, meso, macro and exo that could be put to service in the discovery and nurturing of strengths and resiliency (Ahmed, Amer & Killawi, 2017:48-49; Shaw et al., 2016:36; Winkler, 2014:475). With reference to the ecological systems theory, as one of the adopted theoretical frameworks for the study, I can conclude it provided me with insight that the cause of substance addiction can systemically sought intra-personally, interpersonally and environmentally. Substance addiction not only affects the person who is addicted, but also the CSO-partner, the couple and the family systems and other meso-level micro-systems (Ebersohn & Bouwer, 2015:2; Pavelova, 2014:105). Departing from the ecological systems perspective, I also concluded that to address the challenges of CSOs living with a partner with a SUD calls for a multi-system level intervention. As Pardeck, (1988:141) noted all the systems are involved and can facilitate the enhancement of social functioning of CSOs and their partners with the SUDs. These include the extended family system, the neighbourhood, community and other critical social systems.

On reflection, the trifocal theoretical framework adopted in this study, and especially after exploring the experiences, challenges and coping strategies of CSOs living with a partner with a SUD, I concluded that, through this research endeavour in which I promoted the CSOs as the main characters in this micro-system level dyadic plot of substance addiction, they do not fit the label of “pathological victims”. They can from a strength-based perspective and through applying the resiliency theory, rather be seen as the “courageous victors” (Monk et al., 1997:4). Should CSOs living with a partner with a SUD continue to see themselves as “victims”, according to Peled and Sacks (2008:400), they might be prevented from accessing the social and professional support in our societies. Their adversities should be appraised by noticing how they continuously bounce back from them entitling them to be regarded as worthy victims seeking help in their own right.

5.2.1.2 Research questions, goals and objectives formulated for the study

Forming part of Chapter One, and emanating from the two-pronged research problem identified (Chapter One, sub-section 1.3.1); research questions were formulated to guide this investigation. In addition, research goals were formulated with objectives to become the steps to the realisation of the stated goals. In the discussion to follow, and by way of summary, the research questions, goals and objectives are repeated and conclusions are drawn to indicate if the questions were answered and the stated goals and objectives met.

The research questions proposed for the study were as follows:

- *What are the experiences, challenges and coping strategies in relation to living with partner with a SUD?* The answers to this research question are covered in Chapter Three of this report. The responses from CSO-participants reflected that the experience of living with a person with a SUD is extremely stressful, impacting negatively upon them and changing them personally and socially. Their partners’ SUD and resulting related behaviour ignited feelings of anger and frustration left them feeling trapped, lonely, sad, embarrassed, humiliated, hopeless, inferior, and hurt. They also experienced feelings of shame which eventually caused them to detach emotionally from their

partners. The challenges experienced revolved around poor communication, arguments, accusations, intimate partner violence, and the substance addicted partner's lack of responsibility, erratic, reckless and manipulative behaviour. The influence of the partners' SUD on the children and the CSOs' fear of the partner's possible relapse were also mentioned as challenges. Various coping strategies were reported. These included: covering up the partner's SUD; turning to abusing substances themselves as a way of coping; setting boundaries and self-care; threatening to leave or divorce the partner, or requesting the partner to leave; obtaining a protection order and enlisting the help of the police; avoiding the partner and withdrawing from social life; taking control; managing to keep the home life together and reaching out for help.

- *How and with what would CSOs living with a partner with a SUD like to be supported by social workers?* This question was answered in Chapter Four of this report where the suggestions for social work support obtained from the CSO-participants as well as from their partners with the SUD, who were recruited as additional sample group, are presented. The partners with the SUD's unequivocally admitted that their CSO-partners were severely affected by their substance addiction and were in need of social work support. For both the CSOs and the partners with the SUD as participants the topical aspects to be covered during the provision of social work support were many. These included: information on the topic of drugs and its effects; personal and relational boundary-setting; skills in effective partner communication; anger management skills, rebuilding self-esteem, parenting skills and information on relapse and its management. In addition, the CSO-participants wanted information on how to behave towards the partner with the SUD; life-skills and decision-making skills, and how to regain self-confidence and independence. Couple and marriage counselling and support group sessions were suggested by participants from both sample groups as was an own-programme, tailor-made for the CSO, as were suggestions for how such programmes should be offered. Both participant groups also identified court officials, health and welfare professionals and ministers of religion and recovered CSO-volunteers

as ones who should be knowledgeable and helpful individuals with whom CSOs could speak to about their concerns. These persons were at the interface of societal problems and need to be accessible; they are situated at micro-systems and meso-system level and should knowledge and skill-wised informed by SUDs and be skilful to support CSOs. Given the participants' struggle to reach out for help, participants from both sample groups offered suggestions on how to publicise information on support available CSOs living with a partner with a SUD.

Given the information obtained from the participants and presented as research findings in Chapters Three and Four of this report I can conclude that the stated research question formulated at the outset of the study as sign-post guiding this endeavour were answered.

The summary of the goals as formulated for this research endeavour and the conclusion of their realisation is depicted in Table 5.1 below.

Table 5.1 Summary of the goals for the study and the conclusions on its realisation

The following goals were formulated at the outset of the study: To -	Conclusive statement on the realisation of the stated goals formulated for the study.
<ul style="list-style-type: none"> develop an in-depth understanding of the experiences, challenges and coping strategies of a CSOs living with a partner with a SUD 	I obtained an in-depth understanding of the experiences, challenges and coping strategies of a CSOs living with a partner with a SUD which I have comprehensively described in Chapter Three of this report.
<ul style="list-style-type: none"> report on the suggestions on how and with what CSOs living with a partner with a SUD would like to be supported by social workers 	In Chapter Four I provided a comprehensive account of the suggestions from both participant groups on how and with what CSOs living with a partner with a SUD would like to be supported by social workers
<ul style="list-style-type: none"> proffer guidelines for social work intervention to support CSOs living with a partner with a SUD. 	In this Chapter under the sub-heading of recommendations I present the guidelines for social work intervention supporting CSOs living with a partner with a SUD.

Given the information provided in Table 5.1, I can confirm and conclude that the goals formulated for this study were met.

To assist with realising the goal, I formulated a number of research objectives. These are indicated below and italics underneath each of the stated objectives I would provide cross-references to the places in the report where these objectives were operationalised as confirmatory conclusion that these objectives, originally stated at the outset, had been met.

To

- obtain a sample of CSOs living with a partner with a SUD in Benoni, Pretoria, and Randburg

In Chapter Two (sub-section 2.5.1) I presented a description on how I obtained a sample of CSOs living with a partner with a SUD in the mentioned geographical areas. In addition, I also in the same Chapter (see Table 2.1 and specifically the information provided next to the characteristic “qualitative research embraces the idea of an emergent design) how I decided to expand the population to also include another sample group, namely: the CSOs-partner’s with the SUD, and my motivation for doing so.

- collect data by means of a narrative writing exercise and individual in-depth interviews.

For the description on how this objective was operationalised the reader is referred to Chapter 2 (see sub-section 2.6) where I provided a description on how I prepared the CSO-participants for the processes of data analysis with respect to the narrative writing exercise and two follow-up individual in-depth interviews. In this same section I also described how I prepared the partners with the SUD as participants for the individual in-depth interviews I had with them. A description is also provided on the instructions provided for completing the narrative exercise and the aspects and topical question that were to be covered in the in-depth interviews with the respective sampled participant groups.

- explore the experiences, challenges and coping strategies of CSOs living with a partner with a SUD and suggestions on how and with what they would like to be supported by social workers.

The exploration of the mentioned aspects in this objective was done through the methods of data collection as mentioned in the previous objective and explained under sub-section 2.6 in Chapter Two.

- analyse the data thematically, implementing the eight steps of Tesch, (in Creswell, 2014:198).

Under sub-section 1.6.5 in Chapter One these steps for qualitative data analysis as proposed by Tesch (in Creswell, 2014:198) were introduced and the reader is referred to sub-section 2.7 in Chapter 2 for the description on how I applied these steps to analyse the data in meeting this stated objective.

- describe the explored experiences, challenges and coping strategies of CSOs living with a partner with a SUD and suggestions on how and with what they would like to be supported by social workers.

For the description of these aspect referred to in the objective mentioned the readers are referred to Chapters Three and Four of this report where the findings are presented.

- interpret the data and conduct a literature control.

In addressing this objective, the respective themes were mostly divided into subthemes and presented as such. In a few instances the information under a subtheme was further divided and presented as categories. Storylines quoted from the narratives and the transcribed interviews were used to substantiate the mentioned themes, subthemes and categories. Extant literature was used mainly to confirm the thematic research findings or to provide a back-drop to a specific theme, subtheme (and where applicable, a category).

- draw conclusions and make recommendations comprising of guidelines for social work intervention to support CSOs living with a partner with a SUD.

This Chapter serves as testimony of the realisation of this objective in that it details the conclusions arrived at and the recommendations forwarded, inclusive of the guidelines for social work intervention to support CSOs living with a partner with a SUD.

In concluding this summary of Chapter One of this report, the second part of this chapter will be devoted to introducing the research plan with reference to the research approach and design adopted for the study. A qualitative research approach was decided upon and the collective instrumental case study and phenomenological research designs and an explorative, descriptive and contextual strategy of inquiry were adopted as it befits the qualitative research approach. The proposed research methods inherent in the chosen approach and research design, were introduced focusing specifically on the aspects of the research population, sampling, participant recruitment, preparation for and methods of data collection, data analysis and verification. Furthermore, it was indicated how the ethical principles would be upheld, followed by the clarification of the key concepts in this study.

In reflecting on the compilation of the research plan and how challenging this exercise was, I arrived at the conclusion that the time and effort devoted to this exercise of drafting the research plan was extremely important as it helped me to focus, made me aware how crucial a research plan is for a research endeavour to succeed – it is proverbially the foundation on which the house is built.

5.2.2 Summary and conclusions: Chapter Two - An applied description of qualitative research process

Chapter Two commenced with a motivation for why it was deemed necessary to devote a whole chapter of this thesis to a description of how the research plan was applied. Two reasons were indicated. The first was to inform the reader how the research plan, which in the domain of qualitative research is commonly regarded as a “rough sketch” (Devers & Frankel, 2000:253), was filled in and/or adjusted, and completed by specifically describing how the initial plan was operationalised. Second, this chapter had to serve as the basis for a research audit trail in that it had to contain a systematic account the research approach, design and methods as well as a record of the researcher’s choices; decision pathways taken, and interpretation done during the research process.

I proceeded by expanding on the description provided on the nature of *qualitative research* (as adopted *approach* for the study) introduced in Chapter One (see sub-section 1.4.1) and in tabulated format indicated how the following characteristics inherent to qualitative research were applied in the research process. From the literature consulted (indicated below) on characteristics of qualitative research and how these were applied in this study, I can by way of conclusion confirm that qualitative research

- is geared towards a complex detailed understanding and description of an issue following an in-depth exploration and by using multiple sources of data collection (D’Cruz & Jones, 2014:21; Morrow, 2007:211; Mathani, 2004:53, 57);
- holds the promise of empowering participants (Dyregrov et al., 2011:687; Kvale, in Rizq, 2008:43);
- allows for a factual and flexible style of writing and reporting (Lichtman, 2014:45; Creswell, 2014:205);
- acknowledges the context surrounding the issue being investigated (Fontana and Prokos in White and Drew, 2011:9; Hennink et al., 2011:110; Mathani, 2004:55);
- aims to address knowledge gaps;

- focuses on narratives, themes and stories (Lichtman, 2014:45; Gosselin, 2012:48; Frey et al., in Chesebro & Borisoff, 2007:6);
- is in-depth and on small scale (Creswell, 2016:7; Wu, et al., 2016:499; Hennink et al., 2011:84; Suri, 2011:65).
- relies on the researcher as primary instrument for data collection and analysis (Creswell, 2014:185; Yilmaz, 2013:317; Pezalla, Pettigrew & Miller-Day, 2012:167; Borland, 2011:7);
- occurs in natural settings (Creswell, 2016:6; Creswell, 2014:185; Chesebro & Borisoff, 2007:8);
- deals with the whole (Mathani, 2004:55; Lichtman, 2014:42);
- is inductive (Creswell & Poth, 2018:63; Pistrang & Barker, 2012:6; Nicholls, 2009:531);
- embraces the idea of an emergent design (Brown in Lichtman, 2014:40; Yilmaz, 2013:312; Maxwell, 2013:30).

In addition, and owing to the fact that the qualitative research approach is favoured for investigating ill-defined and under-researched topics, and by engaging vulnerable and marginalised populations (Creswell, 2016:8; Dempsey, et al., 2016:480; Ritchie & Lewis, 2005:32-33), I arrived at the conclusion that this emergent, inductive, interpretive and naturalistic approach (Yilmaz, 2013:312) was well-suited for investigating the experiences, challenges and coping strategies of CSOs living with a partner with a SUD, as well as to gather suggestions on how, and with what, they would like to be supported by social workers. What rendered the qualitative research more appropriate was the fact that the topic of CSOs living with a partner with a SUD and their help-seeking for social work has been ill-researched (McCann et al., 2017:19; Wilson et al., 2017:56; Orford et al., 2009:380; Copello et al., 2005:380). Adding to this is the reality that for many the topic of one's own SUD, or the SUD of a relative is enclosed in stigma and shame, making this a vulnerable and sensitive topic and the people affected by this, a vulnerable group (Creswell, 2016:8; Dempsey et al., 2016:480).

Concerning the aspect of *research design*, I employed the collective instrumental case study design and the phenomenological research design, regarded as

qualitative research designs (Hood, 2016:170), as well as an explorative, descriptive and contextual strategy of inquiry. The collective instrumental case study was employed as it afforded me an in-depth exploration of the experiences, challenges and coping strategies of CSOs in relation to living with a partner with a SUD, across multiple cases, using of various data collection methods (Boblin et al., 2013:1268; Wahyuni, 2012:72; Creswell et al., 2007:245, 246). Upon reflection I arrived at the conclusion that this design was well-suited given the goals of the study. By employing the collective case study instrumentally, it, in particular, enabled me to realise the goals of gaining in-depth insight into the phenomenon under investigation. It facilitated the process of gathering suggestions informing practice by way of the recommended guidelines for social work intervention supporting CSOs. I also came to the conclusion that the phenomenological research design adopted was a good-fit as it allowed me to explore, specifically, the lived-experiences of the CSO-participants in the context of their partnership relationships with partners with SUDs. Operating from a phenomenological stance, I requested them to transform these lived-experiences into consciousness and articulate the meaning and the connotations they attach to these life experiences (Bakanay & Çakır, 2016:163; Hood, 2016:165; Yates & Leggett, 2016:229; Hudson, et al., 2015:362, Turner, et al., 2013:307; Finlay, 2012:172).

Due to a scarcity in the scholarly literature on social work interventions focusing exclusively on the support of CSOs of a partner with a SUD, the explorative research design was applicable. The descriptive research design as a strategy of inquiry, upon reflecting and conclusion appeared to be an apt decision as it allowed for a comprehensive description of the experiences, challenges and coping strategies of CSO living with a partner with a SUD (see Chapter Three), as well as their suggestions for social work support (see Chapter Four). I considered the participants' personal and relationship contexts in relation to their living with a partner with a SUD; in Chapter Three and Chapter Four and presented the biographical particulars of the participants. In doing so, I addressed aspects related to the socio-cultural context. In addition, as part of the contextual design, I provided what Hennink et al. (2011:288) refer to as the "methodological context" by describing the settings where the data was collected and the accompanying logistics and

challenges. Finally, by including and describing the strength-based perspective, the ecological-systems theory and the resiliency theory as theoretical frameworks for the study, I provided the “theoretical context” in that it became the background for the research findings (Wu et al., 2016:498; Maxwell, 2013:49; Hennink et al., 2011:288).

In reflecting on the collective instrumental case study design and the phenomenological research design as well as the explorative, descriptive and contextual strategy of inquiry employed in this study I can conclude that these designs were well-suited and befitting in that it helped in one way or another to realise the goals set for this study.

Reflecting on the aspect of *population and sampling*, the initial population from which a sample was drawn comprised of all CSOs, with specific reference to spouses, partners, and fiancées of partners with a SUD living in the Gauteng Province of South Africa and more specifically in the cities of Pretoria, Randburg and the East Rand. Given my decision to also include their partners with the SUDs to share their thoughts and suggestions on how their spouse, partners and fiancées (as CSOs) could be supported by social workers in this context of living with them as partners with a SUD, I had expanded the boundaries of the population to also include them as an additional sample group.

I can conclude that the decision to demarcate the geographical boundaries of the study to the mentioned cities within the Gauteng Province, in addition to the fact that they readily accessible for me who resides and works in Pretoria it also turned out to be a cost and time-wise consideration.

Within the stated geographical boundaries mentioned under population, I reached out to existing treatment centres and support groups for persons with SUDs, and their significant others in these areas, as social settings where likeminded people congregate, an activity Trotter (2012:400) refers to as “geographical sampling”. I identified individuals at these settings I could contact them with the request to act as gatekeepers. Not only would and did they assist me to gain entry to the research settings, but they also were instrumental in referring individuals who showed an

interest in participating in this research project to me or arranged for me to get in contact with such interested individuals. I recruited participants for the sample of CSOs purposively according to an inclusion criteria list devised for this purpose (see Chapter 1: sub-section 1.5.1). Purposive sampling implies that I used my own judgment in selecting participants who would be in the best position to provide, an information-rich, experience-based, and first-hand perspective on the topic under investigation and invite them intentionally to bring their perspectives into the study (Patton in Reybold et al., 2012:700; Dudley, 2011:145; Abrams, 2010:538; Padgett, 2008; 53; Flick, 2007:27; Sheppard, 2004:94). As for the partners with the SUD as participants, I for all practical reasons used an existing network with reference to the CSO-sample group to recruit their partners with a SUD for the sample of partners with a SUD. However, this latter group had to also meet the criteria of inclusion devised in respect of them (see Chapter Two, sub-section 2.5.1), resembling the notion of purposive participant recruitment.

In reflection on the participant recruitment strategy employed, I arrived at the conclusion that the recruitment strategy followed for identifying social settings and individuals at these settings was appropriate. To focus on what Trotter (2012:399) refers to as geographical sampling, I went to settings where persons with SUD and their partners congregate; identified gatekeepers and people who could introduce me to individuals who might be interested in participating in this research endeavour. This in my view was a good and beneficial strategy to obtain a sample of information-rich CSO-participants. Using an existing network of CSO participants to assist in recruiting their partners with the SUD for participation in this study was also a fitting decision taken.

Prior to the embarking on the collection of data process from the sampled participants, I undertook a pilot study. Several researchers used the strategy of a pilot study with the aim to refine the research instruments (Singh, 2015:137; Gillham in Sampson, 2004:385) and to do a dress rehearsal on the logistics and activities related to data collection and the implementation of the data collection methods (Singh, 2015:138; Yin, 2011:37; Kim, 2010:191). Also suggested in the literature is that the pilot study provide an opportunity for assessing the researcher's ability and

readiness to execute the qualitative data collection process (Beebe & Lancaster in Kim, 2010:191; Neale et al., 2005:1588).

One CSO participant, Mandy and her husband Philip, was selected for and agreed to participating in the pilot study. Mandy, as well as Philip took part in all the data collection activities planned for the main study. Mandy on completion of the data collection process indicated that the process and format of the methods of data collection was fine and she would not change anything except that she hinted the involvement of her husband could also be beneficial to provide for a more comprehensive understanding on the support needs of CSO-partners living with a partner with a SUD. Phillip, after the interview with him, also had no suggestions for further change in respect of the questions in the interview-guide and the method of data collection he was engaged in.

As depicted in Chapter Two (see sub-sections 2.4.1 and 2.6) the *methods of data collection* employed with the CSO participants included a narrative writing exercise, complemented by two follow-up individual in-depth interviews. With the written exercise the CSO participants were requested to write a “story” about their experiences, challenges and coping strategies in relation to living with a person with a SUD. The written exercise was complemented by a first follow-up individual, in-depth interview, during which the content of the written narrative was further explored and clarified. In the second follow-up individual in-depth interview the respective CSO participants were requested to forward suggestions on how they and others in a similar position could be supported by social workers in view of living with a partner with a SUD. Additionally, in-depth individual interviews were conducted with the partners with a SUD to get their views and suggestions on how and with what social workers can support the CSOs living with a partner with a SUD.

In reflecting on the methods of data collection employed with the respective participant groups I arrived at the conclusion that implementing these selected methods of data collection were appropriately suited for obtaining the information required to answer the research questions. In addition, to the data collection methods allowing the CSO-participants to share their experiences, challenges and

coping strategies as it relates to living with a partner with a SUD, they benefitted the CSOs in terms of gaining (additional) insight into the issues being discussed resulting in increased self-awareness; experiencing feelings of empowerment, and a sense of purpose (Dyregrov et al., 2011:687; Gale in Rizq, 2008:42). I also concluded that for their partners with the SUDs, the in-depth interviews held with them in a sense forced and encouraged them to divert the focus from themselves, and to reflect on the impact their substance addiction had, or maybe still was exerting on the relationships with their partners. I therefore deduced that this was an insightful experience to this participant-group. For me as the primary instrument of data collection, engaging with both the CSOs and the partners with the SUD as participants allowed me an exclusive first-hand opportunity to gain insight into the CSOs experiences.

The data collected were subsequently analysed according to the eight steps of thematic data analysis as suggested by Tesch (in Creswell, 2014:198). In reflecting on the step-wise approach to and manner for analysing the data I conclude that it assisted me to tackle this mammoth task of managing the large volumes of data and eased the process of analysing it in an orderly and systematic fashion. I also enlisted the services of an independent coder to analyse the data set independently. This decision taken, although money-wise a costly exercise, upon reflection and conclusion was money spend wisely as it assisted with authenticating and substantiating the findings I deduced from the collected data, and in so doing enhanced the trustworthiness of the findings (Wahyuni, 2010:72)

As qualitative research primarily focuses on interpreting and describing the subjective meaning of experiences in order to develop greater understanding of a phenomenon (Lichtman, 2014:8-12; Rubin & Babbie, 2013:40; Popay, Rogers & Williams in Fossey et al., 2002:723), such interpretations and descriptions must comply with scientific standards, especially obtaining *trustworthiness* or validity; rigor as well as subjectivity and creativity must be incorporated (Rubin & Babbie, 2013:261; Sarantakos, 2013:102; McBrien, 2008:1289; Johnson in Whitemore et al., 2001:522). For the purpose of this study, I had chosen to follow Guba's classical model of trustworthiness in qualitative research as referred to by various authors

(Lietz & Zayas, 2010; Shenton, 20014: Krefting, 1991), employing the four general criteria to assess research, namely credibility, transferability, dependability and confirmability, as it applies to qualitative research. The various strategies I employed (depicted in sub-section 2.8.1 of Chapter Two) to enhance this study's credibility, transferability, dependability and confirmability, of the mentioned criteria, upon reflection and in conclusion, supported me to comply with the scientific standards of validity and rigour required in planning and implementing a research project and reporting the research findings.

As social research has to be conducted in an ethically responsible fashion it calls on the researcher to display academic integrity and honesty, and respect for other people (Thomas, 2017:520; Punch, 2016:23). Mindfulness about the ethics to be observed and the ethical challenges to be addressed was considered through the research endeavour from its conception to its completion (Richards, 2015:15). In this regard, I adopted the following ethical principles for this research project obtaining informed consent, confidentiality and anonymity, minimising harm and debriefing, as well as management of information. Both participant groups were informed about the aim of the study and what their participation would entail; their consent to participation were sought and it was clearly stated they were under no obligation to participate and could, without any penalty, withdrew from the research at any stage. I upheld anonymity insofar the participants' identities were concerned and managed the data in a confidential fashion. I ensured that their participation did not result in any obvious harm being experienced. Debriefing of participants was also put in place should the need arise. Involving the participants with regard to the ethical principles set them at ease to participate spontaneously.

In reflection, I can conclude that conducting myself in an ethical manner, acting with honesty and integrity, and applying the mentioned ethical principles, especially, in recognition of the fact that the participants are perceived to be vulnerable (as explained earlier in this Chapter) contributed to the participants feeling safe. This further served to the advantage of this research endeavour in that with the participants feeling secure and at ease they were open to share their experiences, challenges, coping strategies, suggestions and views openly and honestly favouring

me in the developing an in-depth insight into the phenomenon being researched and ensured that the guidelines for social work support to be recommended are service user-based and informed.

5.2.3 Summary and conclusions: Chapter Three - Research findings of the experiences, challenges and coping strategies of a CSO living with a partner with a SUD

Concerning the demographic particulars of the 12 CSO-participants, the following information was reported. Ten of them are female; two male, with nine being White and three, Coloured. Their ages ranged from 23 to 61 years of age. The length of the relationships with their respective partners ranged from three to 35 years. Seven of the CSOs were married, two were engaged, two living together, and one was in civil union. Nine of the CSO-participants reported to having children with the number amongst them ranging from one to three children.

Concerning the qualifications of participants, three had tertiary qualifications, with eight of the participants stating Matric as their highest educational qualification and one person indicated Grade 10 as her highest educational qualification. Eleven of the CSO-participants were gainfully employed at the time of the fieldwork, and one was retired.

At the time of the research, nine of the CSOs' partners were at intermitted states of sobriety in that they were either still using substances or had relapsed on a number of occasions. Only three of the CSO participants' partners managed to stay sober for more than twelve months. Five of the twelve CSOs have sought help for their circumstances. Three CSOs admitted to having used or abused substances themselves.

In reflecting on the biographical information provided I arrived at the following conclusions:

- Six of the twelve participants fit into the stage of young adulthood (ranging from 18-40 years of age) and the other six in the middle adulthood stage (40-

65 years of age) according to Erikson's life stages of psycho-social development (Dunkel & Harbke, 2017:59; Donald, et al., 2010:60-64).

- Nine of the twelve CSO-participants are female of which of eight of them were at the time of the fieldwork in relationships with male counterparts confirming the trend I want to present as conclusion that in general, more males than females are inclined to get involved in abuse of chemical substances (Rodriquez, et al., 2013:628; Sudhinaraset, et al., 2013:35; Cranford, et al., 2011:21).

The remainder of this chapter was devoted to presenting the findings related to the experiences, challenges and coping strategies of the CSO participants in relation to living with a partner with a SUD under six themes to be briefly summarised next and the conclusion drawn presented. The consulted literature resonating with these respective research findings are also indicated.

- **Theme One: CSOs' experiences of living with a partner with a SUD**

The CSO-participants described their relationship experience living with a partner with a SUD as being stressful (Wilson, et al., 2017:57; Wood, et al., 2017:36; Nagesh, 2015:373; McCann, et al., 2017:2; Gupta et al., 2014:81; Hudson et al., 2014:106; Rodriquez et al., 2014:294). Some reported that substance addiction contributed to their partner's distrustfulness (Fletcher, 2013:328; Nastasic, 2011:94). Their partners' SUDs and addiction-related behaviour and personality changed them into becoming different to who they used to be (O'Brien et al., 2016:68; Dethier et al., 2011:152). The partners' substance addiction resulted in some of the CSOs becoming isolated and trapped resulting in a state of emotional enmeshment (Nagesh, 2015:374; McNeece & DiNitto, 2012; Kinney, 2012; Denning, 2010; Gudzinskiene & Gedminiene, 2010; Perkinson, 2008).

From the research findings presented under this theme of CSOs' experiences of living with a partner with a SUD I draw the conclusion that for these participants it was overall a negative experience, impacting on their personal safety and their psychosocial well-being and growth.

- **Theme Two: CSOs' feelings and emotional reactions to their partners' SUD**

After reflecting on the feelings and emotional reactions reported by the participants experienced in relation to their partners SUD, I concluded the feelings and emotional reactions were, without exception, all negative. They pointed to experiencing a variety of feelings and emotional reactions. These related to feelings of anger and frustration (Wilson et al., 2017:56; Nagesh, 2015:374; Perkinson, 2008:241); feeling trapped and lonely in their partner's all-consuming web of SUD. (Perkinson, 2008:406; Black, 2001:15); feelings of sadness, embarrassment, shame, humiliation, despair, hopelessness and fear (Wilson, et al., 2017:56; McCann et al., 2017:4; O'Doherty et al., 2016:227; Klostermann & O'Farrell, 2013:235; Dethier et al., 2011:152; Tangney & Dearing in Hernandez & Mendoza, 2011:376; Gostecnik et al., 2010:371; Peled & Sacks, 2008:398). Some of them also indicated feeling inferior and blamed themselves for their circumstances (Askian et al., 2016:276; Tangney & Dearing in Hernandez & Mendoza, 2011:376; Peled & Sacks, 2008:398; Perkinson, 2008:245). In addition, feelings of hurt and shame were expressed and eventual emotional detachment from their partners with a SUD (Weiss et al., 2016:428; Hudson et al., 2014:106; Peled & Sacks, 2008:395).

- **Theme Three: Challenges experienced regarding a partners' SUD-related behaviours**

The CSOs reported experiencing an array of challenges emanating from their partners' SUD-resultant behaviour. For some of them their partners' substance addictions were challenging their relationships in that it impaired the communication between them (Klostermann & O'Farrell, 2013:235; Dethier et al., 2011:151-152; Craig, 2004:173), caused the substance addictive partners to become argumentative and accusatory²⁰, even resorting to intimate partner violence (Choenni et al., 2017:37; Wilson et al, 2017:123; Choo, Guthrie, Mello, Wetle, Ranney, Tape &

²⁰ This tendency of being argumentative and accusatory ties in with the subtheme referred to that the addictive partner's personality changes when under the influence or intoxicated.

Zlotnick, 2016:195; Guthrie & Kunkel, 2016:435; O'Brien et al., 2016:88; Rodriguez, Overup & Neighbours., 2014; Hudson et al., 2014:106; Klostermann & O'Farrell, 2013:235; Gostecnik et al., 2010:370). Another challenge reported was that the partners got so consumed in their addictions that they neglected their responsibility of taking care for themselves, household matters (like financial obligations) and/or their primary relationships (Nagesh, 2015:374; Randle et al., 2015:81; Gupta et al., 2014:82; Rodriguez et al., 2014:299; Husaarts et al., 2011:38; Nastasić, 2011:93). The manipulative, erratic and often reckless behaviour the CSOs attributed to their partners' substance addictions was highlighted as another challenge causing tension in their relationships (Prout, et al., 2015:124; Hawkins & Hawkins in McNeece & DiNitto, 2012:260; Husaarts et al., 2012: 38; Kinney, 2011:201). The impact that the partner's addiction exerted on the children was also mentioned as a challenge (Lander et al., 2013:194, 197; Hawkins & Hawkins in McNeece & DiNitto, 2011:256-284; Jesuraj, 2012:33-43; Perkinson, 2008:240-248; Copello et al., 2005:369-385; Black, 1982:22). The partner's possibility of relapsing was furthermore expressed as both a fear and a challenge (O'Farrell & Schein, 2011:202).

From the challenges reported by the CSOs I arrived at the conclusion that a partner's substance addiction (or SUD) disrupted and threatened the bio-psycho-social functioning, well-being and intimate relationships at micro-level, starting with affecting the person with the addiction and extending to those significant others they closely interacted with and were related to.

- **Theme Four: Coping strategies employed to mitigate and manage the experiences and challenges related to living with a partner with a SUD**

In view of mitigating and managing the experiences and challenges the CSOs experienced in relation to their partners' substance addiction, they reported the employing the following coping strategies.

Some of them coped by covering up the partner's SUD by keeping a façade; pretending that all is fine at the home front; trying to keep the family together; taking over responsibilities (Askian et al., 2016:270; Jesuraj, 2012:37; Peled & Sacks,

2008:395; Perkinson, 2008:244; Craig, 2004:176), and lying and making excuses for the partner. In addition, the CSOs also reported threatening to leave or divorce, or requested the partner to leave as coping strategies, with three of them also obtaining a protection order and enlisted the help of the police as ways of coping (McCann et al., 2017:2; Gupta et al., 2014:84). Avoiding or withdrawal from the partner and from social life (friends and family) to spare embarrassment was the way of coping reported by some of the CSOs²¹ (McCann et al., 2017:2; Klostermann & O'Farrell, 2013:235; Kinney, 2012:210; Hussaarts et al., 2011:44; Gostecnik et al., 2010:371). Taking control and managing home-life in an attempt to keep the family together (Lander et al., 2013:196; Peled & Sacks, 2008:395; Craig, 2004:179) was a further coping strategy reported. Reaching out for help to manage and cope with the partner's SUD also came to the fore (Jason et al., 2016:335; Toner & Velleman, 2014:147; Kinney, 2012:211; Lewis et al., 2011:173).

In reflecting on the coping strategies used by the CSOs to mitigate and manage the experiences and challenges the CSOs encountered in relation to their partners' substance addiction, I arrived at the following conclusions: The CSOs' coping strategies employed resonated with what Papalia et al. (2007:425) termed as "adaptive" and "maladaptive" coping. The former being considered a constructive way of coping while the latter is viewed as a non-constructive way of coping which is explained by these authors as striking out at others or indulging oneself which can be translated as giving oneself up, or handing the reins over. The CSO-participants coping strategies also corresponded with responding to the challenges by either "putting up", with them, "withdrawing" from them or "standing up" to them, mentioned as ways of coping by McCann et al. (2017:02) in the context of substance abusing partners' aggression, violence and substance abuse-related behaviours. Against this background, I concluded that CSOs coping strategies of covering up, adopting the philosophy of joining in with the partner's SUD, blocking out feelings, withdrawing, and taking over responsibilities are indulging ways of coping, or ways of putting up with the current state of affairs or withdrawing from it, all pointing to maladaptive

²¹ This coping strategy ties in with the coping strategy of covering up, as well as with the aspect of emotional enmeshment mentioned under Theme 1 above

ways of coping. It can even be labelled “enabling” coping strategies, inadvertently allowing the person with the SUD to continue abusing (Hawkins & Hawkins in McNeece & DiNitto, 2012:263; Perkinson, 2008:244; Craig, 2004:176). The CSOs references to focusing on work; keeping busy, threatening to leave or divorce, or requesting the partner to leave or obtaining a protection order and enlisting the help of the police and reaching out as additional coping strategies employed can be considered adaptive ways of coping, or standing up – taking action. Considering the coping strategies mentioned, I further concluded that the respective CSOs in their attempts to cope with a partner’s SUD did not only resort to applying only adaptive or maladaptive coping strategies, but used a combination of both. This caused me to further conclude that a partner’s SUD can be so emotionally and psychologically taxing on the non-using partner, that employing maladaptive coping under certain circumstances and in response to the challenges experienced can be seen as the only way of coping in order to survive.

- **Theme Five: CSOs’ accounts of what motivated their partners to enter treatment**

From the CSOs’ accounts of what motivated their partners to enter treatment they reported the following: Partners being hospitalised for SUD-related incidences, a partner’s affair coming into the open resulting in the issue of the substance addiction being spotlighted, the CSO’s decision to leave her husband and obtaining a protection order, filing for a divorce, giving the partner an ultimatum to go for treatment or the relationship will end, obtaining a court order to force partners to enter treatment, and the partners decided on their own to go for treatment after being motivated by their CSOs. The most, if not all, these factors can be regarded, what the literature refers to, as “external” motivators (Stokes, 2017:106-110; Meyers, Roozen, Smith & Evans, 2014:300; Fletcher, 2001:53-56; Sterk et al., 2000:845) in that they “coerced” the partner to “choose” to go for treatment.

Concerning the aspect of some of the CSOs motivating their partners to go for treatment it confirms the literature pointing out that the CSOs are an important adjunct to substance addicted partner’s treatment, with them becoming agents of

change and in the efforts of maintaining sobriety (Daley & Feit, 2013:161; Denning, 2010:164; Peled & Sacks, 2008:400).

- **Theme Six: CSOs' views on the future prospects of their relationship with the partner with a SUD**

With the reality of relapse being an integrated part of SUDs and recovery (Yang, Mamy, Gao & Xiao, 2015:1), I enlisted the CSOs views on the future prospects of their relationships with their partners with the SUDs. From their responses, the following three subthemes were deduced: Some CSOs saw a future for their relationships with their partners and undertook to remain committed to their relationships with their partners and will not give up on them; others forecasted their future relationships with their respective partners as conditional – if they relapse, they leave, and some saw their future relationship prospects with their partners as uncertain with no guarantees.

A final conclusion on Chapter Three: The CSO-participants accounts on their experiences, challenges and coping strategies in relation to living with a partner with a SUD as presented under the six themes (divided into subthemes) as presented in Chapter Three and summarised and concluded here contributed to the realisation of the first research goal formulated for the study and contributed to the body of knowledge on the topic of CSO-partners in the context of a partner's SUD.

5.2.4 Summary and conclusions: Chapter Four - Research findings on suggestions for social workers support to CSOs of a partner with a SUD - CSOs and their partner with the SUDs' suggestions

Concerning the demographic particulars of the partners with the SUD as sample group the following was reported: Nine are male and three female and their ages ranged from 22 to 64 years of age. Nine of them are White and Three Coloured and when comparing this with their CSO-partners racial groupings none of the couples were in mixed partnership. Jane and Honey was at the time of the fieldwork in a same-sex marriage (civil union).

One of the participants indicated a tertiary qualification as highest educational qualification; nine had completed Matric, with two who report their highest educational qualification as Grade 10. As was the case with the CSOs, all of their partners with the SUD were gainfully employed at the time of the fieldwork.

Gleaning from the ages of the partners with the SUDs in view of writing a conclusion, it became clear that seven fit into Stage 6 (Intimacy versus Isolation, or young adulthood) of Erikson's psychosocial developmental stage life-cycle (Linerós & Fincher, 2014:41). Five of the partners with the SUD were in Stage 7 – Generativity versus Stagnation or middle adulthood. Eleven of the couples were in the same stage of their lifecycle with one couple, Elsa (young adulthood) and William (middle adulthood) being in different stages. Another conclusion arrived at was that the partners' SUD hampered and/or extended both their and their CSO-partners' completion of their respective psychosocial life-stage developmental outcomes. For the couples who were in the development life-stage of intimacy versus isolation, partners' SUD interrupted the achievement of intimacy in their partnership relationships – instead it created isolation and loneliness. This appeared to especially true for the SUD-participants given fact that substance addiction has the propensity to consume and isolate the person entangled in the addiction (Kinney, 2011:202; Hagedorn & Hirshhorn, 2009:48). For the couples who were in the developmental life-stage of "generativity versus despair", the SUD encroached on partners with addiction's ability to acquire generativity. The addiction turned them into self-absorbing individuals who became stagnant leading to deterioration at multiple levels putting the CSOs in states of despair. (Rowe, 2012:60; Kinney, 2011:201).

The remainder of this chapter was devoted to presenting the findings related to the suggestions for social work support forwarded by both the CSO-participants as well their partners with the SUDs. This was presented under five themes which branched out into subthemes to be briefly summarised next, and the conclusion drawn presented. The consulted literature resonated with these respective research findings are also indicated.

- **Theme One: Partners' with SUDs admitting that partners were severely affected by their substance addiction and are in need of social work support**

All the partners with a SUD admitted that their CSO-partners had been adversely affected by their substance abuse and addiction stating and were of the view that the CSOs require professional help (Fals-Stewart et al., 2009:118; Peled & Sacks, 2008:390; Arkin et al., 1990:125-126) and could benefit from social work support. This finding was supported by literature indicating that one spouse's SUD negatively affects a marriage with both the abusing and the non-abusing spouses facing physical, emotional, social and economic difficulties impacting negative on marital satisfaction (Saunders et al., 2016:237-243; Cox et al., 2013:161-162; Nooripour et al., 2013:26; Amato & Previti, 2013:161; O'Farrell and Clements, 2012:123; Kinney, 2011:301-339; Cranford, et al., 2011:211). Reflecting on my social work involvement with service users with SUD and their significant other, I can conclude that this research finding and the literature confirming this is true and that social work support for CSOs help-seekers in their own right is required (Wilson et al., 2017:57).

- **Theme Two: Participants' suggestions on topical aspects to be covered during the provision of social work support to the CSOs**

Seven topical aspects were suggested by both the CSOs and partners with a SUD to be covered during the provision of social work support to CSO. These included providing information about drugs and its effects (Haskell et al., 2016:11; Sherrell & Gutierrez, 2014:27; McNeece & DiNitto, 2012:151; Orford et al. 2009:391; Orford et al., 2007:34, 36; Craig, 2004:177-178) helping them to set personal and relationship boundaries (Galea in Green, 2014:944; Orford et al., 2007:34; Pagiun, 2006:128); communication skills (Nooripour, et al., 2013:26; Fals-Stewart et al., 2009:119), anger management training (Lloyd et al., 2017); the rebuilding of their self-esteem (Pardini et al., 2000:347), parenting skills, and managing SUD relapses (Ferrari et al., 2014:856; Farabee et al., 2013:206). The CSOs added to this the need for practical advice (Rhodes, et al., 2017:126; Haskell et al., 2016:1; Toner & Velleman,

2014:147; Cullen & Carr, 1999:523; Arkin et al., 1990:126), acquiring life-skills and decision-making skills, and re-building self-confidence (Rodriguez et al., 2014:299; Denning, 2010:166; Peled & Sacks, 2008:400).

It can be accepted by way of conclusion that the suggested topics are relevant for inclusion in a social work intervention programme for CSOs and will be helpful in supporting the recovery of both the CSO and partner with a SUD in the journey to recovery and maintenance of sobriety.

- **Theme Three: Participants' suggestions on the format in which the social work support is to be offered**

Suggestions on the format in which social work support should be offered were requested from both CSO and their partners with a SUD. They suggested couple or marriage counselling (McCrady, et al., 2016:443-459; Wesley, 2016:89-92; Fletcher, 2013:327-352; Klostermann & O'Farrell, 2013:234-247; O'Farrell & Clements, 2012:122-144; Sprenkle, 2012:3-29; Fals-Stewart, et al., 2009:115-125; McCollum, et al., 2003:1-19); support group sessions (McNeece & DiNitto, 2012:135; Kinney, 2012:310), as well as establishing an own tailor-made programme for CSOs (Wilson et al., 2017:57; Orford et al., 2009:380). In addition, the CSOs suggested one-on-one sessions for those who do not want to be in groups, as well as family sessions to accommodate children in the relationship (Fals-Stewart et al., 2009:118).

It is concluded that all the suggested formats forwarded for social work support to the CSOs, and the couple and family as system at the micro-level; confirmed by the literature consulted; are directive and functional in view of the guidelines for social work intervention to support CSOs to be recommended.

- **Theme Four: Role-players at meso-system level identified to provide support to CSOs living with a partner with a SUD**

Most of the participants in this study mentioned the challenge experienced in finding appropriate professional support for either their own substance addiction or support for their partner. The participants in Wilson et al.'s (2017:56) study focusing on the aspect of how online counselling can support partners of individuals with problem alcohol or drug use mentioned a similar problem. The participants from my study made mention of several professionals at the meso-system level to offer support to both the CSOs and their partners with SUDs. These included medical practitioners, psychologists, social workers and ministers of religion as well as court officials, (Leahy et al., 2015:124, Pulford et al., 2011:224; Orford et al., 2007:42. They further suggested that these professionals, as part of their training or continuous professional development, need to be equipped with the knowledge required to assist CSOs either in their professional capacity or by networking with others involved in the field of SUDs. It was also suggested that those CSOs who have recovered can be trained to provide information and support.

- **Theme Five: Participants' struggle to reach out and find help and suggestions on ways to publicise information on support for CSOs living with a partner with a SUD**

Participants indicated that they struggled to reach out for help because they do not know that help was available or where to find it. Considering the lack of knowledge and skills of professionals as reflected in the previous theme, they also felt that appropriate and accessible information about CSOs was not available and suggested ways of marketing and making such information available. Similar suggestions appeared in consulted literature like publicising information in the print media (Link, Hefner, Ford & Heurta 2016:664), electronic and social media (Wilson et al., 2017:60; Chuang & Yang, 2014; Woodward et al., 2014:939; Wolf-Branigin, 2009:340) and billboards and posters. A convincing case can also be made to include the workplace as an avenue to make information available to support CSOs living with a partner with a SUD. From the information provided, the marketing of

support for SUDs pointed strongly to the electronic media that would definitely be a useful option for professionals and service organisations, catering for help-seeking CSOs, to pursue.

5.3 LIMITATIONS INHERENT IN THIS STUDY

The following limitations inherent in this study need to be acknowledged:

5.3.1 Limitations related to the generalisability of the research findings. The qualitative research approach was applied for the purpose of this study in view of obtaining an in-depth understanding what it is like for a CSO to live with a partner with a SUD. As the qualitative research approach does not aim to generalise research findings to broader contexts, but rather supports the idea of recruiting a small sample of information-rich participants (Cruz & Tania, 2017:181; Rubin & Babbie, 2013:40; Neale et al., 2005: 1584; Mahtani, 2004:55) in order to obtain in-depth context-bound information on the issue at hand, the generalisation of the findings to broader contexts is not a priority. This aspect needed to be acknowledged as limitation.

5.3.2 The lack of African and Indian participants included in the sample needs to be mentioned as a limitation. This exclusion was not intentional but the research sites or social setting and support groups who were identified within the given geographical boundaries set for the study predominantly catered for service users from the White and Coloured population groupings.

5.4 RECOMMENDATIONS

Informed by my own social work practice experience in the field of service delivery to service users with SUDs and their significant others; peer consultation and feedback; the empirical research findings (Chapters Three and Four) and literature research undertaken for this study, various recommendations are proposed and will be presented under the following sub-headings:

- Guidelines for Social Work intervention to support CSOs living with a partner with a SUD;
- Recommendations for Social Work education and training; continuous professional development (CPD), as well as training of other professionals and lay persons involved in offering services in the field of SUD-treatment and recovery
- Recommendations for further research.

5.4.1 Guidelines for Social Work intervention to support CSOs living with a partner with a SUD - recommendations

The tabulated recommendations (Table 5.2) relate to the guidelines for Social Work intervention to support CSOs living with a partner with a SUD and represent the realisation of the third goal formulated for this study (See Chapter One, sub-section 1.3.2). As mentioned under sub-heading 5.4, the recommendations are empirically supported and literature informed. The recommended guidelines for social work intervention are *practice-directed* and focus on aspects of *programme*, *programme-foci* and *format*, and the *publicising* of social work interventions aimed at supporting CSOs living with a partner with a SUD.

Table 5.2: Guidelines for Social Work intervention to support CSOs living with a partner with a SUD - recommendations

Recommendations – It is recommended that -	Cross-reference to empirical research finding informing the stated recommendation
<ul style="list-style-type: none"> social workers in social work practice service organisations inclusive of the National, Provincial and Local Departments of Social Development, NGOs, CBOs and FBOs, Public and Private Treatment Centres, as well as private practitioners offering social work services in the field of SUDs formulate <ul style="list-style-type: none"> (1) lobby for policies²² mandating (2) the develop of programmes tailor-made to and for providing social work interventions in the form of psychosocial support to CSO-partners living with a partner with a SUD, and (3) make the resources available for the development of such specific programmes 	<p>See Chapter 4, Theme Three: Subtheme 3.1: Category entitled “<i>own-programme tailor-made for CSOs and programme stipulations suggested</i>”</p> <p>This recommendation is specifically underscored by the fact that CSOs in their own right are entitled to professional support to address their help-seeking needs caused by and in response to a partner's SUD – see Chapter Four: Theme One (Wilson, 2017:57; Bradshaw et al., 2015:314; Orford et al., 2009:380; Peled & Sacks, 2008:390)</p>
<ul style="list-style-type: none"> the tailor-made programmes for social work intervention to support CSO-partners living with a partner with a SUD include the following topical aspects, but be flexibly applied according the help-seeking CSO-partner's needs – <ul style="list-style-type: none"> ○The identification of experiences related to living with a partner with a 	<p>See Chapter Three – Theme One</p>

²² See the Prevention and Treatment of Substance Abuse Act (Act 70 of 2008 – Chapter Ten)

<p>SUD and making allowance for the sharing of such experiences.</p> <ul style="list-style-type: none"> ○ The identification of challenges experienced as result of a partner's SUD and providing social work support and guidance on how to address the challenges ○ An exploration of the coping strategies employed to manage and mitigate the experiences and challenges experienced in relation to living with a partner with a SUD, and providing guidance and suggestions on constructive ways of managing and mitigating the challenges experienced in the context of living with a partner with a SUD ○ Providing information on ways to support the partner with the SUD to enter treatment ○ Providing information on the topic of drugs and its effects ○ Providing information on how CSOs can set boundaries for themselves to accommodate their relationship with the substance addictive partner ○ The provision of communication skills and strategies for improving the partner-communication ○ Information on anger management and ways to constructive anger management ○ Strategies for rebuilding the CSOs self-esteem 	<p>See Chapter Three - Theme Two</p> <p>See Chapter Three – Theme Three</p> <p>See Chapter Three – Theme Four</p> <p>See Chapter Four: Subtheme 2.1 - Category One</p> <p>See Chapter Four: Subtheme 2.1 - Category Two</p> <p>See Chapter Four: Subtheme 2.1 - Category Three</p>
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<ul style="list-style-type: none"> ○ Information and pointers regarding parenting and raising and protecting children in the context of a partner's SUD ○ Information on the occurrence of a relapse in the cycle of substance addiction and recovery – CSOs ways of managing it ○ Information on how the CSO can support the partner with the SUD ○ Life skills, focusing specifically on decision-making ○ Guidance on and strategies for regaining self-confidence and independency as part of the CSOs' own recovery. ○ Pointers and guidance on how to restore trust in the partnership relationship 	<p>See Chapter Four: Subtheme 2.1 - Category Four</p> <p>See Chapter Four: Subtheme 2.1 - Category Five</p> <p>See Chapter Four: Subtheme 2.1 - Category Six</p> <p>See Chapter Four: Subtheme 2.1 - Category Seven</p> <p>See Chapter Four: Subtheme 2.2 - Category One</p> <p>See Chapter Four: Subtheme 2.2 - Category Two</p> <p>See Chapter Four: Subtheme 2.2 - Category Three</p> <p>See Chapter Four: Subtheme 2.3</p>
<ul style="list-style-type: none"> • the tailor-made programme directed at social work intervention providing psychosocial support to CSO-partners living with a partner with a SUD offered by way of – <ul style="list-style-type: none"> ○ Couple or marriage counselling ○ Support group sessions ○ Individual counselling for the CSOs who do not want to be in a support group ○ Family counselling • the tailor-made programme, when offered in a group work context or as a 	<p>See Chapter Four: Subtheme 3.1 - Category One</p> <p>See Chapter Four: Subtheme 3.1 - Category Two</p> <p>See Chapter Four: Subtheme 3.2 - Category One</p> <p>See Chapter Four: Subtheme 3.2 - Category Two</p> <p>See Chapter Four: Subtheme 3.1 - Category Three</p>

<p>support group, to be homogenous as far as membership is concerned</p> <ul style="list-style-type: none"> • the tailor-made interventions for CSOs be made compulsory • social workers make every effort to get the buy-in of the CSOs when offering such intervention and that it is responsive to their help-seeking needs • just as the case with the treatment programmes for the partners with the SUD, the tailor-made interventions for the CSOs also include an aftercare component 	<p>See Chapter Four: Subtheme 3.1 - Category Three</p> <p>See Chapter Four: Subtheme 3.1 - Category Three</p> <p>See Chapter Four: Subtheme 3.1 - Category Three</p>
<ul style="list-style-type: none"> • social workers in the development of tailor-made programmes to specifically provide social work interventions supporting the CSOs of partners with SUDs that they take into consideration the key barriers to help-seeking of this service user groups with specific reference to practical considerations such as transport challenges, availability of time, the financial cost attached to the interventions offered, child-care, and geographical accessibility (Wilson et al., 2017:56) 	<p>See Chapter Four: Subtheme 3.1 - Category Three</p>
<ul style="list-style-type: none"> • social workers lobby for a multi-disciplinary collaboration and network between private, public and volunteer organisations (as micro-systems interfacing at a meso-system level) to offer health, welfare, judicial, protective and religious/spiritual services 	<p>See Chapter 4: Theme 4: Subthemes 4.1 – 4.3</p>

<ul style="list-style-type: none"> ○ Social media (Facebook, twitter) as way to advertise social work programmes and support service to CSOs living with a partner with a SUD ○ Billboards and posters as way to publicise social work programmes and support service to CSOs living with a partner with a SUD ○ The workplace as avenue to advertise social work programmes and support service to CSOs living with a partner with a SUD 	<p>See Chapter Four Subtheme 5.1 – Category 3</p> <p>See Chapter Four Subtheme 5.1 – Category 4</p> <p>See Chapter Four Subtheme 5.1 – Category 5</p>
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5.4.2 Recommendations for Social Work education and training; continuous professional development (CPD), as well as training of other professionals and lay persons involved in offering services in the field of SUD-treatment and recovery

The recommendations listed below, based on the research findings, are directed to Social Work education and training and CPD, as well as to inform professionals (also including CPD training) from other disciplines and volunteer counsellors on the topic of CSO-partners experiences, challenges and coping strategies in living with a partner with a SUD; their help-seeking and needs for professional and non-professional support, as well as the modes of support and the avenues to publicise such support:

- The incidence of SUDs is high both internationally, which United Nations on Drugs and Crime, [2016:1] gives as an estimated 12% of a population, and locally, almost 13% of the population (Herman, Stein, Seedat, Heeringa, Moomal & Williams, 2009:340-341). It is therefore recommended that the information that has become available through this research endeavour be included in the syllabi of modules at undergraduate Social Work training focusing on substance addiction as social problem since it is one of the fields of social work practice it will enhance and strengthen such a course.
- At institutions where Social Auxiliary Work is offered, that information related to this topic be included in the syllabi. Information can be provided on alcohol and drug abuse; the treatment of these addictions; the impact of a family member's alcohol and drug on the family as a whole and on family relationships, the CSOs' experiences, challenges and ways of managing their partner's SUD, the needs of a CSO in recovery as a person in their own right and the roles of social auxiliary workers and social workers role in the recovery of persons with a SUD and CSOs of a partner with a SUD.
- As a variety of disciplines, such as Medicine and Psychiatry, Nursing Science, Psychology and Practical Theology, provide health, psychological and spiritual

support and services to service users affected by SUD. The empirical and literature research findings can be incorporated in their syllabi as well and the guidelines suggested be presented in CPD-training activities.

- To equip social workers who have already qualified and are employed in the welfare sector, continuous professional development (CPD) training offerings are recommended on the topical aspects as identified in this study (see Chapters Three and Four) through workshops, seminars and conferences. The guidelines recommended for Social Work support to CSOs living with partners with SUDs can also be presented as focus for CPD-training activities.
- Workshops and seminars for managers or the management of treatment facilities, support groups and religious organisations involved in SUDs as in-service training, are recommended to create more sensitivity and understanding on the plight of the CSO of a partner with a SUD and to support and service them more efficiently, or alternatively to develop and present intervention programmes for the CSOs alongside already existing programmes for SUDs.
- Workshops for service providers offering treatment or support for persons with a SUD on effective marketing strategies for their services with the inclusion of their service when providing for support to the CSO-partners as persons in their own right.
- Awareness campaigns about services for CSOs of partners with a SUD marketed in the printed, public and social media, including radio talks and television appearances by experts in the field as well as testimonies from persons affected and recovered also to promote sensitivity and knowledge about the plight of CSO partners and the availability of their services.

5.4.3 Recommendations for further research

Motivation to undertake this study was initially based on my experience with SUDs as a practising social worker who realised that the CSO of a partner with a SUD is inadequately recognised in all forms of service delivery. I furthermore found a stillness in the knowledge base within Social Work on this topic, both nationally and internationally, and it is recommended that more research is undertaken specifically on matters concerning CSOs living with partners with a SUD.

Acknowledging the fact that this study focused on a small sample located in a small geographically delimited urban area in only one of South Africa's nine provinces, Gauteng, it is recommended that this research, be replicated on a larger scale. Importantly too, that the study areas are located in the other provinces and includes representatives of all the other population groups who live in South Africa's so-called Rainbow Nation as its people have much to offer.

The following topics are suggested to be placed on an agenda for further research on CSOs of partners with a SUD.

- Barriers to help-seeking of CSOs living with a partner with a SUD given the suggestion that “more research specific to partners and their help-seeking needs are required” (Wilson et al., 2017:56).
- An exploration into the marketing strategies of services organisations to advertise their service offerings to services users with reference to persons with SUDs and their CSOs.
- An exploration into African CSO-partners' experiences, challenges and coping strategies of CSOs of partners with a SUD, especially in the rural confines of South Africa to determine and develop cultural appropriate guidelines for social work intervention.
- Exploring the experiences, challenges and coping strategies of CSOs of partners with a SUD from the LGBTIQ community to determine and develop appropriate guidelines for social work intervention.

- Exploring CSO-partners' nature and experiences of the services provided to them at the treatment facilities and support groups their partner with the SUD attended.
- An exploration of the information and skill-levels of staff and volunteers to provide support to CSO-partners of clients with SUDs.
- The development of tailor-made treatment and support programmes for the CSO of a partner with a SUD.

5.5 CHAPTER SUMMARY

With this chapter I presented a summary of the research project by summarising the main aspects covered in the preceding chapters and drawing conclusion culminating the recommendation forwarded in this chapter.

I started out by providing a reflective summary on the background to, and historical overview of the phenomenon of SUDs and CSOs living with a partner with a SUD. This was followed by a reflection on the motivation for and presenting a conclusion on the contribution of the study. The research questions, goals and objectives were revisited and conclusion arrived at on their realisation. The theories with respect to the strength-based approach, the resiliency theory and the ecological systems theory were revisited and the conclusions drawn on their fittingness within this research project indicated. An overview of the research plan was provided before conclusions were drawn on the way it was applied. Additionally, focusing also on the ethical considerations adhered to in this research.

In the third part of this chapter a summary on the biographical particulars of the CSO-participants were provided, followed by a synopsis of the six themes deduced from the data collected focusing on their experiences, challenges and coping strategies in living with a partner with a SUD. These summaries were complemented with conclusions. I then proceeded to summarise the biographical particulars of the partners with a SUD, followed by a summary of the suggested guidelines for social work support as contained in five themes that emerged from the data analysis process. The conclusions arrived at were indicated.

Finally, this chapter reflected on the limitations of the study before recommendations were made relating to specific guidelines for social work intervention to provide psychosocial support to CSOs living with partners with SUDs. The recommendations, specific to the guidelines for social work intervention, were informed by the findings of the study and presented in table format (Table 5.2) with cross-references, linking it to the thematic presentation of the research findings where the participants' voices were added to inform and authenticate the recommended guidelines. In addition, recommendations directed at social work education and training and continuous professional development (CPD), as well as the training of her professionals and lay persons involved in the recovery of SUDs and suggested topics for further research related to the study were put forward.

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ADDENDA

LIST OF ADDENDA

Addendum A: INFORMATION AND INVITATION LETTER TO SIGNIFICANT OTHERS OF PARTNERS WITH SUBSTANCE USE DISORDERS TO PARTICIPATE IN THE RESEARCH PROJECT

My name is Peter Schultz. I am a Lecturer in Social Work at UNISA (University of South Africa) and work as Consulting Social Worker at Mighty Wings Life Centre assisting with people and their families struggling with substance abuse.

I am currently registered for a doctoral degree in Social Work at UNISA. In fulfilment of the requirements for a doctoral degree a research project must be undertaken. For the purpose of this research it was decided to focus on developing guidelines for intervention for significant others of partners with substance use disorder.

This research project is the result of many years of experience in the addictions field, assisting both the addicted person and those closely involved with them. Based on this experience it was determined that well developed treatment and support systems exist and are accessible to persons struggling with substance abuse but, in comparison, the same does not apply to those involved in their lives. This research aims to address this imbalance.

As a significant other in the life of somebody with substance use disorder, you have been selected and are requested to participate in this research. Your participation is voluntary and all your contributions will be managed confidentially. All the information is obtained by means of writing about your circumstances as well as interviews that will be audio-taped and which will contribute towards guidelines for intervention. Collecting the information will be administered by the researcher. Should you at any stage want to withdraw your participation or require any counselling following your participation, this will be arranged.

Your choice to avail yourself to this study or should you wish to withdraw at any stage or even refuse to be involved in this study will be respected. Your personal

ideas and all your contributions to this study, should you decide to participate, are very valuable and will be appreciated.

The personal questions which will be directed to you includes your age, gender, marital status, qualifications, employment, marital status and length of your relationship with your partner with a substance use disorder, number of children in your care, as well as whether you have tried to obtain assistance with the problem before and if you yourself have used or abused any substances.

Further questions regarding the study will include open ended questions about your experiences, coping strategies and challenges while living with your partner. The open ended questions will allow you an opportunity where you can share how you have been affected by substance abuse as well as make suggestions from your experience how this can be addressed in general. The questions will give an indication of your general behaviour and attitudes as well as how you tried to manage the situation. Your partner will also be invited to participate and asked his or her opinion about how you may be assisted. Finally you will be requested to provide suggestions on how you or persons in similar situations like you can be assisted by a Social Worker.

Please do not hesitate to ask where you are unclear about this letter or require any further information.

Thank you,

Peter Schultz

Student Number: 3185648

Contact number: 0833245575

STATEMENT BY RESEARCHER

I, Peter Paulus Schultz, declare that I have explained the information given in this document to

_____ (name of participant).

He/she was not placed under any pressure or obligation and given ample time to ask me any questions relating to the research.

Signed at _____ on _____ 20____
(place and date)

Signature of researcher

Signature of witness

IMPORTANT MESSAGE TO PARTICIPANT

Dear Participant

Thank you for your participation in this study. Should at any time during the study an emergency arise or you suffer any harm or discomfort as a result of the research, or you require any further information with regard to the study, feel free to immediately inform me or phone me afterwards at 083 324 5575.

INFORMATION AND INFORMED CONSENT DOCUMENT²³

THE EXPERIENCES, CHALLENGES AND COPING STRATEGIES OF CONCERNED SIGNIFICANT OTHERS LIVING WITH A PARTNER WITH A SUBSTANCE USE DISORDER: INFORMING GUIDELINES FOR SOCIAL WORK INTERVENTION

CONTACT TELEPHONE NUMBER: 083 324 5575

<p>DECLARATION BY OR ON BEHALF OF THE PARTICIPANT:</p> <p>I, THE UNDERSIGNED, _____ (name), [ID No: _____]</p> <p>_____ the participant of _____</p> <p>_____ (address)</p> <p>HEREBY CONFIRM AS FOLLOWS:</p> <p>1. I/the participant was invited to participate in the above research project which is being undertaken by Peter Schultz of the Department of Social Work in the School of Social Science and Humanities at the University of South Africa, Pretoria, South Africa.</p>	<p><u>Initial</u></p>
<p>2. The following aspects have been explained to me/the participant:</p> <p>2.1 Aim:</p> <ul style="list-style-type: none"> The investigator(s)/researcher(s) are studying the experiences of partners living with a person abusing chemical substances 	<p><u>Initial</u></p>

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<ul style="list-style-type: none"> The information will be used to/for determine guidelines for a narrative-based social work intervention 	
2.2 I understand that I will be participating voluntarily in the research project and trust that with my participation I may make a constructive contribution to others encountering the same situation	<u>Initial</u>
2.3 Risks: My participation to this research has no risk other than the slim possibility of identification.	<u>Initial</u>
2.4 Possible benefits: As a result of my participation in this study only other persons in similar situations may benefit from my contributions towards a social work intervention	<u>Initial</u>
2.5 Confidentiality: My identity will not be revealed in any discussion, description or scientific publications by the investigators/researchers.	<u>Initial</u>
2.6 Access to findings: Any new information/benefit that develops during the course of the study will be shared with me.	<u>Initial</u>
2.7 Voluntary participation/refusal/discontinuation: My participation is voluntary. My decision whether or not to participate will in no way affect me now or in the future.	<u>Initial</u>
3. The information above was explained to me/the participant by _____ (name of relevant person) in Afrikaans/English/Sotho/Xhosa/Zulu/other _____ (indicate other language) and I am in command of this language/it was translated to me satisfactorily by _____ (name of the translator). I was given the opportunity to ask questions and all these questions were answered satisfactorily.	<u>Initial</u>
4.	<u>Initial</u>

No pressure was exerted on me to consent to participate and I understand that I may withdraw at any stage from the study without any penalty.		
5. Participation in this study will not result in any additional cost to me.		<u>Initial</u>
I HEREBY CONSENT VOLUNTARILY TO PARTICIPATE IN THE ABOVE PROJECT. Signed/confirmed at _____ on _____ 20____ _____ Signature or right thumbprint of participant		_____ Signature of witness

Addendum C: PERMISSION TO USE MIGHTY WINGS LIFE CENTRE AND CAD JAKARANDA TO RECRUIT PARTICIPANTS FOR RESEARCH PURPOSES.

Motivation

I have registered for doctoral studies in Social Work and would like to do my research at Mighty Wings Life Centre (MWLC) and Christian Action for Dependence (CAD) in Pretoria.

My aim is to compile guidelines for social work intervention for the significant others of persons struggling with chemical substance abuse. Significant others may include a spouse, partner or fiancé living with somebody struggling with chemical substance abuse. The guidelines aims to address the recovery of the significant others (supporters) in their own right.

In order to continue with the research, I have to clarify certain issues prior to drafting a proposal which includes, amongst other things, permission from the organisation where the research is envisaged. Once in place, I will be able to draft a proposal for submission to the Board and University.

Involving MWLC and CAD in the research does give us an opportunity to assess the way we currently work with supporters. The research will not interfere with the current programme and I undertake to keep you updated as I continue. All ethical protocol of confidentiality, management of information and consent from people involved, will be upheld.

I trust that this request meets with your approval and that the research will add significant value to the programmes of MWLC and CAD.

Peter Schultz

5 AUGUST 2015



Mighty Wings Life Centre

PO BOX 2769, Lonehill, 2062,
Johannesburg, Gauteng,
South Africa

Intl +27 10172 602 2049

www.mightywings.co.za

REG No: 656 083 034

MPO No: 104348

Reg No: 2009/0939105

5 October 2015

Mr Peter Schultz

Mighty Wings hereby give you permission to conduct your research with significant others of partners on the program.

We believe that your research will add tremendous value to the program of Mighty Wings Life Centre and our clients.

Chanene Van Zyl

Director

IN THE SHADOW OF YOUR WINGS I WILL MAKE MY REFUGE, UNTIL THESE CALAMITIES HAVE PASSED BY. PS 57:1



www.cad.org.za

CAD JAKARANDA

NG Church

Villieria

Pretoria

20 April 2016

Mr Pieter Schultz

CAD Jakaranda hereby gives you permission to conduct research with partners of CAD and we look forward to be a part of your success.

Thank you

Jansie van der Merwe

Chairman CAD Jakaranda (Christian Action for Dependence)

Addendum D: RESEARCH INSTRUMENT

Research Instrument for significant other of a partner with a SUD

A Biographical Information

1. How old are you?
2. Gender (as observed)
3. Race (as observed)
4. Marital status
5. How long are you involved with your partner?
6. Number of children in your care
7. Qualifications
8. Employment
9. Have you at any time abused chemical substances? YES/NO
10. Have you gone for help before? YES/NO
11. If yes, when and why?

B Narrative inquiry

1. Instruction for writing the story

“Write your story detailing your experiences on how it is (was) for you to live with your partner addicted to a substance. Elaborate on the feelings and challenges you experienced and what you did/you do to manage to cope living with a partner addicted to substances.”

2. I am inquisitive about your experiences **when** writing the first story

“What was it like for you to sit down, think through and write your experiences as instructed?”

3. First follow-up interview

Due to the fact that this interview explored the content of the written narratives, focus areas or themes, rather than questions facilitating the interview, would be provided. Focus areas will further explore experience-wise on the participants' feelings; ways in which they coped and managed

their lives as well as the challenges that they had encountered in the context of living with a partner with a SUD.

4. Second follow-up interview

“Against the background of the experiences shared in the previous session, what, in your perception/understanding could be important aspects or suggestions for social work support to assist you, and/or persons in similar situations like you?”

Research Instrument for partner with a SUD

A Biographical Information

1. How old are you?
2. Gender (as observed)
3. Race (as observed)
4. Qualifications
5. Employment

B Interview questions

From your perspective -

- how would you describe the effect of living with a person with a SUD on the partner?
- how could partners living with a person with a SUD be assisted by social workers?
- with what could social workers support the partners living with a person with a SUD?

Addendum E: FEEDBACK FROM PEERS REGARDING MOTIVATION FOR THE RESEARCH

The Assistant Director, SANCA Western Cape

- In your opinion, does existing treatment programmes adequately address the needs of Partners? YES/NO²⁴

Please motivate your answer shortly...

“NGO and State Department’s working with addiction rarely have the time, inclination or the manpower to spend any time on this. Outcomes are usually statistically driven and working with the needs of partners appears to be a secondary issue which does not necessarily reflect on the quality of the Social Workers case-load”

- In your opinion, does treating Partners warrant a separate recovery/treatment programme? YES/²⁵NO

Please motivate your answer ...

“The emotional damage inflicted on partners are directly transferred to the new family and creates conflict which is rarely traced back to the original trauma. This often destabilizes the new family. Thus partners often end up in a relationship which could best be described as “functional” *dysfunction: The relationships endure with massive emotional costs to one partner and offspring*”.

The Director, LULAMA Clinic, Durban

- In your opinion, does existing treatment programmes adequately address the needs of Partners? YES/ NO²⁶

²⁴ The option “highlighted” was the respondent’s response.

²⁵ The option “highlighted” was the respondent’s response.

²⁶ The option “highlighted” was the respondent’s response.

Please motivate your answer shortly...

“Very few treatment programmes include structured family/significant other programmes and this is definitely a gap in services. As you know, Lulama is one of a small number of centres which provides for family/significant other groups as PART of the treatment programme, and also offers a group for children (4 – 12 years) of patients in treatment. The lack of family/significant other involvement very definitely impacts on the aftercare process.”

- In your opinion, does treating Partners warrant a separate recovery/treatment programme? YES²⁷/NO

Please motivate your answer shortly...

“Although I am of the opinion that a separate programme is warranted it is imperative that, where the addicted person is involved in treatment, the significant other programme dovetails with this and runs parallel. Furthermore, in the same way as I would advocate that partners are involved in the treatment process of the addicted person, the reverse is also true. One cannot separate the two processes ...Sabotage by Significant Other of the addict’s recovery if not treated”.

Senior Lecturer, HUGENOTE KOLLEGE

- In your opinion, does existing treatment programmes adequately address the needs of Partners? YES/ NO²⁸

Please motivate your answer shortly ...

“The involvement of Partners during the treatment of the addict mainly focuses on the recovery of the addict. Although it does address the impact of the addiction on the Significant Other, this forms part of assisting the addict to make amends and to

²⁷ The option “highlighted” was the respondent’s response.

²⁸ The option “highlighted” was the respondent’s response.

rebuild damaged relationships. In my experience, the Significant Other needs to attend a specific programme (not a short-term process) to understand addiction and recovery regarding the addict, to understand the addiction and recovery processes of the family and to develop own “recovery” skills. This is not the focus of treatment programmes”.

- In your opinion, does treating Partners warrant a separate recovery/treatment programme? YES²⁹/NO

Please motivate your answer shortly...

“Please also see my answer above. In my opinion it is financially and practically not always possible to involve both the addict and the Partners in the same programme. In addition, the complex inter-personal dynamics between these two might cause that they defocus during the treatment period. I can, however, see that a separate programme for Partners could contribute to a focused and efficient way to assist them. In my experience, once the Significant Other becomes healthy and stops enabling the addiction, the addict self begins to become more ready to consider treatment..... I do believe that the two recoveries (i.e. the recovery of the addict and the recovery of the Significant Other) should not be dependent on each other”.

All three the respondents felt that the issue of treating partners in existing treatment programmes is insufficient and does not adequately address treatment of them. Reasons for this were ascribed to:

1. Time and manpower constraints by NGO's and the State
2. Needs of partners appear to be secondary to those who abuse substances.
3. Very few programmes or centres make provision for treating Partners and if done as PART of treatment of the addict.
4. It is needed to support the aftercare.

²⁹ The option “highlighted” was the respondent's response.

5. Assisting Partners longer term with understanding addiction and recovery, the recovery process of the family and developing their own recovery skills is generally not part of treatment.

On the question as to whether a separate program is needed, all three of the respondents answered in the confirmative. Reasons for this include the following:

1. Partners' experience emotional damage and trauma which needs to be treated. If not treated family is destabilized and becomes functionally dysfunctional.
2. Must dovetail and run parallel with treatment of addict. Treatment must be simultaneous. If not the SO can sabotage the recovery of the addict.
3. Consider financial and practical arrangements for simultaneous treatment
4. Separate (parallel) program for SO helps them to be more focused. The two recoveries should not be dependent on each other.

Addendum F: FEEDBACK FROM SIGNIFICANT OTHERS REGARDING THE MOTIVATION FOR THE RESEARCH

From the feedback received so far from three supporters, it became clear that none of them have received any assistance before joining the programme they are currently in. The following matters were addressed:

- Their opinion whether supporters require a separate treatment programme was answered in the affirmative by all three respondents. Reasons given were as follows:
 1. They need to be able to express themselves openly
 2. Financial concerns in terms of paying for treatment.
 3. Addict's behaviour caused suffering and family upheaval.
 4. Must learn to restore relationship with addict again.
 5. Must learn to deal with own pain as had to deal with emotional realities without self -medicating as did the addicts.
 6. Must learn to deal with realities from a supporter's point of view.
- Two of the three respondents felt more could be done to assist families with addiction problems. Reasons include the following:
 1. More information to families within the communities in terms of where and how to get help.
 2. Involvement at rehabs but at lower cost and feedback from rehabs on addict's completion of treatment.

It is clear from the feedback from supporters that they have been adversely affected by the addicts' problems and they themselves need help. Furthermore greater access to information in terms of assistance within the community is required which can lead to help earlier in the addiction process.

The questionnaire merely needed to determine their perceptions as partners and will be addressed in much greater detail during the research.

Addendum G: ETHICAL CLEARANCE TO UNDERTAKE THE RESEARCH



DEPARTMENT OF SOCIAL WORK RESEARCH AND ETHICS REVIEW COMMITTEE

3 November 2014

Ref#: DR&EC_2014_008
Name of Applicant: Schultz, PP
Student#: 03185648

Dear Mr Schultz

DECISION: ETHICAL APPROVAL

Name: **Mr. PP Schultz**, Farm Road, Equestria. Cell no 0833245575
012 429 6392. E mail: schulpp@unisa.ac.za

Supervisor: **Prof AH Alpaslan**

Title of Proposal: **THE EXPERIENCES, CHALLENGES AND COPING STRATEGIES OF CONCERNED SIGNIFICANT OTHERS LIVING WITH A PARTNER WITH SUBSTANCE USE DISORDER: INFORMING GUIDELINES FOR SOCIAL WORK INTERVENTION**

Qualification: **D Phil in Social Work**

Thank you for the application for research ethics clearance by the Department Of Social Work Research And Ethics Review Committee.

The application was reviewed in compliance with the UNISA Policy on Research Ethics by the abovementioned Committee at a meeting conducted on 18 September 2014.

Final approval is granted for the duration of the project.

The proposed research may now commence with the proviso that:

- 1) *The researcher will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.*
- 2) *Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the Department of Social Work's Research and Ethics Review*



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Committee. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.

- 3) *The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.*
- 4) *[Stipulate any reporting requirements if applicable].*

Kind regards,

Signature: _____

Prof AH Alpaslan

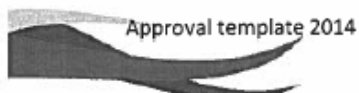
Chair: Department of Social Work Research Ethics Review Committee

alpasah@unisa.ac.za

Signature _____ 05/11/2014

Prof J Murray

Manager Postgraduate studies - College of Human Sciences



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Addendum H: DEBRIEFING LETTER



6 January 2016

To whom it may concern:

Re: Confirmation to assist with debriefing of research participants

I hereby confirm that I have offered to provide debriefing and counselling to research participants in Mr Schultz's PhD research project titled "Revisiting and re-authoring the narratives of partners living with a person abusing chemical substances: guidelines for a narrative-based social work intervention".

I am a registered social worker in private practice (SACSSP Reg No: 10-32445; BHF Practice No: 0674427) with a special interest in substance abuse prevention, intervention and treatment.

Yours sincerely

Mandy Stokes
Social Worker
SACSSP 10-32445

Addendum I: STUDY-RELATED WORKSHOPS ATTENDED

DATE	TOPIC	PURPOSE OF ATTENDING
May 2013	Co-dependency 2 day workshop	To obtain further information and latest literature on significant others affected by SUDs
January 2014	Re-storying our Extra-ordinary Lives 2 day workshop	To obtain practical information on narrative interviewing and enquiry
August 2014	Advanced workshop on Narrative Therapy 1 day follow-up workshop	To obtain hands-on experience of being subject of narrative interviewing
January 2015	Organisation Development on Substance Abuse Intervention 1 day seminar	To gather information about faith-based and community-based services on SUDs in Gauteng
May 2015	Child Trauma 2-day conference	To obtain information on process trauma on human development in relation to SUDs
September 2015	Managing Substance Abuse in the Workplace Half day seminar	To obtain insight on how SUDs impacts on employment
March 2016	R and D Workshop 1 day workshop	To obtain information on UNISA and Departmental requirements for Doctoral Studies
July 2016	Case-studies in Narrative Interviewing 1 day workshop	To gain more insight into the interviewing process
March 2017	R and D Workshop 1 day workshop	To obtain information on UNISA and Departmental requirements for Doctoral Studies
June 2017	The Forgotten Ones Half day Seminar	To gather information on the effects of SUDs on family life

Addendum J: INITIAL REFLECTING ON MY POSITION AS RESEARCHER

25 Feb. 2016

FURTHER REFLECTION ON THE NARRATIVE AND ITS APPLICATION IN RESEARCH

Having studied BOLD 2012 (26-28 Feb 2016), the researcher became aware that his research and involvement has a strong emphasis on co-constructing and wondered whether this should not include this in the title. It is acknowledged that co-construction is an integral part of the narrative approach and as the research involves processes of development in which the researcher is involved, it inadvertently forms part of the research.

Bold (2012:104) cited Yow and indicated seven questions necessary for the researcher to address in both the research and co-constructing process:

- i. **Why are you doing the research?** This question perhaps requires a more personal than professional answer, with the latter having been addressed in the introduction to the research. Addressing this matter is very applicable and warranted as the answer to this matter provides the context for the co-constructing partners, but also is an attempt to clarify whose voice (researcher or participant) is actually being heard.

In an attempt to clarify the voice, it is deemed necessary that the position and background (context) of the researcher is stated up front when the research material and methods is being dealt with. This background would be a given and common ground in all the sessions. **It is suggested that I give a brief background history of myself as researcher indicating my stance and hopefully quieting as far as possible my voice. The following background is offered:**

I grew up in South Africa during the Apartheid-era characterized, amongst other things, by a rigid conservative and cultural system with pre-conceived ideas about people and people groups. I was brought up in a white middle-class family and have two sisters younger than myself. Family life has been strongly influenced by the views of society of the time, but also ongoing conflict between my Afrikaans father and Dutch mother primarily due to their different perceptions of life; mom growing up as over-protected teenager during the second world war and dad a sanguine artist with his head in the clouds, but emotionally explosive when crossed.

At school as a physically small boy with a strong Dutch accent, I was made fun of until grade 5, often reprimanded for ending up in fights when I caught those teasing me. In my father's eyes I was not "man" enough to put a stop to this so I eventually learnt to survive by becoming like them. However in High School the visits from our family in Holland usually led to discussions about society and politics, creating an awareness to no longer be like them as they were unjust.

So both at home and outside home I learnt when and how to become emotionally involved but also how to keep a safe distance. Helping others in need became a strong drive and eventually contributed to my involvement in the helping profession.

- ii. **Ideology/philosophy of the researcher.** *My philosophy in life is based on a number of concepts and statements .I value the differences in people and believe there is a “place in the sun for all of us”, I acknowledge we live in an imperfect and broken world, but if we make sufficient effort we can overcome many if not most of lives difficulties. I acknowledge that for most things in life there is no answer and that’s okey, yet the flip side of the coin is that every problem must have an answer; the tricky bit is to find the answer. I like to analyse situations and people but shun from judging them. I like people but I like to be alone more.*

- iii. **Impact of narrator/participant on the researcher.** *During the session and endorsed by the transcription, I felt a strong sense of empathy towards the participant together with feelings of concern. The feelings I become aware of are triggered by the participant’s strong feelings of hope and she links her well-being in a life with her husband and not in herself. She avoids being inwards focused and may be scared to acknowledge certain realities or fears. It feels as if a greater responsibility or share in the re-storying has to be forthcoming from me, which I recognise will soften the voice of her story and should be refrained from. I realize I cannot do her journey FOR her, neither do I want to, as it is HER story*.*
There is also the awareness of possible transference and counter-transference. Based on the age difference between the researcher and participant the equating the relationship as a father/daughter relationship cannot be ruled out. Her references to her grandfather as the only caring older male figure may also cause resemblance with the researcher.

- iv. **The similarities and differences impacting on the interpersonal relationship.** *Perhaps one similarity that I share with the participant is that we are both working towards what we can refer to as a “better” situation. We are both carrying white middle Christian class norms and standards. Differences will become more obvious as the sessions continue*

- v. **Choice of topics/themes used during research.** *I am fairly satisfied with the topics/themes/questions I applied as it was clear for me from the onset that these are the areas with which I wanted to work. However, it is in the application of the topics that I feel I could have been more direct and shorter. I find myself that I become too long-winded, often out of fear that they do not understand the question. Furthermore I do not feel led by the participant in the topic (what of the story) but rather the direction in which the participant is taking the story (where-to).**

- vi. **Any other interpretations of the context?** *As is the case with point (v), the stories have so far been written down and the analysing (other interpretations) will become more clear during the follow-up sessions.*

- vii. **How am I affected by the research?** *With the research being in the phase of a pilot study, and only one session completed, I already become aware of the intensity of the in-depth work, but also the amount of analysis required in this type of research which includes co-construction. I also become aware of the pull between emotional involvement and keeping an emotional distance; I cannot help her – only she can help her.*

It also needs to be pointed out that studying the book by Bold came at a very appropriate time as it encouraged the researcher to do a lot of self-analysis in terms of his contributions and influence in the narrative process during the research.

Addendum K: AN EXAMPLE OF RESEARCH LOGBOOK: AN EXCERPT

JUL 2016	<p>Contact and meet with gate-keepers.</p> <p>Communication with a participant.</p>	<p>6/7/2016: Attend DAC meeting in Oliewenhoutbosch. Explained my need for research especially amongst families from the African community. The understanding of the committee was that treatment was for the addict and family needs to support sobriety. When asked about the family this was not regarded as important and indicated that the wife can never take control or set boundaries for the husband. The understanding of marriage in their culture even in westernized community would have difficulty to accommodate this. Furthermore their priority was to focus on the youth as this was a crisis in their communities.</p> <p>10/7/2016: Attend meeting at MWLC in Randburg to identify participants for research. Explained the research to the group of supporters of whom one person was keen to become involved. After screening and providing information, a date was set for the first appointment.</p> <p>18/7/2016: The following gate-keepers were approached:</p> <ul style="list-style-type: none"> • Phoned Social Worker in Private Practice to make enquiries about possible participants but this was not feasible. He was willing to assist and we scheduled and interview • The Chairperson from CAD in Lyttleton was followed up with the promise to invite me to a meeting. • Castle Carey Treatment Centre was approached but declined. • Stabilis Treatment Centre was approached and I was again referred to the CAD. The Chairperson invited me to their next meeting on 25 July. <p>25/7/2016: Attended CAD in Pretoria and explained about the research and its importance inviting members to consider participation. After the meeting three members provided their names and contact information to participate. After screening and information was provided we agreed to follow up telephonically and forward the consent forms electronically</p> <p>26/7/2016: Email communication to first participant: Attached are the letter of invitation, consent form and instruction for the first session, namely to reflect in writing to me what your experiences were in dealing with your situation. Because the research is actually English, all the forms are in English. If at all possible, I would appreciate it if you want to write in English for me your story, but if you prefer to do it in Afrikaans, I can translate it.</p>
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	<p>The assignment is as follows:</p> <p><i>Write your story detailing your experiences on how it is (was**) is for you to live with your significant other addicted to a substance? Elaborate on the challenges you experienced and what you did/you do to manage while living with a significant other addicted to substances?</i></p> <p>Once you finish, you can return it to me in PDF format as attachment to an email so that I can work through it for our second session on a Thursday where we will discuss it. I also just need to get the consent letter from you. There is another session where we discuss guidelines for assistance to the partner only and later also involve your partner. We can discuss the details of this when we see each other.</p> <p>Thanks in advance for your willingness to be part of the research</p>
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Addendum L: WRITTEN CONSENT FROM CONTACT PERSONS TO USE THEIR NAME IN THESIS

From: Schultz, Peter <schulpp@unisa.ac.za>

Sent: Monday, 18 June 2018 10:39

To: Jansie van der Merwe <cadpretoria@gmail.com>; 'chanene@mightywing.co.za' <chanene@mightywing.co.za>; Mandy Stokes <stokes.mandy@gmail.com>; Dr Michiel van der Merwe <director@stabilistc.co.za>

Subject: DOCTORAL THESIS

Dear Colleagues

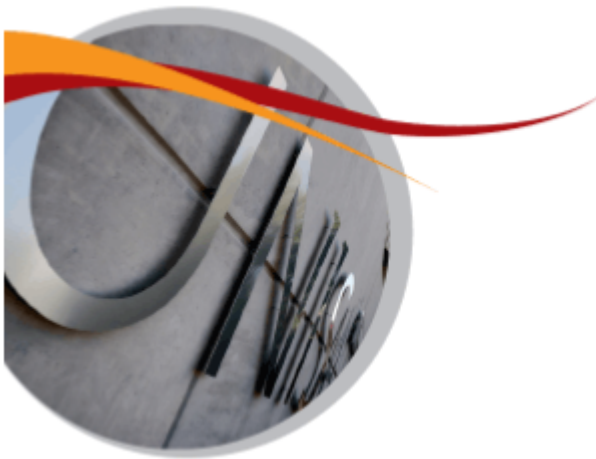
Attached please find an extract from my thesis which will be handed in by end of this month. You will note in yellow that I made reference to your names in the context of recruitment of participants.

Please check if you are comfortable with the reference in the thesis. If you are happy with the reference, please provide me with a signed written consent form to that effect. If you are not happy, please let me know and I will remove your name from the document.

Thank you very much.

Regards

Peter Schultz



Peter Schultz

**Coordinator: Higher Certificate
in Social Auxiliary Work**

Department of Social Work

Theo van Wyk 5th floor 19

Tel. 012 429 6392

schulpp@unisa.ac.za

UNISA | 
university
of south africa

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Hi Peter

I hereby consent that you may use my name in your thesis with regards to recruiting clients.

I trust that the above is sufficient and if not, kindly contact me should you require anything else.

Kind regards,

Chanene Van Zyl

Director (072-602-2049)




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WRITTEN CONSENT TO USE NAME IN THESIS

The responses in relation to the requests extended to the respective contact persons (as depicted in Figure 2.1 above) to act as gatekeepers by assisting me in providing access to research sites and potential participants varied. Of the 16 contacts made, 12 of the contact persons and individuals initially showed considerable interest in participating but eight were faced with practical and/or ethical issues. Four of the sixteen contacts, namely, the AA, Al-Anon, Nar-Anon and Castle Carey declined or did not respond to the emails, denying me access to their respective research sites and potential participants. This left me with four sites, namely the three MWLC branches and one CAD group who were prepared to accommodate me and assist with identifying possible participants and participant recruitment.

Having received permission from MWLC through their Director, Chanene van Zyl¹, to conduct research at their branches I contacted the Branch Managers of the three MWLC-branches. I also approached two social workers in private practice (Jacques Botes and Mandy Stokes), working with clients with SUDs, to help locate more participants. As CSOs do not make up a large part of the private social workers' caseload and they were concerned about ethical matters, both of them referred me to other facilities in a better position to assist me in finding participants. I then contacted the Stabilis Treatment Centre located in the northern Pretoria as it primarily focuses on the person with a SUD, but also includes add-on sessions with CSOs. I telephoned the Director, Dr van der Merwe who, in principle was keen to assist, but foresaw ethical and practical difficulties and referred me to the Christian Action for Dependence (CAD) that meets weekly on their premises. The Chairperson of CAD, Jansie Nel, was very excited about the proposed research project, willing to assist and even set up an appointment for me to attend a meeting where I could explain the purpose and needs for the research and requested the voluntary participation from those who were interested.



M N van der Merwe
19/6/2018

¹ Only the names of persons who provided written permission to use their name in my report are mentioned.



18 June 2018

TO WHOM IT MAY CONCERN:

I hereby give Peter Schultz permission to use my name in his doctoral thesis.

Yours sincerely

A handwritten signature in black ink, appearing to be 'Mandy Stokes'.

Mandy Stokes

WRITTEN CONSENT TO USE NAME IN THESIS

The responses in relation to the requests extended to the respective contact persons (as depicted in Figure 2.1 above) to act as gatekeepers by assisting me in providing access to research sites and potential participants varied. Of the 16 contacts made, 12 of the contact persons and individuals initially showed considerable interest in participating but eight were faced with practical and/or ethical issues. Four of the sixteen contacts, namely, the AA, Al-Anon, Nar-Anon and Castle Carey declined or did not respond to the emails, denying me access to their respective research sites and potential participants. This left me with four sites, namely the three MWLC branches and one CAD group who were prepared to accommodate me and assist with identifying possible participants and participant recruitment.

Having received permission from MWLC through their Director, **Chanene van Zyl**¹, to conduct research at their branches I contacted the Branch Managers of the three MWLC-branches. I also approached two social workers in private practice (**Jacques Botes and Mandy Stokes**),

Congratulations with this great achievement! All in order with me and consent provided. Good luck with the last stretch!



19/08/2018

Jacques H Botes

Social Worker in Private Practice
BA(SW) . MA Social Science (Unisa)
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"I am no longer talking simply about psychotherapy, but about a point of view, a philosophy, an approach to life, a way of being, which fits any situation in which growth – of a person, a group, or a community – is part of the goal". Carl Rogers

¹ Only the names of persons who provided written permission to use their name in my report are mentioned.

Yes, I approve.

Jesus-Liefde

Warm regards

Jansie van der Merwe

Chairman / Voorsitter:

CAD Jakaranda

(Christelike Afhanklikheidsdiens /
Christian Action for Dependence)

Sekretaresse / Secretary:

CAD Noordelikes / N.T.V.L

Tel nr: 079 241 4653 / 083 462 1486

www.cad.org.za

Facebook: Christelike Afhanklikheidsdiens

NPO 059212

ABSA Bank Rek nr: 9248250393

On Mon, 18 Jun 2018, 10:39 Schultz, Peter, <schulpp@unisa.ac.za> wrote:

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Regards

Peter Schultz