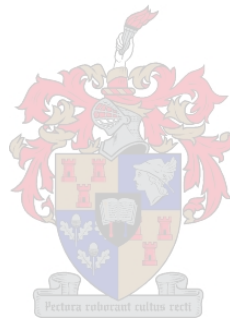


**Exploring factors shaping family involvement in promoting the participation of adults with
substance use disorders in meaningful occupations**

By

Theodora Mildred Chikwanha

**Dissertation presented for the degree of Doctor of Philosophy (Occupational Therapy) in
the Faculty of Medicine and Health Sciences at Stellenbosch University**



Supervisors

A/Prof Lana van Niekerk

Professor Moses Ikiugu

April 2019

Declaration

By submitting this dissertation electronically, I declare that the entirety of work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that publication thereof by Stellenbosch University will not infringe any third party rights and I have not previously in its entirety or in part submitted it for obtaining any qualification.

Date: April 2019

Copyrights © 2019 of Stellenbosch University

All rights reserved

Acknowledgements

I would like to acknowledge the following individuals for supporting me through my PhD journey

Firstly I would like to thank my supervisors Professor Lana Van Niekerk and Professor Moses Ikiugu for their unwavering support and guidance throughout the research process despite their busy schedules. Their constructive feedback made me think critically throughout the research process.

My research assistants Miss Sithokozile Ndlovu, Mr Kuziwa Dengure and Mrs Rachel Chirambaguhwa, without your assistance, the data gathering process would have been a nightmare.

My husband, Mr Maxwell Antony Muchengi, thank you for all the support throughout my PhD journey.

My siblings Isaac, Audrey and Edward, thank you for believing in me. Without your financial and emotional support I would not have been able to achieve what I have achieved.

My mother Mrs Alice Chikwanha and my mother in law Mrs Eunice Muchengi, thank you for looking after the kids all the times I had to travel to South Africa.

My Children Tanatswa, Mazviita and Kutenda thank you for all the hugs and kisses when I was stressed because of the pressure from work and from school.

My child minder Shyron Rusambo, thank you for taking good care of my kids all the time I was away from home.

All my study participants-thank you allowing me into your lives.

Abstract

Background and rationale

Approximately 60% of re-admissions at the main acute mental health units at two of the referral hospitals in Zimbabwe comprise of adults with substance use disorders. Occupational therapy management of individuals recovering from substance use disorders at these institutions begins in the acute phase when clients are hospitalised. There are no rehabilitation programmes with defined minimum care standards in which occupational therapy is available to people with substance use disorders. Follow up of clients in their homes is also not possible due to limited financial and human resources. There is therefore no further psychosocial support or follow up rehabilitative care for clients with substance use disorders post discharge, their families take over the caring role.

Aim

In this study, I explored the influence of the family on rehabilitation outcomes by examining the extent to which family involvement promoted participation in meaningful occupations by adults recovering from substance use disorders.

Specific objectives

The specific objectives of this study were to:

- Explore how a family member's substance use affected his/her occupational patterns as well as those of other family members
- Investigate what made it difficult or easier for families to support a family member who was undergoing occupational therapy to help modify substance use behaviour

- Investigate how involvement of family members in occupational therapy interventions influenced participation in meaningful occupations by adults with substance use disorders
- Develop a treatment framework for family based occupational therapy interventions for substance use disorders in the Zimbabwean context

Methodology

This study was positioned within a decoloniality perspective. A qualitative design using a narrative inquiry approach was used to conduct this study. Fourteen family units with an adult family member recovering from substance use disorders participated in the study. Purposive maximum variation sampling was used during recruitment. Narrative interviews on the family's experiences of living with an adult family member with a substance use disorder were conducted. Data were transcribed and analysed using interpretive narrative analysis strategies.

Results

The theme "Reconstructing occupational participation through transactions enacted within the family context" emerged as the overarching theme during data analysis. The overarching theme comprised of two subthemes namely i) Occupational disruption from an intrapersonal and interpersonal perspective and ii) The centrality of the family in creating opportunities for participating in occupations. Exploring the connections between these subthemes and the overarching theme afforded the exploration of factors shaping family involvement in promoting the participation of adults with substance use disorders in meaningful occupations.

Conclusion

The findings indicated that the family is extremely important in the management of substance use disorders. Through support from family members, the relatives who were recovering from substance use disorders were able to identify new occupational opportunities and reconstruct occupational participation. The new opportunities for occupational participation facilitated future participation in occupations that were health enhancing. These findings provided useful insights into the occupational therapy services that would be contextually relevant for individuals recovering from substance use disorders in Zimbabwe. A treatment framework which is occupation based and initiated by the families was proposed as a sustainable approach to providing post discharge occupational therapy services.

Opsomming

Agtergrond en rasionaal

Ongeveer 60% van hertoelatings tot die belangrikste akute geestesgesondheidsorgeenhede by twee van die verwysingshospitale in Zimbabwe bestaan uit volwassenes met substansgebruiksteurings. Arbeidsterapie insette in die behandeling van individue met substansgebruiksteurings by hierdie instellings begin in die akute fase, wanneer kliënte in die hospitaal opgeneem word. Daar is geen rehabilitasieprogramme met bepaalde minimum sorgstandaarde waarin arbeidsterapiedienste beskikbaar is vir mense met substansgebruiksteurings nie. Die gebrek aan finansiële en menslike hulpbronne beteken ook dat daar geen dienste is vir opvolg van kliënte na ontslag nie, daarom neem families die versorgingrol oor.

Doel

Die studie het die invloed van familiegesinsbetrokkenheid op die rehabilitasie-uitkomste van volwassenes wat herstel van substansgebruiksteurings ondersoek ten einde hul rol te bepaal in die bevordering van deelname in betekenisvolle aktiwiteitsverrigting.

Spesifieke doelstellings

Die spesifieke doelstellings van hierdie studie was om te ondersoek:

- Hoe 'n familielid se substansgebruik sy/haar aktiwiteitsverrigting sowel as dié van ander familieledede beïnvloed het.
- Wat dit moeiliker of makliker gemaak het vir families om 'n familielid te ondersteun wat arbeidsterapie ontvang het om die gebruik van substans te help verander.

- deelname in betekenisvolle aktiwiteitsverrigting beïnvloed het vir volwassenes met substansgebruiksteurings.
- Ontwikkeling van 'n behandelingsraamwerk vir familie-gebaseerde intervensie vir die hantering van persone met substansgebruiksteuring in Zimbabwe.

Metodologie

Die navorsing is binne 'n dekolonialiteitsperspektief gedoen. 'n Kwalitatiewe navorsingsontwerp, met 'n narratiewe ondersoek benadering, is gebruik. Veertien familie-eenhede waarvan een volwasse familielid herstel van 'n substansgebruiksteuring het aan die studie deelgeneem. 'n Doelgerigte steekproef met maksimum variasie is gebruik vir werwing van familie-eenhede. Narratiewe onderhoude om 'n familie se ervaring om te leef met 'n volwasse familielid met substansgebruiksteuring is uitgevoer. Data is getranskribeer en geanaliseer met behulp van interpretatiewe narratiewe analise strategieë.

Resultate

Die tema "Rekonstruksie van aktiwiteitsverrigting deur middel van onderhandeling binne die familie konteks", is tydens data-analise ge-identifiseer. Die oorkoepelende tema het bestaan uit twee subtemas naamlik i) Ontwrigting van aktiwiteitsverrigting vanuit 'n intrapersoonlike en interpersoonlike perspektief en ii) Die kernrol van die familie om geleenthede te skep vir deelname aan aktiwiteite. 'n Ondersoek na die verband tussen die subtemas en die oorkoepelende tema het die verkenning van faktore wat 'n rol gespeel het in familiebetrokkenheid by die bevordering van deelname van volwassenes met substansgebruiksteurings in betekenisvolle aktiwiteite, tot gevolg gehad.

Gevolgtrekkings

Bevindinge van die studie het aangedui dat families uiters belangrik is in die hantering van substansgebruiksteurings. Vanweë die familie se ondersteuning kon familieledede wat herstel van substansgebruiksteurings nuwe aktiwiteite identifiseer en aktiwiteitsverrigting herbou. Die bevindinge het gelei tot nuttige insigte aangaande kontekstueel-relevante arbeidsterapiedienste vir individue wat herstel van substansgebruiksteurings in Zimbabwe. 'n Aktiwiteitsgerigte, familie-geïnisieerde behandelingsraamwerk word voorgestel as 'n volhoubare benadering tot die verskaffing van arbeidsterapiedienste na ontslag.

Definition of terms

Occupation - Everyday activities that people do as individuals, in families and with communities to occupy time and bring meaning and purpose to life. Occupations include things people need to do, want to and are expected to do. (WFOT 2013)

Occupational imbalance-Loss of balance in occupational participation which occurs when a person is unoccupied under occupied or over occupied. (Brown and Hollis 2013)

Occupational deprivation-Being restricted, or hindered from acquiring or participating in occupations that are, enjoyable, use innate capacities and are consistent with personal interests and skills. (Brown and Hollis 2013)

Occupational choice-The decision regarding participation in occupation. (Gallagher 2015)

Occupational trajectory-The course that a person's occupational participation may follow across their lifespan. (Aldrich 2008)

Occupational repertoire-The set of occupations an individual has at a specific point in the life course. (Peters, Galvaan, Kathard 2013)

Family-Cultural and social relations of kinship that transcend the nuclear family to include the extended family. (Asare and Danquah 2017)

Health - A state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. (WHO 2006)

Wellbeing- A general term encompassing the human life domains including mental, physical and social aspects. (WHO 2006)

Participation -Involvement in life situations. (WHO 2001)

Meaningful time use-The ability to choose to participate in meaningful occupations. (Helbig and Mackay 2003)

Substance-Any licit or illicit drug that can cross the blood brain barrier to alter the brain functions including perception, mood, consciousness, cognition and action. (WHO 2006)

Acute intoxication-A transient condition following ingestion of psychoactive substances that result in disturbances of consciousness, cognition, perception, affect or behaviour. (WHO 2006)

Withdrawal-The experience of a set of unpleasant symptoms following the abrupt cessation or reduction in the dose of a psychoactive substance which has been consumed in high enough doses for a long enough duration for a person to be physically or mentally dependant on it. (WHO 2006)

Harmful use-Pattern of psychoactive use that damages health. It is associated with social consequences such as family or work problems. (WHO 2006)

Dependence-A cluster of physiological, behavioural and cognitive phenomena in which the use of psychoactive substance takes on a higher priority for a given individual than other behaviours that once had greater value. It is characterised by a strong craving to use substances and a loss of control over its use. (WHO 2006)

Illicit substances-Psychoactive substances for which production and sale are prohibited. (WHO 2015)

Recovery-A process of change through which an individual achieves abstinence and improved health, wellness and quality of life. (Sheedy and Whitter 2009)

List of tables

Table 1: Long term effects of commonly abused drugs (adapted from WHO intervention guide for substance use disorders in non-specialised health settings)	22
Table 2 : Sociodemographic characteristics of participants	75
Table 3: Composition of the family units during interviews	81
Table 4: Representation of the overarching theme and subthemes.....	163
Table 5: Comparison of the dominant occupations before substance use disorder and new occupations identified during recovery.....	174

List of figures

Figure 1: Organisation of health care system in Zimbabwe	32
Figure 2: Summary of the data analysis process.....	86
Figure 3 : Representation of the process that resulted in the disruption of intrapersonal and interpersonal occupational participation patterns	165
Figure 4: An illustration of the process of facilitating future participation in meaningful occupations	172
Figure 5: Illustration of the multidisciplinary team required in the provision of services for prevention and treatment of substance use disorders in Zimbabwe	193
Figure 6: An illustration of the collective occupational reconstruction treatment framework ...	195

List of appendices

Appendix 1: HREC approval	232
Appendix 2: MRCZ approval	233
Appendix 3: Harare Central Hospital Approval	234
Appendix 4: JREC approval	235
Appendix 5: MRCZ renewal.....	237
Appendix 6: JREC renewal.....	238
Appendix 7 Sociodemographic data abstraction form:.....	240
Appendix 8: Original English interview guide	241
Appendix 9: Original Shona interview guide	243
Appendix 10: Revised English interview guide.....	245
Appendix 11: Revised Shona interview guide.....	247
Appendix 12: English informed consent form	249
Appendix 13: Shona informed consent form	253

List of abbreviations

WHO: World Health Organisation

MOHCC: Ministry of Health and Child Care

HREC: Health Research Ethics Committee

MRCZ: Medical Research Council of Zimbabwe

JREC: Joint University of Zimbabwe and Parirenyatwa Hospital Ethics Committee

Table of Contents

Declaration.....	1
Acknowledgements	2
Abstract.....	3
Opsomming.....	6
Definition of terms	9
List of tables.....	11
List of figures.....	12
List of appendices.....	13
List of abbreviations	14
Table of Contents	15
Chapter 1: Introduction	20
1.1 Introduction.....	20
1.2 Background to the study	20
1.3 Substance use disorders and occupational therapy	23
1.4. Substance abuse in Zimbabwe	28
1.5 The socioeconomic context in Zimbabwe and its impact on substance use disorders	29
1.6 The family in the Zimbabwean context.....	30
1.7 Overview of health care services in Zimbabwe	30
1.7.1. The development and organisation of occupational therapy services in Zimbabwe... 33	
1.7.2 Services for managing substance use disorders in Zimbabwe	34
1.7.3 Policy framework guiding the management of substance use disorders	35
1.8 Philosophical underpinnings of the study	36
1.9 Problem statement	39
1.10 Purpose of the study.....	40
1.11 Research question	40
1.12 Aim	41
1.12.1. Specific objectives	41
1.13 Synopsis of the study.....	41
1.14 Conclusion	42
Chapter 2: Literature Review	43
2.1 Introduction.....	43
2.2 A general overview of substance use disorders	43

2.3 An occupational perspective of substance use disorders	44
2.4 Factors associated with substance use.....	47
2.4.1 Sociodemographic factors associated with substance use	48
2.4.2 Contextual factors associated with substance use	49
2.5 The impact of substance use on occupation.....	52
2.5.1 The impact of substance use on the occupations of the individual using substances... 52	
2.5.2 The impact of substance use on the occupations of other family members	55
2.5.3 The impact of substance use disorders on neurocognitive functioning.....	56
2.6 Family involvement in interventions for substance use disorders.....	58
2.7 Occupational therapy interventions for substance use disorders.....	61
2.8 Conclusion	63
Chapter 3: Methodology.....	65
3.1 Introduction.....	65
3.2 Selecting the research methodology for the study.....	65
3.3 Qualitative Research design.....	66
3.4 Narrative inquiry	67
3.4.1 Narrative inquiry in occupational therapy and occupational science research.....	68
3.5 The study methodology.....	70
3.5.1 Gaining access to participants	70
3.5.2 Preparation to enter the field	70
3.5.3. Participant recruitment	72
3.5.4 Participant selection.....	74
3.6 Pilot study	78
3.7 Data gathering.....	79
3.7.1 Conducting the narrative interviews.....	80
3.7.2 The interview setting	83
3.8 Data capturing and management	84
3.8.1 Transcription and translation	84
3.9 Data analysis.....	85
3.9.1 First level of analysis.....	87
3.9.2 Second and third levels of analysis.....	88
3.10 Scientific rigour of the study	89

3.10.1 Audit trail.....	89
3.10.2 Reflexivity	90
3.10.3 Peer debriefing.....	91
3.10.4 Prolonged engagement	91
3.10.5 Member checking of transcripts	92
3.10.6 Triangulation	92
3.11 Ethics	93
3.11.1 Autonomy	93
3.11.2 Respect for persons.....	95
3.11.3 Beneficence	96
3.11.4 Privacy and confidentiality.....	96
3.12 Conclusion	97
Chapter 4: First level of analysis	98
4.1 Introduction.....	98
Shumba`s Narrative: I am not ready for change	98
Nzou`s narrative: We have come a long way.....	98
Shumba`s story: I am not ready to change	99
Nzou`s story: We have come a long way	105
Zuva`s narrative: It was not an easy journey but I just stayed on	109
Ndakaziva`s story: The experiment that went wrong.....	113
Danai`s story: I want to stop but I have nothing else to do	123
Themba`s story: The ball is in your court	127
Tatenda`s story: I know I can change	135
Gandibas`s story: Quitting is not easy when there are drugs everywhere.....	142
Gamuchirayi`s story: Just give me more time and I will change.....	146
Tapera`s story: Lost opportunities.....	155
Nhamo`s story: I need a fresh start	159
4.2 Conclusion	161
Chapter 5: Second level of analysis	162
5.1 Introduction.....	162
5.2 Overarching theme: Reconstructing occupational participation through transactions enacted within the family context	162
5.3 Occupational disruption from an intrapersonal and interpersonal perspective.....	164

5.3.1 Changes in occupational participation patterns	165
5.3.2. Uncertainty over future occupational participation	170
5.4. The centrality of the family in creating opportunities for participating in occupations	172
5.4.1 New opportunities for participating in occupations	173
5.4.2 Availing resources to facilitate resumption of participation in meaningful occupations	
5.5 Conclusion	178
Chapter 6: Discussion	179
6.1 Introduction.....	179
6.2 Factors shaping family involvement in promoting the participation of adults with substance use disorders in meaningful occupation	179
6.2.1 The family context and its influence on the family`s involvement in promoting the participation of adults with substance use disorders in meaningful occupations	180
6.2.2 Opportunities for participation in occupations created within the family unit.....	185
6.3 Conclusion	188
Chapter 7: Conclusion and Recommendations	189
7.1 Introduction.....	189
7.2 Main findings from the study and their implications for occupational therapy practice	189
7.3 Presentation of the collective occupational reconstruction treatment framework	191
7.4 The outline of the collective occupational reconstruction treatment framework	194
Stage 1: Situational analysis	196
Stage 2: Identifying resources for occupational reconstruction	196
Stage 3: Occupational reconstruction	197
Stage 4: Evaluation.....	197
7.5 Comparison of the proposed collective occupational reconstruction treatment frameworks with existing occupational therapy frameworks.....	198
7. 6 Recommendations from the study	200
7.6.1 To occupational therapists	200
7.6.2 To the Ministry of health and child care.....	201
7.6.3 Lecturers at the University of Zimbabwe	202
7.7 Study limitations	203
7.8 Conclusion	204
Glossary of Zimbabwean terms used in the study	205
References.....	206

Appendices.....	231
Appendix 1: HREC approval.....	231
Appendix 2: MRCZ approval.....	232
Appendix 3: Harare Central Hospital approval.....	233
Appendix 4: JREC approval.....	234
Appendix 5: MRCZ Renewal.....	236
Appendix 6: JREC renewal.....	237
Appendix 7: Sociodemographic data abstraction form.....	239
Appendix 8: Original English interview guide.....	240
Appendix 9: Original Shona interview guide.....	242
Appendix 10: Revised English interview guide.....	244
Appendix 11: Revised Shona interview guide.....	246
Appendix 12: English informed consent form.....	248
Appendix13: Shona informed consent form.....	252

Chapter 1: Introduction

1.1 Introduction

The intention of conducting this research study was to explore the factors that shape family involvement in promoting the participation of adults with substance use disorders in meaningful occupations. In this chapter, I introduce the study by giving the background, describing substance use in Zimbabwe and the services that are available for managing substance use disorders. A brief overview of the family within the Zimbabwean context and the socioeconomic environment and their impact on mental health services in Zimbabwe with special emphasis on occupational therapy services for substance use disorders will also be given. I will further highlight the significance of the study, and clarify the role of occupational therapy in the treatment of individuals with substance use disorders and introduce the concepts of participation and meaningfulness from an occupational perspective. The philosophical perspective underpinning this research and the questions which were answered through this research as well as the research objectives that guided the study will also be presented. The chapter will end with a synopsis of the study.

1.2 Background to the study

Substance use disorders are defined in the latest edition of the Diagnostic and Statistical Manual for Mental Disorders (DSM-5) (1) as: maladaptive patterns of substance use indicated by continued use of substances despite knowledge of persistent or recurrent social,¹ occupational, psychological, or physical problems resulting from use. A person with a substance use disorder repeatedly places him/herself in physically hazardous situations due to the substance seeking

¹ It is assumed that the word occupation in this definition is used in the vocational sense

habits. (1) The World Health Organisation (WHO), in its publication of the latest intervention guide for mental, neurological and substance use disorders, (2) identified drug and alcohol use disorders as well as intoxication, overdose, withdrawal, harmful use and dependence as substance use disorders. Substance use disorders are chronic in nature (3) and are characterised by repeated cycles of cessation and relapse. (4)

The high prevalence of substance use disorders is a global public health issue as it is common throughout the world and affects many communities. (5) There is evidence to show that more males than females are affected by substance use disorders, but females tend to escalate their substance use at a faster rate than males. (6) An estimated 250 million adults worldwide are reported to have used drugs at least once and 0.6% of these adults develop substance use disorders. (6) Approximately 14% of the global burden of disease is attributable to substance use and most of the people who are affected in low to middle income countries including Zimbabwe have no access to the required treatment and rehabilitation services. (7)

Continued use of substances results in damage to organs and functional impairments. As can be seen from Table 1 below, the long term consequences of primary or secondary use disorders vary and may include severe health problems due to significant damage to major body organs as well as restrictions in personal activities and participation in all life situations. (8) Opioids have been reported to have the most harmful effects on health. (8) The available literature on the production, trafficking and use of substances has revealed a global increase in the market for cocaine, cannabis and opioids. Misuse of prescription and illicit drugs as well as increased cannabis use are of major concern in most African countries. (9)(10) The most commonly abused drugs in Africa include alcohol, tobacco, cannabis and a variety of illicit substances. (11)

Table 1: Long term effects of commonly abused drugs (adapted from WHO intervention guide for substance use disorders in non-specialised health settings)

Type of drug	Effects of prolonged use
Alcohol	Brain atrophy Liver cirrhosis Gastritis Anaemia
Benzodiazepines	Memory impairment Risk of fatal overdose
Opioids	Constipation Risk of sedative fatal overdose Hypogonadism
Tobacco	Lung cancer Cardiovascular disease
Cocaine	Hypertension Increased risk of cerebrovascular disease Increased risk of cancers
Cannabis	Psychosis Lack of motivation Difficult concentrating Risk of myocardial infarction and stroke
Volatile solvents	Decreased cognitive function Dementia Increased risk of heart attacks
Hallucinogens	Psychosis

The preventative, treatment, rehabilitation and care services required for the effective management of substance use disorders continue to overburden public health systems globally. (10)(12) The World Health Organisation estimates that costs associated with managing substance use disorders is expected to treble from the current US\$2.3million by the year 2030. (7) This escalation in cost implies an increase in the burden of substance use disorders. Generally, treatment services for persons with substance use disorders are grossly underdeveloped in most low to middle income countries. (2)(13) Services are provided by non-specialist health care workers mostly doctors, nurses and lay health workers as well as other professionals with health promotion roles such as teachers. It has been documented in studies that there are benefits of utilising non specialist health professions in managing substance use disorders (14)(15) but there is inconclusive evidence that these non-specialist health care workers can provide specific interventions effectively.

1.3 Substance use disorders and occupational therapy

Occupational therapy was founded on the premise that occupations affect the health of individuals. (16) Participation in occupations can meet spiritual and health needs, in the process enhancing quality of life, sustaining families and communities. Such participation includes looking after oneself and others and taking part in activities that are perceived to be productive and that promote health and wellbeing. (16)(17)(18) There are many definitions for occupation within the occupational therapy and occupational sciences literature. The definition by the World Federation of Occupational Therapists (19) in which occupations were defined as everyday activities that people do as individuals, in families and with communities to occupy time and bring meaning and purpose to life was adopted in this study This definition captured personal and interpersonal aspects of occupation which were aligned to the focus of the study. In this

study the occupations of the individuals with substance use disorders were considered to be nested in the occupations of the entire family. This was deemed important in understanding how substance abuse by one family member would impact on the occupations of other family members.

Individuals can engage in occupations that are unhealthy thereby becoming vulnerable to the negative effects of participation in these occupations. (20) Substance use may be viewed as one of those unhealthy occupations that negatively affect a person's occupational identity, participation and performance patterns and capacity.

Some of the deleterious effect of substance dependence include harmful behaviour patterns that impact on the user's quality of life in a negative manner. (21) Occupational therapy has a major role in the management of clients recovering from substance use disorders. (21)(22) Many such clients spend a great deal of their time in activities directed towards seeking the substances of abuse, using the substances or recovering from the effects. (21) Important social, occupational or recreational activities are given up or reduced because of substance use. (23) Occupational therapy enables such individuals to develop skills, coping strategies and satisfying, balanced lifestyle to substitute for substance use routines. (24)

Facilitation of participation in meaningful occupation is the hallmark of occupational therapy. (17)(25)(26) The general consensus in the occupational therapy and occupational science literature is that participation in occupations is an individual experience which can best be understood by situating the occupations in context. The recognition of the importance of participation in enhancing quality of life is underscored by World Health Organisation. (27) The definition of participation by Law (28) resonates well with the overriding principles and focus of

occupational therapy. She defined participation as “involvement in formal and informal everyday activities leading to satisfaction, development of various skills and a sense of competency.”

One of the basic principles in occupational therapy theory is that participation in meaningful occupations will enhance occupational performance and contribute to quality of life. (30) In order for participation to be meaningful there must be clearly set goals, a balance between the challenge offered by an activity and individual skills as well as appropriate and timely feedback to performance. (29) Meaningfulness is one of the therapeutic aspects of occupation which is derived from the connection between the mind and body. (31)

A number of scholars (17)(32)(33)(34)(35)(36)(37)(38) describe meaningfulness in different ways but the common qualities that reflect meaningfulness include having a choice and control over the occupation in which one participates, congruency with personal values, beliefs and life goals, ability to foster a sense of self competency and accomplishment and facilitating experiences of enjoyment as well as social connectedness. Hammel`s (17) definition of meaningfulness captured the characteristics highlighted above. She described meaningfulness as the belief that one is doing the right thing that he or she values leading to feelings of positive self-worth, accomplishment and competency. (17) She proposed that having a choice regarding whether or not to participate in an occupation enhanced an individual`s perception of an occupation as meaningful.

There is a common understanding in occupational therapy that meaningfulness is a subjective experience that is characterised by several qualities. Leufstadius et al. (38) posited that meaningfulness of an occupation was contextual and can only be perceived and expressed by the individual performing the occupation at that point in time. Ikiugu (39) concurred with

Leufstadius et al. (38) and suggested that while the experience of meaningfulness remained individual, occupations provided shared meaning for social units such as families.

In her presentation of the Eleanor Slagle memorial lecture, Trombly (31) proposed that there was a difference in the meaningfulness that was derived from “occupation as end” and “occupation as means”. She highlighted the fact that when occupation was used as an end, meaningfulness was derived from being able to participate in it, because the individual perceived the occupation as important according to personal beliefs, values and culture. This meaningfulness can be measured using an indicator such as satisfaction with participation in an occupation. On the other hand the meaningfulness of occupation “as means” stems from its potential to stimulate positive associations and its contribution to recovery. (31)

An important aspect to consider when describing meaningfulness of occupations is the source of the meaning. Leufstadius et al. (38) explored the sources of meaning of occupations among Swedish community dwelling adults (n=103). Five main sources of meaning were identified. These were connection with others, enjoyment, being productive and having a sense of achievement, being occupied and having routines and projects and taking care of oneself to maintain health. The themes resonated well with findings from similar studies in Sweden. (40) They supported the assertion by Trombly (31) that meaningfulness was experienced from occupations that have different functions.

Hancock et al. (26) conducted a similar study to the one by Leufstadius et al. (38) and further explored the relationship between occupations, sources of meaning and stage of recovery for adults living with mental illness (n=78). This was a mixed methods study in which participants completed the recovery assessment scale and the valued role classification scale. The sources of

meaning were explored qualitatively. In their findings Hancock et al. (26) reported that irrespective of the stages of recovery, time use, financial gain and other socially derived aspects of meaning similar to those reported by Leufstadius et al. (38) and Tjörnstrand et al. (40) were the most frequently prioritised by people living with mental illness. These findings demonstrated the need by occupational therapists to consider that for most adults with mental illness meaningfulness was centred on being with others, belonging, giving or contributing and being valued by others.

Despite recommendations by scholars in occupational therapy and occupational science to conduct research that provides evidence to further clarify the concept of meaningfulness, literature on this concept is still dominated by theoretical papers and qualitative research. Hitch et al. (41) conducted a metasynthesis of lived experiences of engagement in activities and occupations by people who had experienced psychosis. They identified nine qualitative studies published in the occupational therapy literature. In these studies individuals who had experienced psychosis described their engagement in occupations as relating to other emotions and identity, their health and wellbeing, relationship with friends, family and community as well as choice of activity. The conclusion from this study was that individuals with psychosis had to be viewed as occupational beings and their participation in meaningful occupations should be considered as an important outcome of occupational therapy interventions. The findings from this metasynthesis highlight components that should be considered by occupational therapists in their evaluation of meaningfulness of occupations for individuals with psychosis. While this metasynthesis focused on psychosis only, these findings could be applied to the evaluation of meaningfulness of occupations in other mental illnesses.

Objective measurement of meaningfulness remains a challenge in occupational therapy. A search of the literature for evidence on the measurement of meaningfulness of occupations among clients with mental illness yielded one quantitative study. This study was conducted by Goldberg et al. (30) who examined the relationship between engagement in meaningful activities and quality of life. In this cross sectional correlational study, individuals (n=32) with mental illness who were attending a mental health agency programme completed the engagement in meaningful activities survey which was used to measure 12 descriptions of perceived meaning of an occupation in an individual's life. The findings indicated that engagement in meaningful activity was significantly related to higher quality of life scores. Despite the small sample size used and the cross sectional nature of the study, this study constituted an initial step towards building evidence base for the objective assessment of meaningfulness.

This is an important initial step because meaningfulness of occupation remains the core construct that underlies the philosophy of occupational therapy. (42) As such it is important to carefully consider how to identify the meaning of occupations in all occupational therapy interventions. In this study it was assumed that identifying meaningful occupations for adults recovering from substance use disorders would facilitate their participation in health enhancing occupations.

1.4. Substance abuse in Zimbabwe

The increasing rate of substance abuse in Zimbabwe is a major public health concern. (43) There is paucity of research in which the actual prevalence of substance abuse in the country has been recently investigated, but available data indicate that the problem is increasing in Zimbabwe as is the case in most African countries. (8)(10)(12)(44) In Zimbabwe the dangerous drugs act prohibits the importation and exportation of dangerous drugs. (45) However various surveys

conducted in the country have revealed that the country is no longer just a transit state but illicit substances are now sold and consumed in the country. (46) This situation is made worse by high levels of corruption in the country which have made the country's borders less secure and as a result more and more illicit substances are finding their way into the country. (47) The commonly abused substances in Zimbabwe include cannabis, ecstasy, heroin, cocaine, glue, zed, alcohol and pharmaceutical drugs. (11) Cannabis or *mbanje* as it is locally called is the most abused drug because it is locally grown. There is gross underreporting of the gravity of the problem of substance use because available statistics only capture incidences of users in the health care system leaving out those who do not seek help from health care facilities. (11)

1.5 The socioeconomic context in Zimbabwe and its impact on substance use disorders

An appreciation of the socioeconomic environment in Zimbabwe is essential for a better understanding of the context in which services for substance use disorders are being provided. Economic growth in Zimbabwe has been on a downward trend for the past ten years. Low levels of investment and poor performance of the mining, agricultural and manufacturing sectors resulted in the World Bank revising the economic growth rate for Zimbabwe downwards to 3% from the initial projection of 4.2 %. (48) This downward trend in the economy is further confounded by a large national debt (approximately \$10 billion at the moment). (48) Some formal businesses and industries have continued to retrench workers; others have closed down due to the unfavourable economic climate prevailing in the country. (49) Rising unemployment rates have resulted in a concomitant increase in informal businesses and industries with the majority of Zimbabweans aged between 19 and 45 years joining the informal sector. (48) The informal sector in Zimbabwe comprises of small to medium scale businesses that are involved in

manufacturing and selling of various commodities. (50) The overall impact of these socio-economic challenges has been significant, including a steep decline in health budgets.

1.6 The family in the Zimbabwean context

The concept of the African traditional family is very broad and has interesting variations across the continent. (51)(52) The idea of a family implies an enduring emotional relationship. (53) In Zimbabwe the family is premised on an expansive kinship network and is dominated by a patriarchal system. (54) Family descent is traced through the father. (55) The organisation of the traditional family in Zimbabwe is founded on collective relationships. The family prescribes the expected behaviour by family members and is involved in decision making in all aspects of life including health.

There is no single definition for family and existing definitions are influenced by cultures and belief systems. (53) Definitions of the family may change according to changing social circumstances. In my search for a suitable definition of family, I acknowledged that culture and beliefs change with time and therefore the definitions of the concept of family are not static. In this study I used the definition by Asare and Danquah (55) in which family was defined as ‘cultural and social relations of kinship that transcends the nuclear family to include the extended family’. (p1) This definition captured the understanding of the family concept within the Zimbabwean context.

1.7 Overview of health care services in Zimbabwe

In order to understand the challenges faced by individuals with substance use disorders seeking rehabilitation in Zimbabwe, it is important to understand how health care delivery is organised in the country. Health care services in Zimbabwe are decentralised and can be accessed at primary,

secondary, tertiary and central levels as shown in Figure 1. (48)(56) These services are largely provided through the public health care system, but mission hospitals, non-governmental organisations, company operated clinics and private clinics provide complementary services. Despite the decentralisation of health care services, administrative and policy related activities for the public health care system remain centralised within the Ministry of Health and Child care (MoHCC). (43)

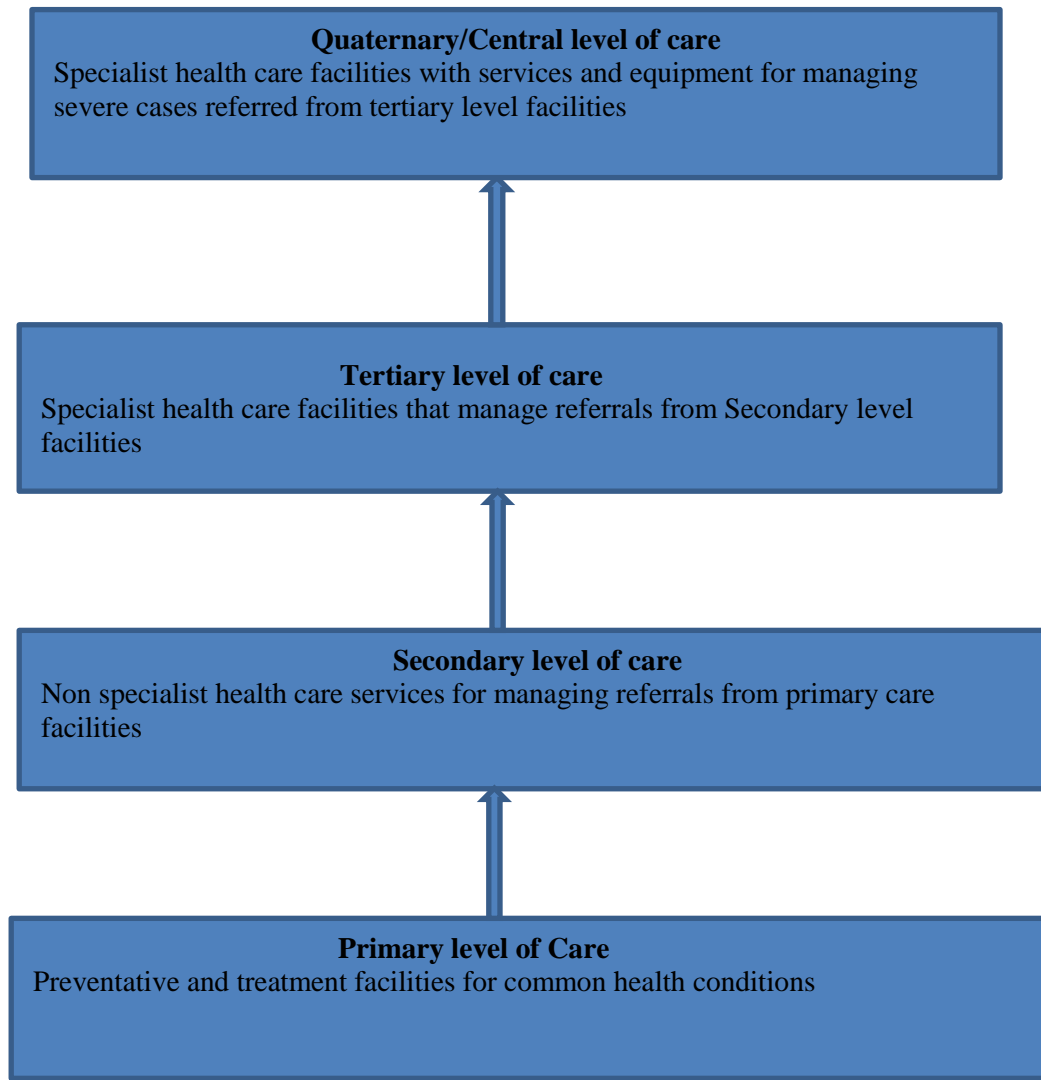


Figure 1: Organisation of health care system in Zimbabwe

1.7.1. The development and organisation of occupational therapy services in Zimbabwe

The evolution of occupational therapy in Zimbabwe dates back to the colonial era. During this time occupational therapy services were provided to a few white minorities by expatriate therapists who had trained outside Zimbabwe mostly, in Europe. A few years before Zimbabwe's Independence in 1980, Zimbabwean students were given scholarships to train as occupational therapists in European Universities. The majority of these European trained occupational therapists returned to Zimbabwe after qualifying. As more and more occupational therapists returned home, they joined the first association of occupational therapists in Zimbabwe (Rhodesian Association of Occupational Therapists) which spearheaded the development of the training curriculum for occupational therapists in Zimbabwe. The local training of occupational therapists resulted in occupational therapy services being accessible to the indigenous Zimbabweans.

Occupational therapy services in Zimbabwe are mostly provided in central and provincial hospitals; only a few district hospitals have occupational therapy services. Rehabilitation technicians provide services that would ordinarily be offered by occupational therapists at most of the district hospitals. These rehabilitation technicians are mid-level workers trained to provide components of basic occupational therapy, physiotherapy and speech therapy services.

1.7.2 Services for managing substance use disorders in Zimbabwe

Persons with substance use disorders are treated within the mental health care system in Zimbabwe as there are no facilities dedicated specifically to this problem. Following the attainment of Independence in 1980, policy makers agreed to decentralise mental health services in the country so that they were accessible at the lowest level of care, namely the primary care level. (48) Clinics were built within a radius of ten kilometres from each household and a referral system was put in place to allow referral of patients in need of mental health services from the lowest to the highest level of care where patients could be attended to by specialists in mental health care. (57) The policy makers also proposed that mental health care services be provided free of charge in public health institutions to allow disadvantaged individuals to access mental health services. This meant that the government of Zimbabwe would have a mental health budget to cover all costs incurred during management of clients with mental health problems. This plan was however abandoned due to the continued deterioration of the economy which resulted in the gradual decline in health care budgets. Many mental health care professionals, including occupational therapists, left the country in search of better working environments; which led to a critical shortage of mental health personnel in Zimbabwe. (48) This situation was further confounded by competing health priorities such as managing the HIV/AIDS crisis and outbreaks of other communicable diseases leading to mental health services being given the least priority on the health budget. (48) (57)

Currently there are two acute mental health care units, two long term care units and two forensic care units in Zimbabwe. All these facilities are considered to be at the quaternary level of care as they provide specialist psychiatry services with support from psychiatry nurses, occupational therapists, clinical psychologists, and clinical social workers. Access to mental health services

remains a major challenge in Zimbabwe and patients have to travel long distances to access the services at these central hospitals. There is also poor coordination of existing services between the public and private sectors. Occupational therapy management of individuals recovering from substance use disorders at the two main mental health units in Zimbabwe usually begins in the acute phase when patients are hospitalised. There are no rehabilitation programmes with defined minimum care standards in which occupational therapy is available to people with substance use disorders. Follow up of patients in their homes is also not possible due to limited financial and human resources. There is therefore no further psychosocial support or follow up rehabilitative care for clients with substance use disorders post discharge, hence their families take over the caring role

1.7.3 Policy framework guiding the management of substance use disorders

In Zimbabwe there are general policy frameworks that guide the provision of health care in the country as well as some policies specific to the provision of mental health services, including those for substance use disorders. The national Constitution of Zimbabwe (49) supersedes all other policies in the provision of health care services. This Constitution stipulates that all Zimbabweans have a right to mental health care. It provides for free access to mental health care services. The Ministry of Health and Childcare developed a national strategic policy document, the National Health Strategy (48) guided by the health provisions within the national constitution. This strategy clearly articulated the vision for the Ministry of Health and Child Care with well-defined indicators that were to be evaluated every fifth year to assess the performance of the health care system.

The mental health policy provides a framework for provision of mental health services within the context of primary health care. (58) Its major aim is to harmonise mental health activities at all levels of care with the ultimate goal of improving the quality of care of individuals with mental illness. While this framework clearly spells out the need for comprehensive treatment of individuals with mental disorders as well as the need for training of mental health professionals to provide services at all levels of care, these strategic objectives have not been fully implemented.

In addition, the mental health strategy was developed to operationalise the mental health policy. (59) It focuses on administration and policy, infrastructure and research, mental health promotion and prevention of mental illness, legislation, forensic services and ethics, treatment and rehabilitation, coordination and collaboration as well as mental health information systems. These are the major priority areas for mental health in Zimbabwe. (59) However targets set under each of the priority areas have not been met due to limited financial resources. Therefore the policy specifying these priorities has not been operationalised.

1.8 Philosophical underpinnings of the study

Despite thirty years of occupational therapy training in Zimbabwe, occupational therapy practice and research have remained largely influenced by Western ideologies that shaped the development of the training curriculum. Hammell (60) argued that the occupational therapy theorists who pioneered the profession were “well-educated, urban, middle-class, middle-aged, able-bodied and anglophone with Judeo-Christian backgrounds” and they developed ideas from their own contextual and cultural perspectives. As a result, these Western theories and ideologies pay little attention to the context as well as cultural beliefs, norms and values of indigenous

Zimbabweans accessing occupational therapy services in the public sector. Recently, researchers (60)(61) in occupational therapy have acknowledged that occupational therapy should be informed by indigenous knowledge and proposed the development of new theories of occupational therapy and models that are contextually relevant and respond to the indigenous and cultural values. It is in this regard that the philosophical underpinnings of this study were grounded in the principles of decoloniality. (62)(63)(64)(65)

Decoloniality also referred to as “decolonial thinking” or the “decolonial turn” denotes a “family of diverse positions that share a view of coloniality as a fundamental problem in the contemporary world”. (62) (p2) According to Grosfoguel, (65) the decolonial turn in research is aimed at “transcending and decolonising the Western canon epistemology”. (p.211)

The concept of decoloniality of research methods dates back to the work that was done in Australia, Canada and New Zealand on marginalised populations such as the aborigines in Australia. (65) Maldonado-Torres (62) defined coloniality as the “longstanding pattern of power that emerges as a result of colonialism but define culture, labour, intersubjective relations and knowledge production well beyond the limits of the colonial administration”. (p117) While this definition highlights the existence of coloniality within the realms of power, knowledge and being, decoloniality in research is mainly focused on coloniality of knowledge. The central tenet of decoloniality of research methods is the need to affirm other ways of producing knowledge. Decoloniality of research methods goes beyond proposing a methodology. Rather, it requires deep engagement and rethinking of ways of being, knowing and doing which reflect contextual differences among communities on a global level. (63) Some decolonial scholars (62)(65)(66) proposed the need for decolonising knowledge through “shifting the geography of reason”. This shift entails opening the academic space for thinking and theorising that goes beyond the

Western notions of knowledge production and validation. One of the ways that has been proposed to facilitate the shifting of the geography of reason is to practise “epistemic disobedience”. (67) Mignolo (67) defined epistemic disobedience as the process of de-linking from the Western epistemological assumption of a neutral and detached observational position through which the world is interpreted. He argued that epistemic disobedience allowed researchers to appreciate that knowledge is not universal.

Traditionally the definitions of what is normal and acceptable in research have been foregrounded in Western epistemologies which restricted researchers from marginalised countries from applying research methods that were contextually relevant in their research settings. (63) Therefore decoloniality of research methods provides researchers with an opportunity to rethink the existing research methods. It also allows for application of contextually relevant research methods in addressing local problems. These methods are not restricted by definitions of the ideal as conceptualised in the Western epistemologies.

In this study, I adopted the decoloniality perspective in an effort to apply a methodology that is culturally sensitive throughout the whole research process. During participant recruitment I took into account how Zimbabwean families collectively seek solutions to help a family member with a mental health problem. I therefore considered the family as my study unit. This included the individual with a substance use disorder and the family members who were affected by the substance use disorder. Since Zimbabwe is a patriarchal society, it was important for me to uphold the cultural values of approaching the head of the family unit who is usually the father or a male member of the family whenever an outsider wanted to visit the family. In this study I was the outsider and I contacted the head of the family units to seek permission to conduct interviews

with their families even if the heads of the family units were not going to be present for the interviews.

In my presentation of the narratives I maintained the multiple voices of the family members as I generated the narratives. There is dearth of literature on the advantages and disadvantages of having multiple voices in a single narrative. However in this study this was deemed important as my study unit was the family. The decoloniality perspective also led me to appreciate the “richness of innovation”(66) by using the data gathered in this study to develop a contextually relevant treatment framework for the occupational therapy management of adults with substance use disorders in Zimbabwe. This framework included traditional and faith healers as key stakeholders in the management of substance use disorders. By including traditional and faith healers in the treatment framework, I acknowledged that occupational therapy interventions for substance use disorders should reflect differences in cultural norms, values and practises as they are applied in different settings.

1.9 Problem statement

Approximately 60% of the annual re-admissions at the two main acute mental health units at the referral hospitals in Harare, Zimbabwe are adults with substance use disorders. Since there are no psychosocial support services for these patients following discharge, community- based occupational therapy services may be beneficial in bridging this gap in the continuum of care. However, because the current economic decline resulted in policies not being implemented, reductions in health budgets and scarcity of health professionals, including occupational therapists, such programmes are probably not sustainable. There is therefore a need to explore ways in which families may be involved in occupational therapy programming for people with

substance use disorders in the Zimbabwean setting with a view to optimise the benefits of treatment given the scarce rehabilitation resources.

1.10 Purpose of the study

The purpose of this inquiry was to explore the facilitators and barriers that shape family involvement in the rehabilitation interventions that focus on facilitating resumption of participation in meaningful occupations by adults with substance use disorders in Zimbabwe. Furthermore, the influence of the family on rehabilitation outcomes was explored by examining the extent to which family involvement promoted participation in meaningful occupations by adults recovering from substance use disorders in Zimbabwe. The information obtained from this study was used to develop a framework for family based occupational therapy interventions that focus on involving the family in the occupational therapy management of family members with substance use disorders.

1.11 Research question

What were the factors shaping family involvement in promoting the participation of adults with substance use disorders in meaningful occupations?

1.12 Aim

To explore the role of the family in the rehabilitation of individuals with substance use disorders with emphasis on facilitation of resumption of participation in health enhancing occupations.

1.12.1. Specific objectives

- To explore how a family member's substance use affected his/her occupational patterns as well as those of other family members
- To investigate what made it difficult or easier for families to support a family member who was undergoing occupational therapy to help modify substance use behaviour
- To investigate how involvement of family members in occupational therapy interventions influenced participation in meaningful occupations by adults with substance use disorders
- To develop a treatment framework for family based occupational therapy interventions to treat individuals with substance use disorders in the Zimbabwean context

1.13 Synopsis of the study

This dissertation consists of seven chapters. In chapter one I present the background of the study and its need as well as its philosophical underpinnings. A critical review of the relevant literature guided by the study objectives is presented in chapter two. Chapter three provides a full description of the methodology used to conduct the study. Results of the first and second level of analysis are presented in chapter four and five respectively, while a discussion of findings is presented in chapter six. In chapter seven, I present the conclusions that can be drawn from the study and my recommendations for future research and practise.

1.14 Conclusion

In this chapter, I provided a detailed background to the study and contextualised the problem of substance use and substance use disorders in Zimbabwe. I highlighted the growing problem of substance use in Zimbabwe and the reasons why services for management of substance use disorders have remained very basic. Gaps in the continuum of care for adults with substance use disorders in Zimbabwe were shown to include the absence of follow up services after discharge and absence of rehabilitation services dedicated to the management of substance use disorders. The potential involvement of families as critical stakeholders in the provision of post discharge support services for individuals with substance use disorders were highlighted.

Chapter 2: Literature Review

2.1 Introduction

The literature review presented in this chapter provides a deeper understanding of substance use disorders, their impact on the occupations of the affected individuals as well as their impact on the occupations of the entire family. The chapter commences with an overview of substance use disorders and provides an occupational perspective to understanding substance use disorders. In the chapter, I also provide an overview of the various non pharmacological interventions and highlight the advantages and disadvantages of these interventions to families. The gaps in the literature with regards to defining the role of occupational therapy in managing substance use disorders are noted. A justification is provided for involvement of the family in the interventions.

2.2 A general overview of substance use disorders

An exhaustive literature search, guided by the study objectives and research questions revealed that there is research evidence supporting the neurobiological, (68)(69)(70) psychological, (71) family (72) (73)(74) and social (69)(75) factors contributing to the development of substance use and the associated disorders. Various research studies have been conducted to investigate the neurobiological causal pathway for substance use disorders. (68)(76)(77)(78)(79) Findings from these studies indicate that ingestion of substances stimulates neurobiological changes that are pathological and that these changes trigger the development of addictions. Some authors (68)(77) discuss the genetic factors that explain the differences in individual responses to substances. Evidence is provided supporting the use of pharmacological interventions to reverse the effects of pathological changes that are triggered by substance use. (76)

While the focus of most psychiatric management of individuals with substance use disorders is to reverse the pathology through use of pharmacological interventions, psychologists focus on addressing the cognitive aspects. The general argument in research conducted in the field of psychology is that substance use disorders result from maladaptive cognitive processes and behaviours. (80)(81)(82)(83) Research that has been conducted to explore interventions for substance use disorders from a psychological perspective suggests that a combination of psychosocial interventions and psychological therapies are effective in addressing substance use disorders. (71)

On the other hand findings from studies conducted in the field of sociology suggest that societal inequalities such as poverty, homelessness, unemployment and unequal opportunities to participate in sociocultural activities contribute to the development of substance use disorders. (72)(84)(85)(86) As such, most of the interventions in this field focus on addressing these societal inequalities. (87) Even though research that has been conducted supports the use of different interventions depending on the focus of the field of research, literature provides evidence that these interventions yield better treatment outcomes when used in a complementary way. (76)(88) It is important to note that there is an overlap among some of the interventions that are based on psychological and sociological theories.

2.3 An occupational perspective of substance use disorders

There has been increased recognition in occupational therapy (21)(23)(89)(90)(91)(92)(93) and occupational science literature (94)(95)(96) that substance use has a great impact on human occupation. The dominant discourse of these theoretical and research based literature is that of developing an occupational perspective to understanding substance use disorders. An occupational perspective implies that substance use has an impact on participation in everyday

activities. Framing substance use from an occupational perspective is important in this study because when individuals develop substance use disorders the resulting physical, psychological and sociological consequences impact participation in occupations. In their recent publication of the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSMV) (1), the American Psychiatric Association acknowledged that individuals experiencing substance use disorders often lack meaningful occupation in daily living. However they did not describe the specific areas of occupation that are disrupted by substance use.

The theoretical paper by Helbig and McKay (94) contributed to the preliminary work on conceptualising addictions as occupations. They proposed an occupational perspective of addictions, including substance use based on a review of literature and argued that addiction was occupational in nature. According to Helbig and McKay (94), the causes and consequences of addictions such as occupational deprivation; occupational imbalance and occupational alienation should be taken into account when designing interventions for the treatment of individuals with addictions. Chang (93) supported the notion put forward by Helbig and Mackay (94) and went on to propose that participating in substance use had the same benefits as participating in other occupations. These benefits include providing a sense of control, temporary alleviation of emotional pain and opportunities for peer interactions. Haltiwanger et al. (97) supported the proposal by Chang (93) in their conceptualisation of alcoholism as an occupation.

Kiepek and Magalhães (95) conducted an integrative and interpretive literature synthesis in an attempt to determine whether activities that were classified as addictions and impulse control disorders could be considered as occupations. They identified six key themes which were aligned to the various definitions of “occupation” in the occupational therapy and occupational science literature and concluded that addictions and impulse control disorders could be defined as

occupations. Findings by Kiepek and Magalhães (95) confirmed the earlier conceptualisations of substance use as an occupation.

A similar conclusion to that by Kiepek and Magalhães (95) was reached by Wasmuth et al. (89) in their study conducted to explore the experiences of ten individuals with addiction. They reported that addiction provides structure, value and meaning to the individuals using substances. The authors made an argument in support of the notion that in the absence of alternative occupations, use of substances becomes the dominant occupation to make up for the lack of alternative meaningful occupations. The benefits derived from using substances described by the participants in the study by Wasmuth et al. (89) are similar to the value of occupation that is generally described in occupational therapy and occupational science literature.

Unlike some authors who proposed that substance use be viewed as an occupation based on the positive benefits only, Kiepek and Magalhaes (95) as well as Stewart and Fischer (98) concurred that addictions as in the case with other occupations, are associated with both positive and negative consequences. Kiepek and Magalhães (95) argued that meaningfulness derived from participating in an activity such as drinking contributed to the development of addictions implying that perceiving substance use as a meaningful occupation resulted in increased use of substances. This argument was also supported by Stewart and Fischer. (98) who suggested that failure to acknowledge the negative impact that some occupations have on health and wellbeing could result in developing interventions that were not comprehensive enough to address the negative effects of participation in such occupations.

The body of knowledge on conceptualising substance use as occupation has continued to grow from theoretical conceptualisations to research evidence. (22)(89)(96) The available literature on conceptualising substance use and other addictions as occupations has provided useful insights on the impact of substance use on the individual using substances. Little is known about how substance use as an occupation impact on the occupational participation of family members of the addicted individual. With the current shift in occupational therapy and occupational science literature from individualism to transactionalism (99)(100)(101), more research is needed in order to build the evidence base to explain how addictions as occupations will impact on the occupational performance of other people associated with the individual with a substance use disorder.

2.4 Factors associated with substance use

The literature search did not yield any studies in which the factors associated with substance use among adults were investigated in Zimbabwe. However there was one study which investigated the predictors of illicit drug use among adolescents. (102) This study consisted of a secondary analysis of data that had been collected during the Global School Based Health Survey. Findings revealed that males were more likely to use marijuana or glue than females. In this study, marijuana or glue use was positively associated with cigarette smoking, alcohol drinking and having premarital sex. While the findings in the study highlighted gender as an important predictor for substance use, the data set on which these findings were based could be limited because the data were collected in relation to the survey objectives. The factors identified might therefore not be reflective of the major factors associated with substance use among adolescents in Zimbabwe.

A consistent trend in the literature (103)(104)(105)(106) was that substance use problems that are seen in adulthood usually develop in adolescence. For this reason factors associated with substance use in adolescents cannot be ignored when looking into the risk factors associated with substance use in adults. This literature review therefore included factors associated with substance use in adolescence and adults. There is dearth of literature on the factors associated with substance use in adults from occupational therapy and occupational science research. Studies on the factors associated with substance use disorders in adults have mainly been conducted in the fields of public health, (102)(103)(107)(108)(109) sociology, (69)(84) psychology, (104) and psychiatry. (110) An understanding of the risk factors that have been noted in these fields is important in developing an occupational perspective of the risk factors for substance use.

2.4.1 Sociodemographic factors associated with substance use

Studies conducted across Africa (103)(107)(108)(110)(111) in the last two decades to determine the factors associated with substance use suggest that sociodemographic factors contribute to the increased risk of substance use among adolescents and adults. Even though some of these studies have focused on adolescent groups, the findings can be extrapolated to adults. Hauli et al. (110) conducted a descriptive cross sectional study (n=184) on adults who were accessing psychiatric services in Tanzania to establish the risk factors associated with substance use. Their findings showed that being male, single, having poor educational achievement, unemployment, and having a family history of mental illness as well as having a family history of substance use were significant risk factors for substance use. They also reported that most of the participants mentioned that they were initiated into drug use by their peers when they were still adolescents.

Another cross sectional study (n=207) conducted by Okpataku et al. (107) on adults in Nigeria also reported sociodemographic risk factors for substances use disorders. Gender, level of education, marital status and employment status were risk factors for substance use. Similar cross sectional studies that were conducted in Ethiopia (107) and Sudan (108) reported findings similar to those reported by Hauli et al. (110) The study that was done in Ethiopia (107) also included religion as a risk factor and noted that being Muslim reduced the risk of taking substances.

Some studies that have been conducted outside Africa have also reported similar factors to those that have been identified as contributing to substance use disorders in Africa. Ansari-Moghaddam et al. (104) reviewed the profiles of 536 adults with substance use disorders retrospectively and identified factors that increased the risk of substance use as male gender, being single and having a low level of education. (104) Findings from the same study also revealed that early onset of substance use increased the risk for continued use in later life. In another cross sectional study (n=125) conducted in India , Bashir et al. (111) interviewed adults aged between 20 and 29 years, peer pressure was noted as the most significant factor contributing to the initiation of substance use however all the other risk factors were similar to those reported in the previous studies.

2.4.2 Contextual factors associated with substance use

Contextual factors that contribute to substance use have focused on the family context as well as the community environment. There is overwhelming evidence that suggests that positive family environment reduces the risk of substance use. (112) Positive family environment is characterised by family cohesion, parental modelling, family communication parental

supervision and positive parental influences. (105) Velleman et al. (105) conducted a systematic review to examine a number of family processes that have been associated with initiation and misuse of drugs and alcohol. Findings from the systematic review showed significant associations between alcohol and drug use and family cohesion, family relations, family structure, family communication, family management, family and parental supervision, parental modelling and peer influences. The authors concluded that there was significant evidence for family involvement in the interventions for young people with substance use disorders. Given the evidence that majority of young people who use substances will grow into adults who abuse substances these findings are applicable to families with adults who use substances.

The cross sectional survey conducted by Pizarro et al. (113) to determine family factors associated with substance use revealed that low parental monitoring, family conflict and low levels of positive family relationships were associated with a significantly higher risk of adolescent substance use. These findings were confirmed by Buu et al. (114) in their study that sought to establish the relationship between childhood familial factors and environmental risks on substance use later in life. In addition Buu et al. (114) also reported that parenting styles that are negative and critical were also associated with use of substance in adolescents.

Another contextual factor that is associated with substance use is the family structure. Studies conducted in various settings have consistently revealed the association between family structure and the risk of substance use. Beret et al. (115) conducted a study to establish the relationship between family structure and substance use problems in adolescents. The findings from the study were that children from single parent families were at a higher risk of developing substance use disorders compared to those with both parents. Similar findings were reported in other studies that evaluated family structure as a factor contributing to substance use disorders.

(116)(117)(118)(119)(120)(121)(122) Even though the findings confirmed an association between single parent families and risk of developing substance use, the strength of the association varied across the different studies.

A study (123) that explored the experiences of mothers who were in recovery from substance abuse revealed that “toxic environments” characterised by poverty, all forms of abuse and high availability of drugs and increased opportunity to use the drugs contribute to substance use. This study confirmed the traditional notion that economically deprived communities are associated with increased risk of substance use. (69)(84)(124) However there is now a mixed body of knowledge on the contribution of the neighbourhood environment to substance use as recent studies have reported findings contrary to this traditional notion. Brenner et al. (124) applied a socioecological model in their study on the contribution of the neighbourhood factors to the risk of substance use. Their findings revealed that alcohol use was significantly associated with peer alcohol use and peer support. They concluded that there was no association between neighbourhood disadvantage and alcohol use.

Galea et al. (125) conducted a cross sectional telephone household survey to establish the relationship between neighbourhood income and prevalence and frequency of substance use. Their findings showed that high neighbourhood income was significantly associated with a greater likelihood to use alcohol and marijuana. This is contrary to findings by Buu et al. (114) who reported that lower family status contributed to the increased risk of developing marijuana use disorder in adolescents. The emerging body of knowledge on the contribution of the neighbourhood to substance use disorders suggest the need to generate new evidence on the interplay of the multiple factors associated with increased risk of substance use disorders.

2.5 The impact of substance use on occupation

The innumerable adverse effects of substance abuse on the individual abusing substances are well documented in literature. These include damage to the body structure and function (22), disabling accidents, HIV infections, (126) criminal activity, unemployment, (53)(127)(128) financial problems and family conflicts. (129)(130) Furthermore substance abuse by a family member has been reported to result in high levels of distress in other family members as they cope with the addiction of a significant other in the family. Other family problems associated with substance abuse by a family member include domestic violence, child abuse or neglect and neglect of the family in general. (131) In other words the reviewed literature suggests that substance use results in physical and psychosocial problems.

There is also an emerging body of literature that focuses on the impact of substance use on participation in occupation. (89)(91)(95)(132) From an occupational perspective, the damage to anatomical structures and impaired physiological function as well as the psychological and social challenges resulting from substance use will result in participation restrictions and activity limitations. (27) This will eventually lead to occupational dysfunction and ultimately affect overall quality of life.

2.5.1 The impact of substance use on the occupations of the individual using substances

Several authors reported the impact of substance use on occupational performance of the individuals abusing substances. Martin et al. (130) conducted a non-randomised pre and post-test study (n =75) to evaluate the changes in occupational performance, self-esteem and quality of life among substance users. Occupational performance, self-esteem and occupational identity

were assessed for study participants who were admitted into an institutionalised recovery programme. The three outcome variables were measured at 3 and 6 months post discharge. The findings indicated that clients had low levels of occupational performance, self-esteem and occupational identity when they were admitted into the programme but performance on these variables improved as study participants recovered from substance abuse. These findings suggest that substance use has a negative effect on occupational performance, self-esteem and occupational identity.

In another study, Stone (90) found that substance abuse also had a negative effect on occupational patterns. In this study, ninety two adults who were attending a residential recovery programme completed a lifestyle history questionnaire that evaluated their occupational engagement before joining the recovery programme. Data analysis indicated that substance use significantly affected study participants` time management, participation in other occupations as well as the ability to attend to major life roles. The conclusion from this study was that the limited occupational repertoire that is characteristic of occupations of individuals with substance use disorders will result in individuals failing to meet their obligations causing occupational imbalance.

Davits and Cameroon (132) investigated self-identified competencies, limitations and priorities for change in the occupational lives of people with drug misuse problems. The participants (n=30) who were inpatients undergoing a detoxification programme completed an occupational self assessment questionnaire. The findings revealed that the participants identified the greatest occupational limitations in the areas of financial management, decision making, task completion and working towards goals. They considered taking care of others, being involved as a student, worker, volunteer or family member and working towards goals as important. The results also

showed that the participants prioritised taking care of themselves and their home environment as well as achieving goals.

Further, Wasmuth et al. (89) explored substance use as an occupation. In this study, ten participants with addictions were asked to describe their occupational lives. The authors concluded that lack of opportunities to participate in other occupations resulted in more time being devoted to substance use. They went on to suggest that poor time use patterns contributed to the development of dysfunctional roles and habits which affected the manner in which individuals perform their occupations in various settings. Although the study design used in this study was considered methodologically too weak to fully support these conclusions, these findings serve as preliminary evidence on the impact of substance use on occupation.

In support of the above discussed literature, Helbig and Mackay (94) proposed that impoverished social networks, lack of structure to daily routine, reduced motivation and limited employment and leisure skills were some of the challenges experienced by individuals with substance use disorders. This assertion was confirmed by Martin et al. (123) who explored the experiences of mothers who were in recovery from substance use disorders. They reported that the mothers experienced social impairment which was characterised by limited social networks, a lack of structure and routine in daily occupations, reduced motivation to participate in any activities as well as limited leisure pursuits. In addition, Martin et al. (130) concurred with Stone (90) and Wasmuth et al.'s (89) argument that substance use resulted in a change in occupational identity, disruption in occupational performance patterns as well as reduced occupational performance capacity. The changes ultimately resulted in failure to meet role obligations.

Studies done in other fields have also contributed to the understanding of the impact of substance use on the occupations of individuals abusing substances. Orford et al. (133) interviewed family members (n=800) across 20 countries and found that individuals who used substances often isolated themselves, were not involved in family activities and sometimes became aggressive and physically violent towards family member. While the target of this study was not occupational performance, the behaviours that were reported by family members were likely to impact negatively on the participation in daily occupations.

2.5.2 The impact of substance use on the occupations of other family members

There was a paucity of literature on the impact of substances use on the occupations of other family members in the occupational therapy and occupational science literature. However two studies that focused on caregiving for children with disabilities and its impact on the caregivers' occupations were instructive. In one of those studies, Hodgetts et al. (134) conducted a mixed methods study to examine the impact of professional services on employment and leisure participation of mothers of autistic children. In the initial phase 139 mothers completed a questionnaire that evaluated their care giving experiences in relation to seeking professional services for their children and the impact of their caregiving role on their own occupational participation. In the second phase of the study, in depth interviews were conducted with 19 mothers to explore their caregiving experiences. The findings from this study indicated that occupational imbalance resulted when mothers had to sacrifice their own participation in personally meaningful occupations such as leisure and employment so that they could focus on getting professional services for their children.

In another study (135) mothers participated in a group in which experiences of caring for children with disabilities were discussed. Findings from this study revealed that mothers had to stop participating in their previous roles as they prioritised their caregiving roles and spent more time performing basic caregiving activities such as assisting with activities of daily living. Some mothers adopted new roles such as advocating for their children. This resulted in limited time for the mothers to participate in personally meaningful occupations.

2.5.3 The impact of substance use disorders on neurocognitive functioning

The chronic and relapsing nature of substance use disorders may be explained by the neurochemical changes that occur in the brain due to substance use. (3)(68) In order to have an appreciation of the neurocognitive impairments that are experienced by adults who abuse substances it is important to understand the neurocognitive impact of substance abuse in adolescence because most substance abuse in adulthood begins during adolescence. There is however paucity of studies investigating the neurocognitive impairments associated with abuse of illicit alcoholic beverages that are unique to African countries, even though other commonly abused drugs are discussed in the literature.

Bechara (136) hypothesised that the early onset of substance abuse in adolescence may result in cognitive impairments which are similar to those that occur when a foetus is exposed to alcohol and any other substances. There is a growing body of research evidence which supports the hypothesis by Bechara. (3)(137)(138) This evidence suggests that neurochemical changes that occur in the brain due to substance use may be permanent and are responsible for the neurocognitive impairments (139)(140) diminished will power to resist substance abuse (136) as well as cravings that result in repeated relapses (3) that characterise the recovery process of some

individuals undergoing rehabilitation for substance use disorders. The neurochemical changes compel individuals using substances to continuously use substances despite their harmful effects.

(3)

In a study conducted by Reay et al. (139) it was found that polysubstance use resulted in executive functioning impairments. The researchers compared set shifting, memory updating, social and emotional judgement in adults using multiple substances (n=15) such as ecstasy, cocaine, alcohol, tobacco and cannabis with non-ecstasy using polydrug using controls (n=15). The results indicated that polysubstance use was associated with impairments in all of the executive functioning components.

In another study, Colzato et al. (140) assessed attention in cocaine using polysubstance users (n=18) and compared the results with non-cocaine using polysubstance users (n=18). They found that continued use of cocaine led to reduced attention. While these studies provide useful evidence to help understand the long term sequelae of polysubstance use, the generalisability of the findings from these two studies was limited by the small sample sizes used in both studies.

Further, Squeglia et al. (138) conducted a systematic review on the impact of alcohol and marijuana use on neurocognition, brain structure and function in adolescents. They reported that marijuana and alcohol use changed the neurocognition, brain structure and function. These changes were modulated by substance use patterns as well as the types of substances that were used. However the major shortcoming of the systematic literature review was the absence of longitudinal neuroimaging studies to provide conclusive evidence on the actual changes to the brain over time due to substance abuse.

In another systematic review, Crean et al. (141) examined evidence of acute and long term effects of cannabis use in adults who had a history of cannabis. (141) The independent variables in this review were acute and long term cannabis use and the dependent variables were attention/concentration, decision making, risk taking, inhibition /impulsivity, working memory and verbal fluency. They found that cannabis use impaired executive functioning beyond three weeks after abstaining. The most enduring deficits were reported in decision making, concept formation and planning. The differences in methodologies that were used to conduct the studies included in this systematic review made it difficult to draw a sound conclusion regarding the short term and long term effects of cannabis use on executive functioning.

Despite the dearth of literature that provides conclusive evidence on the actual neurocognitive changes that occur due to abuse of substances, psychosocial and behavioural approaches to substance use disorders should consider the possibility of cognitive impairments in individuals who abuse substance as these are likely to affect treatment outcomes during recovery. An increased understanding of the neurocognitive impact of substance abuse in conjunction with developmental and environmental factors that contribute to substance use would enhance attempts to design more effective strategies for prevention and treatment of individuals with substance use disorders.

2.6 Family involvement in interventions for substance use disorders

Historically substance use disorders were viewed as a problem mainly affecting the individuals using the substances. (81)(126) The family and other people constituting the support networks were involved as adjuncts to treatment. This focus on the index person created a barrier to family involvement in the treatment of substance use disorders. As a result of this emphasis on the

substance users, research did not typically focus on the importance of family involvement in their therapy. This view has since changed and substance use disorders are now viewed by many scholars as a problem affecting families, communities and societies. (89)(142)(143) There is an increased call in particular for family involvement in the treatment and prevention of substance use disorders.

Family involvement in the rehabilitation of individuals with substance use disorders can be conceived on a spectrum from more basic functions to specialised interventions. (144) The involvement of the family in interventions for substance use disorders has been considered to be important for two major reasons: 1) to capitalise on the family's strengths and resources to help address the substance abuse and 2) to address the negative impact of the substance abuse on the family. (53) Furthermore, the family can be critical in responding to early warning signs of relapse and assisting the affected individual to access services. (144) Few inpatient admissions and shorter in patient stay, (144) improvement in access to treatment, completion and positive outcomes (131) can result from involvement of the family in interventions.

Consistent with the above discussion, Velleman et al. (105) suggested that families needed to be equipped with parenting and substance related communication skills in order to be able to provide support to a family member with a substance use disorder. The parenting skills would facilitate development of family cohesion, clear communication, parental supervision and conflict resolution. Substance related skills would facilitate the acquisition of knowledge about substance use disorders and the need for the right attitude and behaviour. According to Velleman et al. (105) confidence is needed to facilitate family communication about drugs. Akram et al. (145) concurred with Velleman et al. (105) and added that families could also be involved in

promoting entry into treatment and maintaining engagement in treatment through joint treatment sessions involving the affected family members and the individuals using substances.

Rane et al. (15) conducted a systematic literature review to establish the benefits of psychosocial interventions involving the families affected by addiction in low to middle income countries. The studies they reviewed consisted of two treatment cohort studies; one cluster randomised clinical trial and one cross sectional study. The review indicated that the psychosocial interventions had positive benefits for the affected family members including lower physical and psychological distress on the affected family members. The families had a better understanding of addictive behaviours. (15) Participation of the families in the intervention for family members with substance use disorders equipped them with adequate knowledge and skills to enable them to help the affected individuals in their journey to recovery. This led to improved treatment outcomes.

In another systematic review, Templeton et al. (71) examined 34 studies conducted between 1979 and 2009. Findings from this review highlighted the major role played by families in the management of alcohol use disorders. Positive treatment outcomes were reported in interventions that addressed the needs of the individuals with alcohol use disorders as well as those of the family members. These findings demonstrated the importance of including families in treatment intervention for substance use disorders. (71) While this systematic review provides useful insights on the role of the family in managing substance use disorders in general, it did not provide information on how the families contributed to the positive treatment outcomes.

A lot of the research on psychosocial interventions involving the family focused on adolescents and not adults. The overview of systematic reviews that was conducted by Jai et al. (146)

identified 46 systematic reviews on psychosocial interventions for substance use disorders in adolescents. The main findings from the synthesis of these systematic reviews was that for the adolescent population, school based interventions based on social influence approaches were more effective in reducing tobacco, alcohol, drug and cannabis use than family interventions. The family interventions were reported to be associated with effective family function and to have small but significant effect on alcohol abuse. The differences in the interventions included in the systematic reviews made it difficult to ascertain precisely the effectiveness of these interventions. The recommendation from this synthesis of systematic reviews was that future research should aim at standardising the interventions as well as the treatment outcomes. (146)

Family members have to deal with difficult complex situations that arise as a result of a relative's use of substances. The stress associated with having a family member with a substance use disorder results in worries about the general welfare of the affected individuals. In order to deal with the stressful experience of having to cope with excessive drug use and the associated challenges, it is important to address the needs of affected family members in the interventions for individuals with substance abuse disorders.

2.7 Occupational therapy interventions for substance use disorders

Treatment of substance use disorders goes beyond maintaining sobriety. Many individuals recovering from substance use experience a loss of an important occupation when they stop using substances. Even though occupational therapy services have been provided in the management of substance use disorders for a longtime there is little evidence to support the clinical effectiveness of occupational therapy in this field. Occupational therapy researchers have put forward theoretical frameworks and models (21)(94)(95)(147) that could help us better

understand how substance use as well as the associated disorders impact on the occupational lives of individuals. However, only a few studies provide evidence supporting the role of occupational therapy in interventions to treat substance use disorders.

In one of those studies, Stoffel and Moyers (22) conducted a systematic review of interdisciplinary literature discussing evidence of interventions for individuals with substance use disorders. This literature search was conducted for the period between 1990 and 2000. Even though the literature search yielded 1000 studies from the fields of psychology, medicine, nursing, social work, public health and occupational therapy, there were only 20 intervention studies. The final analysis of the literature excluded studies from occupational therapy as they were theoretical papers that did not provide evidence for effectiveness of occupational therapy interventions in the treatment of individuals with substance use disorders. This review demonstrated the dearth of research on occupational therapy interventions for substance use disorders. (22) Major findings from this systematic review were that brief interventions, cognitive behavioural approaches, motivational approaches and 12 step facilitation programme were the most effective in the management of substance use disorders in adolescence and adults. Stoffel and Moyers (22) recommended that these strategies should be incorporated in occupational therapy interventions for substance use disorders.

In another review, Mota et al. (92) examined research articles spanning 45 years from 1970 to 2015. The majority of the studies in their review were qualitative studies. Other articles consisted of theoretical papers. There was no strong quantitative evidence to support the role of occupational therapy in the management of addictions. Two of the eight quantitative studies that were reviewed had flawed methods and therefore the evidence they provided about the role of

occupational therapy in the treatment of individual with substance user disorders was not conclusive.

The systematic review by Wasmuth et al. (23) was the first one to establish the effectiveness of occupation based intervention in improving recovery outcomes for clients with substance use disorders. In this review, 26 of the 34 studies were qualitative. The major findings in this review were that the most commonly used occupation based interventions involved use of leisure, social participation and work. Better treatment outcomes were reported in interventions that focused on social participation. (23) While findings from this systematic review provide useful insights into the effectiveness of occupation based interventions in the treatment of substance use disorders, it should be noted that some of the studies included in the systematic review had small sample sizes which affects the generalisability of the findings.

In some studies, attempts have been made to evaluate client satisfaction with occupational therapy interventions for substance use disorders. Peloquin and Ciro (148) conducted a retrospective cross sectional analysis of 1488 client feedback surveys to examine client satisfaction with an occupational therapy self-development activity group. The women who participated in the group were satisfied with the intervention. However this study did not provide information about the exact components of the intervention that the women in recovery reported to be satisfactory.

2.8 Conclusion

The occupational therapy process enables occupational therapists to gather information in order to identify factors predisposing, precipitating and perpetuating substance use. All this information is important in designing comprehensive treatment interventions for substance use

disorders. The focus for occupational therapy in the management of substance use disorders is to provide interventions to prevent promote and facilitate participation in occupations. This is achieved through interventions that facilitate the reconstruction of an individual's occupational life through participation in meaningful occupations that replace substance use. (93) However this literature review highlighted gaps in literature in terms of evidence that supports the role of occupational therapy in substance use management and how families can be incorporated in the occupational therapy process. Without this evidence, the role of occupational therapy will remain unclear and the theoretical knowledge that is available will not translate into effective occupational therapy interventions for individuals with substance use disorders.

Chapter 3: Methodology

3.1 Introduction

In this chapter, I describe the methodology used in conducting this research study. I begin with a justification for the qualitative study design, in particular the narrative approach as the method of choice. I also provide a detailed description of the research process including participant recruitment and selection, data gathering methods, data management and the interpretive process as well as the measures I took to ensure rigour. I conclude the chapter with a detailed account of the ethical considerations during the research study.

3.2 Selecting the research methodology for the study

In my search for a suitable research methodology that was contextually relevant, I asked myself the following questions which are answered in the subsequent sections as I describe the methodology

1. Which research methodology would allow me to focus on experiences of Zimbabwean families with a family member who has a substance use disorder?
2. How do I navigate the cultural norms relating to substance use disorders as they are viewed by families in Zimbabwe?
3. How do I incorporate multiple voices of the family members in my analysis of data without losing focus of the stated purpose of the study during data analysis?
4. How do I align the findings from the data analysis to decolonial thinking?

3.3 Qualitative Research design

In answering my first question with regard to the best research methodology, I chose a qualitative design using a narrative inquiry approach. Qualitative research allows for the exploration of problems affecting society. (149) It is aimed at describing and clarifying human experiences. (150) Creswell (149) suggested that qualitative research is the design of choice when: a) a problem or issue needs to be explored b) we need a complex and detailed understanding of the problem under study c) we want to empower individuals to share their stories, hear their voices and minimise the power relationships that often exist between the researcher and study participant and d) we want to understand the contexts or setting in which the participants in a study address a problem or an issue.

Hollway and Jefferson (151) as well as Creswell (149) argued that the main goal of qualitative research is to identify and describe people's experiences in their natural context. Qualitative research allows for the exploration of meaning ascribed to the occupations people participate in, taking into consideration the contextual factors. This approach contributes to insights into existing or emerging concepts that may help to explain human and social behaviour. (152) Qualitative exploration is generally used to get a comprehensive understanding of phenomena. (153) The focus of this inquiry was to explore the factors shaping family involvement in promoting the participation of adults with substance use disorders in meaningful occupations, lending this study to the rich contextual inquiry characteristic of qualitative research.

Currently there is no study to the researcher's knowledge exploring how the family may be incorporated into the occupational therapy management of substance use disorders. Therefore a qualitative design was appropriate for the generation of new knowledge in this area. This new

knowledge was used to develop context specific family based occupational therapy interventions for management of substance use disorders.

3.4 Narrative inquiry

Narratives are the basic medium through which humans speak and think and are uniquely suited when a researcher wants to comprehend human lives in the context of culture and time. (154)

The narratives are context bound and this facilitates an understanding of the complex relationships between what people do, their health and the context in which they live. (155)

Narrative methods have been referred to as constituting oral biography, case study, oral history, autobiography and life history (156) Consequently, there is a plethora of definitions of narrative.

What is common across these definitions is that they refer to storied data that are elicited through interviews.(157) In this study, I adopted the definition by Moen (158) in which narrative was defined as “a story that tells a sequence of events that are significant for the narrator and his or her audience”. (p.8) This definition captured the intended use of the narratives that were generated in the gathered data.

The focus of narratives is on explication of lived experiences as communicated by individual narrators and transformation of those experiences into a story. (159) Polkinghorne (160) described narrative inquiry as a process in which events and happenings are configured into a temporal unity by means of a plot with a beginning, middle and an end. He argued that the meaning in a narrative is derived from configuration of the contribution of actions and events into a whole episode. (160) Denzin and Lincoln (153) built on Polkinghorne`s argument and suggested that narratives allow the exploration of the narrators` unique, cultural and historical content.

Narrative data are generated through the use of narrative interviews. Narrative interviews can be defined as interactive conversations that allow both the interviewer and interviewee to develop meaning together. (161) The story in a narrative interview emerges from the interaction, exchange and dialogue between the interviewer and interviewee. (162) The narrative interview focuses on the quality of the interaction between interviewer and interviewee with the aim of stimulating conversation. (163)(164)(165)

3.4.1 Narrative inquiry in occupational therapy and occupational science research

The use of stories to understand human experiences has its roots in the social sciences and is premised on the understanding that human beings make sense of their world in a storied way. (166)(167) Stories are a powerful tool in research on human health as they provide socially and culturally situated insights into human action pertaining to health and wellbeing. (168)(169)(170) Narrative research based on oral history is useful in providing an understanding of the occupational nature of human beings as it allows the exploration of occupation which takes into account the contexts in which occupations are situated. (157)(171)(172) Narrative approaches to research on occupational participation have gained momentum as an enriching process of constructing new knowledge in both occupational science and occupational therapy research. (157) Using a narrative approach in this study enabled me to “study experience as story.” (173)(p.479) It also allowed me to recognise my participants as occupational beings who lived storied lives and re-lived their lives by telling their stories which informed my sensibilities of the unique characteristics of human existence in the social world. (174) This was valuable in exploring the experiences of families with family members who had substance use disorders.

Molineux and Richard (157) argued that using storied approaches to understanding occupation enabled the exploration of “meaning, temporality, occupational historicity and the wider contextual dynamics that impact on occupational engagement” (p.52). Caine et al. (175) underscored the importance of considering the dimensions of storied approaches outlined by Molineux and Richard (157) in illuminating key aspects of human experience including identity, hopes, values, and intentions as they influence what people do. These aspects were important in this study as they deepened my understanding of the impact of substance use on the occupations of the individuals using substances as well as on the occupations of entire families.

Various authors (162)(165)(167)(176) recommend the use of a narrative inquiry when exploring topics commonly discussed in occupational therapy such as transitions, recovery from addiction and mental illness as well chronic illness and disability. The storytelling in a narrative inquiry enables study participants to become conscious of their own actions that might have hindered or helped them to participate in occupations. (177)(178) Such benefits resonate well with the principles of occupational science and occupational therapy practice.

A narrative approach was chosen for this study because it allowed for the linking of experiences of families living with a relative with a substance use disorder with the social, environmental, cultural and economic contexts. This contributed to the wholeness of the stories. It also facilitated a deeper understanding of the role of the family in the occupational therapy management of substance use disorders at different stages of recovery. These experiences would have been inadequately captured by preconceived concepts and predefined tools such as those used in quantitative research.

3.5 The study methodology

In this section, I provide a detailed description of how the methods that were used to conduct this study were framed within a decolonial paradigm. I also highlight the decisions that were made during data gathering and data analysis processes and give an overview of the ethical procedures that were observed during the whole research.

3.5.1 Gaining access to participants

The initial stages of gaining access to the family units involved obtaining ethical approval from relevant institutional review boards. Ethical approval was sought and obtained from the Health Research Ethics Committee at Stellenbosch University [HREC Ref S15/05/104] (Appendix 1) and the Medical Research Council of Zimbabwe [MRCZ Ref/A2028] (Appendix 2). Permission was also sought from the Institutional Review Board at Harare (Appendix 3) and Parirenyatwa Central hospitals [JREC Ref 229/15] (Appendix 4). These are the two main referral hospitals for patients with acute, subacute and chronic mental illness and they serve eight of the ten provinces in Zimbabwe. The initial approvals from the Medical Research Council of Zimbabwe and Parirenyatwa hospital were valid for 12 months. However the data gathering process took 18 months. I therefore applied for renewal of the ethics clearance from Medical Research Council of Zimbabwe (Appendix 5) and Parirenyatwa Ethics Committee (Appendix 6).

3.5.2 Preparation to enter the field

As I prepared to enter the field, it was important for me to provide clarity about whom I considered to be the individual with substance use disorders, their families and the study unit. Therefore, for the purposes of this study the individuals who were recovering from substance use disorders were referred to as the index participants. The family members without the index

participant were referred to as affected family members and together they were referred to as the family unit.

It was not possible to visit the institutions from which participants were recruited on a daily basis as I had to fulfil my duties as a junior lecturer at the University of Zimbabwe. I sought the assistance of two occupational therapists to assist with participant recruitment and data gathering. These occupational therapists were in charge of the clinical occupational therapy services at the two institutions and they were not experienced researchers. A meeting was held between the researcher and the two research assistants two weeks before the beginning of participant recruitment to inform the research assistants about the research process and the nature of assistance that was required. In this meeting the roles of the research assistants in the research process were discussed. The following were outlined as the roles of the research assistants:

- Identification of index participants from the clients who were about to be discharged from the inpatient wards.
- Approaching the family members of the index participant during the visiting times to inform them about the study and to find out if they would be interested in taking part in the study.
- Informing interested participants about the study objectives and the whole research process as was outlined in the informed consent form.
- Giving a copy of the informed consent form to the interested families so that they could take it home to discuss with other family members.
- Getting the contact details of the head of the family unit and informing the interested participants that I would phone the head of the family unit for an appointment a day after they were approached by the research assistants.

- Accompanying me to the field during data gathering and setting up appointments with the family units and the psychologist or any other health professionals after the interviews whenever it was necessary.

It was agreed in this meeting that whenever the research assistants identified gaps in the interview process during data gathering, including questions that needed to be rephrased, the research assistants would move into the discussion at an appropriate time without disrupting the flow of the interview. However the researcher remained the main interviewer.

During the same meeting, I also informed the research assistants about the selection criteria that I had set for the study and demonstrated how they were going to complete the sociodemographic data abstraction form (Appendix 7). This form was to be emailed to me to facilitate the participant recruitment process.

3.5.3. Participant recruitment

I considered my second question on how to navigate the cultural norms relating to substance use disorders as they are viewed by families in Zimbabwe in my application of the research methodology during participant selection. Traditionally, research in occupational based on narrative research methods has focused on the individuals with the injury, disease or condition of interests or individual caregivers. In this study, the individuals with substance use disorders and their families were together considered as the study unit. This was in line with the cultural norms that emphasise the collective family actions and decisions that occur during the process of seeking solutions to assist a family member with any illness, injury or disease within the Zimbabwean cultural context.

Maximum variation sampling, which is a form of purposive sampling, was used to select the participants for this research. This approach to sampling enabled the exploration of a wide range of experiences of Zimbabwean families who were staying with an adult recovering from substance use disorders. Factors for which variation was sought were gender, age, marital status, level of education, employment status, place of residence and duration of the disorder. These factors were identified from a review of literature (84)(103)(107)(113) in which factors contributing to substance use in adults were identified. These factors were considered to be applicable within the Zimbabwean context. I anticipated that these factors would add to the diverse experiences of families staying with adult family members who were recovering from substance use disorders thereby maximising the variation within the sample.

3.5.3.1 Inclusion criteria

The index participants whose families were included had to meet the criteria listed below:

- A confirmed diagnosis of a substance use disorder by a psychiatrist. This was done to ensure that all the participants met the WHO (10) criteria for substance use disorders that is used by Psychiatrists in Zimbabwe.
- Aged between 18 years and 49 years. This age group was chosen because of the high prevalence of substance use disorders that has been reported for this age group in Zimbabwe. (43)
- Were able to communicate in either English or Shona as these were the dominant languages in the area where the research was conducted.

3.5.3.2 *Exclusion criteria*

- Index participants who had been previously treated by the researcher were excluded from the study. This was done to minimise the effects of previous therapeutic relationships between the researcher and the individual with the substance use disorder.
- There was need to be realistic with the distance that would be feasible to travel to meet the participants during the data gathering process. Participants who were living outside a radius of 60km from the hospital where they were recruited were therefore excluded from the study.

3.5.4 Participant selection

The research assistants identified index participants who were about to be discharged. They then completed a sociodemographic profile form (see Appendix 7) which they shared with me via email. This not only served to inform me about the participant selection process, but also allowed both research assistants to remain aware of the recruitment process that was happening at the other institution. Once sociodemographic profiles were received by the main researcher, the information was summarised in a biographical table (Table 2). Initially 16 family units were invited to participate in the study and they all agreed to participate. Nine of these family units were recruited from Harare central hospital and seven from Parirenyatwa central hospital. However the interview with the first family unit was considered to be a pilot test and one index participant withdrew from the study leaving 14 participating family units.

Table 2 : Sociodemographic characteristics of participants

Index Participant (Pseudonym)	Gender	Age	Marital status	Highest level of education²	Employment status	Age at onset of use	Substances abused	Average monthly family income³ (US\$)
*Gore	Male	31	Married	Ordinary level	Unemployed	22	Alcohol Cannabis	<\$300
Shumba	Male	22	Single	First degree	Unemployed	13	Alcohol Cannabis Zed Broncleer	>\$900
Nzou	Male	19	Single	Primary level	Unemployed	8	Alcohol Cannabis Zed Broncleer	<\$300
Zuva	Male	41	Married	Ordinary level	Tuckshop ⁴ owner	20	Alcohol Cannabis Broncleer	<\$300
Ndakaziva	Female	24	Single	Ordinary level	Soccer player	14	Alcohol cannabis	\$301-\$600

² The education system in Zimbabwe starts with a basic education known as primary education and then proceeds to ordinary level education up to advanced level education. Successful completion of ordinary level education facilitates enrolment for a certificate or diploma programme at a college. Successful completion of advanced level education enables one to enrol at a college or University

³ According to the Zimbabwe Statistical report on poverty an average household of 5 people requires a minimum of \$430 per month for all expenses

⁴ Small grocery shops that are found in less privileged communities and are usually located within residential stands

Hazviperi	Male	19	Single	Ordinary level	Unemployed	16	Alcohol Cannabis Zed Broncleer	<\$300
Tapera	Male	21	Single	Primary level	Unemployed	16	Alcohol Cannabis Zed Broncleer	<\$300
Chipo	Female	32	Divorced	Diploma	Unemployed	21	Alcohol	>\$900
Danai	Male	24	Single	Ordinary level	Suspended	13	Broncleer Cannabis Blue diamond	<\$300
Gandiwa	Male	25	Single	Ordinary Level	Unemployed	15	Alcohol Cannabis Haloperidol	<\$300
Gamuchirayi	Male	37	Divorced	Advanced level	Unemployed	18	Alcohol Cannabis	\$301-\$600
Themba	Male	34	Single	Undergraduate degree	Unemployed	16	Alcohol Broncleer	>\$900
Dadirayi	Female	35	Married	Ordinary level	Employed	21	Alcohol	>\$900
Tatenda	Male	23	Single	EMM Certificate	unemployed	13	Cannabis	<\$300
↓Batsirai	Male	23	Single	Ordinary level	Unemployed	14	Alcohol Cannabis Broncleer	<\$300

Nhamo	Male	26	Single	Ordinary level	Unemployed	18	Alcohol Cannabis Broncleer	>\$900
-------	------	----	--------	----------------	------------	----	----------------------------------	--------

*Pilot interview † Withdrew from study

3.6 Pilot study

A pilot interview was conducted with one of the family units at the family home with the index participant, his wife and young brother. The whole interview was 45 minutes long. Both research assistants were present for this initial interview. The interview transcription provided me with immediate feedback about the data generation process. As I was reading the transcript, I realised that I had not generated much of a narrative. In my attempt to ask all the questions on the interview guide (see appendices 8 & 9), I disrupted the flow of the interview and the transcript had short responses which did not resemble narratives. It was difficult to generate a coherent story from these short responses. It became apparent that the interview guide was disrupting the flow of the narratives. I also used the feedback from the research assistants following the interview to revise the interview guide.

There is a general consensus among many authors that the interview guide should not be rigid. (154)(179)(180)(181) Other authors also concur that narratives are generated only when the right questions are asked. (154)(182) In order for the narratives to flow well it is preferable to conduct unstructured interviews that open up the conversation and allow the respondents to respond freely. (141) I therefore revised the interview guide (Appendices 10 & 11) and rephrased the questions and ended up with fewer questions. I also reflected on my interview skills and noted that I needed to allow the participants' time to narrate their experiences whilst taking note of any questions and then ask the questions at the end.

3.7 Data gathering

After the pilot interview and analysis of the information, I continued with the data gathering process. The data gathering process and participant recruitment happened simultaneously in this study. Therefore as the data gathering process continued it became apparent that even though there was a pre-set selection criteria at the onset, there was need to remain flexible and consider other characteristics that brought variation to the sample which had not been included in the initial selection criteria. I became more aware of the different kinds of stories that I needed to consider in order to bring maximum variation to the sample. I had to make a decision on the possible ways of varying my sample further. I added the types of drugs being abused, age of onset of substance use, dual diagnosis and the composition of the family unit to the categories to consider during participant recruitment. The voices of the participating family members were deemed important and thus needed to be heard in the family narratives. It was therefore important for me to be able to communicate with participants in their first languages during the data generation process. Language is the product of cultural conventions and gives coherence to life stories. (183)(184) Smith et al. (184) suggested conducting interviews in the local language as one way of ensuring that accurate meaning is captured during data generation. I therefore engaged a linguist to assist with translation of the English interview guide (Appendix 8) from English to Shona (Appendix 9) which is one of the local languages. This was done to ensure that the intended meaning of the questions would be maintained. Fortunately all the participants in this study could engage in either Shona or English. This made the data generation process a lot easier as I was able to engage the participants without the assistance of an interpreter.

3.7.1 Conducting the narrative interviews

I spent an average of one and half hours with each participant in order to generate data during the initial interviews. In all the interviews I conducted, I applied the basic phases of a narrative interview as outlined by Jovchelovitch and Bauer (154) which are preparation, initiation, main narration, questioning and concluding the talk.

3.7.1.1 Preparation for the interview

During this phase, I familiarised myself with the literature on substance use disorders and how families of those who had the disorder were affected. This familiarity enabled me to come up with the initial interview guides (appendices 8 & 9) consisting of questions that were relevant to my research question and objectives.

3.7.1.2 Initiation

During the initiation phase the head of the family welcomed me and the research assistants and introduced the family members who were present to us. After the introductions, the head of the family unit asked me to take over and run the meeting. I explained the context of the inquiry as well as the processes of data gathering to the participating family units before asking the head of the family to sign the consent form (Appendices 12 & 13). I also asked for permission to record the interviews and explained to the family units why this was important. I then asked my opening question as a way of initiating the interviews. Even though some of the index participants were still abusing substances, none of them showed signs of intoxication during the interviews. The composition of the family units during the interviews is summarised in Table 3 below.

Table 3: Composition of the family units during interviews

Family unit	Head of the family unit	Family members who participated in the study
Shumba`s family	*Shumba`s father	Shumba Shumba`s mother Shumba`s paternal cousin
Nzou`s family	Nzou`s father	Nzou Nzou`s father Nzou`s stepmother
Zuva`s family	Zuva	Zuva Zuva`s wife
Ndakaziva`s family	Ndakaziva`s father	Ndakaziva Ndakaziva`s parents
Chipo`s family	Chipo`s older maternal aunt	Chipo Chipo`s two maternal aunts
Danai`s family	Danai`s mother	Danai Danai`s mother Danai`s sister
Themba`s family	*Themba`s father	Themba Themba`s mother
Dadirai`s family	Dadirai`s husband	Dadirai Dadirai`s husband
Tatenda`s family	*Tatenda`s father	Tatenda Tatenda`s mother
Gandiwa`s family	Gandiwa`s mother	Gandiwa Gandiwa`s mother Gandiwa`s young brother
Gamuchirayi`s family	Gamuchirayi`s father	Gamuchirai Gamuchirayi`s parents
Hazviperi`s family	Hazviperi`s father	Hazviperi Hazviperi`s parents
Tapera`s family	Tapera`s mother	Tapera Tapera`s mother
Nhamo`s family	Nhamo`s grandfather	Nhamo Nhamo`s grandparents

*The heads of the family units gave us the permission to proceed with the interviews in their absence as they were working outside Harare at the time of data gathering

3.7.1.3 Main narration

In the main narration the family units were asked to talk about their experiences of living with a family member with a substance use disorder. It is recommended that during this phase the influence of the interviewer should be minimal. In a narrative interview it is important to reconstruct social events from the participants' point of view. (154)(185) Using the key lessons learnt from the pilot interview, once the family units started narrating the stories of their experiences of living with a family member with a substance use disorder, I listened attentively and encouraged them to continue using non-verbal signals. However while I was listening, I was taking notes of any clarifications that I needed. I also became flexible in my interview approach throughout the data generation phase because I realised that the data generation process was evolutionary and I did not have to use the interview guide in the same way for all the participants because each family had a unique way of telling their story. I therefore let the participants lead the interview. The research assistants also moved into the discussion at appropriate times without disrupting the flow of the interview. This further enriched the data generation process as the researcher assistants were also occupational therapists working with clients with substance use disorders.

3.7.1.4 Questioning phase

As the participants signalled that they were approaching the end of their main stories, I asked the questions in order for them to clarify any facts on which I was not clear. I gave time to the research assistants to ask any questions as well. As a precaution I was careful not to point out contradictions in the narratives. I also avoided the "why" types of questions which would have turned the interview process into an interrogation.

3.7.1.5 Concluding talk

At the end of the interview, after switching off the recorder, I engaged the participants in small talk before leaving their homes. I noted any extra information that may not have come up during the formal interviews and wrote this information in my reflexive journal as soon as I returned to my office.

3.7.2 The interview setting

I considered the setting for the interview as a key aspect of the narrative design. Jovchelovitch and Bauer (154) stated that the narrative interview should take place in a setting that encourages and stimulates an interviewee to tell a story about some significant event in their life and social context. Gubrium et al. (186) presented a similar position and went on to discuss challenges that can occur in familiar places such as distractions due to the presence of other people and general constraints in the surroundings. I therefore allowed the participants to choose a venue in which they felt comfortable for the interview. I explained to them that the interviews were to be recorded and therefore they had to consider this in their choice of an interview setting. All the participants chose to have the interviews at their homes. I had an opportunity to meet the participating family units in their own environments and I was also shown some of the places that the participants were referring to in their interviews. This allowed me to have a better appreciation not only of the family contexts but also of their communities and home environment. The interview setting therefore became an integral part of the data gathering process.

3.8 Data capturing and management

All the interviews were recorded using a battery operated pro series digital recorder. Even though I was vigilant about ensuring the batteries were working each time I was about to start recording, I also used my I-phone as a backup recorder. As soon as I got to my office, I transferred the interviews onto the research computer which was password protected. These same interviews were stored on an external hard-drive which was kept under lock and key in the research office.

3.8.1 Transcription and translation

After completing the interviews my next step was generating transcripts. My intention was to capture the reality and complexity of conversations. An occupational therapist who had been trained in transcription, transcribed all narratives including the researcher`s question. Pseudonyms were used to identify the transcripts and any identifying information that might have linked the transcript to the participants was changed. Footnotes were used to document my immediate reactions to the interviews during the transcription process. This was done to take note of any subjective influences which might have distorted the data analysis process. Contradictions or gaps in transcripts were also noted.

All the transcripts were in English. Since I am fluent in both English and Shona I translated all the interviews which were in Shona into English. I asked the same translator who had assisted with translating the interview guide to provide a second opinion on the translation. We listened to the original interviews together while following the English translations of the transcripts. As we listened to the interviews, the translator highlighted the areas that were not clear and in which the original meaning expressed by study participants might have been lost during translation.

These discrepancies were discussed at the end of each interview. However all the words which described phenomena that were unique to the Zimbabwean culture were not translated into English so as to maintain their original meanings.

3.9 Data analysis

During this stage my objective was to address the third question, “how do I incorporate multiple voices of the family members in my analysis of data without losing focus of the stated study purpose?” The data analysis process summarised in Figure 2 demonstrates an interpretive process that occurred at three levels of analysis which I describe in detail below.

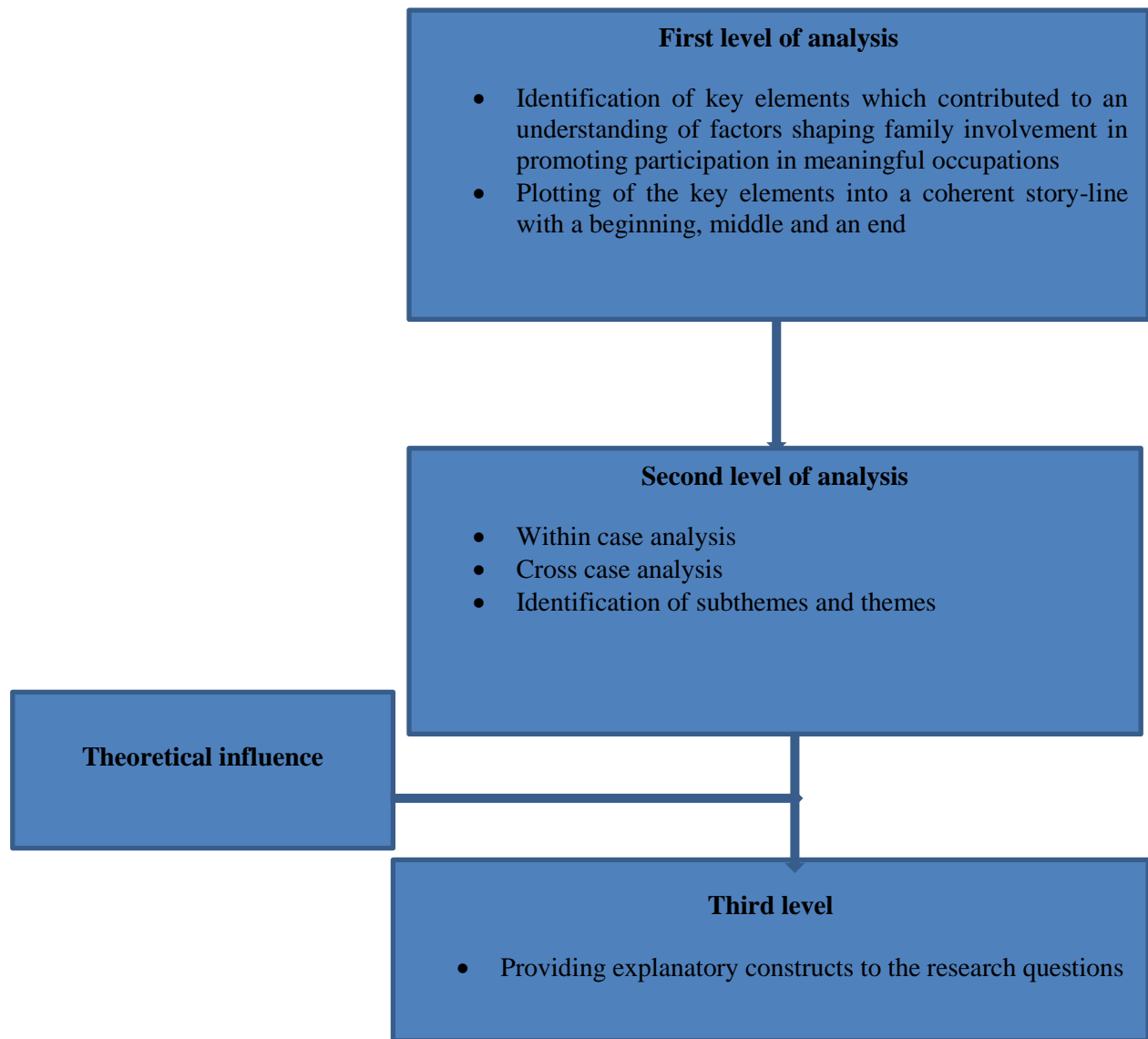


Figure 2: Summary of the data analysis process

3.9.1 First level of analysis

The first level of analysis involved the narrative analysis of each of the 14 cases. In my attempt to preserve the voices of the participants, all the narratives were developed in the first person language. Narrative analysis procedures as suggested by Polkinghorne (160) were used. These procedures included:

- Providing a description of the context in which the stories were unfolding. According to Polkinghorne the description of the context allows the researcher to attend to the contextual features that give specific meanings to events so that their contributions to the plot can be understood. (160) This contextualisation brought out the uniqueness of the experiences of each of the participating family units.
- Relating events and actions to one another by configuring them as contributors to the advancement of a plot. (160) The interviews were read repeatedly to develop familiarity with the data. I then analysed the narratives for key elements which were contributing towards an understanding of the role of the family in the rehabilitation of individuals with substance use disorders and the perceived facilitators and barriers to promoting the participation of adults who were recovering from substance use disorders in meaningful occupations.
- While organising participants' stories into a chronological sequence, I looked for connections among key elements while clearly outlining turning points within the participants' experiences. I arranged related elements into paragraphs. The subheadings to these paragraphs resulted from an ongoing interpretive process. I also described the decisions that were made by the families in trying to provide opportunities to participate

in alternative occupations other than substance use and considered the historical impact of previous events that had led to increased or decreased substance use. These descriptions allowed me to identify those strategies that had worked in supporting a family member to reduce the substance use.

- The events and actions as recorded in the interviews were plotted into a story with a beginning, middle and an end. The decision about the beginning and end to each story was part of the interpretive process and was guided by the research questions. I applied the principles of emplotment to select simple successive events and transform them into meaningful story.

3.9.2 Second and third levels of analysis

The second level of analysis involved a within case and cross case analysis of the research stories generated during the first level of analysis. This was guided by Creswell's (149) recommendation of identifying key elements within cases that can be used to generate categories to explain the phenomenon under study across cases. During this stage, I carefully read the narratives that had been generated from the first level of analysis in order to become more and more familiar with the participants stories. I then identified key elements in each of the stories that were aligned to the objectives of the study. I summarised this information on an excel spreadsheet. I conducted a cross case analysis. This process entailed manual colour coding of the constructs that were emerging from the analysis. Different colours were used to identify different constructs. This process facilitated the identification of categories that deepened my understanding of the factors shaping family involvement in promoting participation in meaningful occupation. These categories were then organised into subthemes which culminated

into themes. The third level of analysis emanated from the second level of analysis. This level involved providing explanatory constructs for the research findings in response to the objectives of the research. These explanatory constructs are presented in chapter seven in the form of a discussion.

3.10 Scientific rigour of the study

The need to ensure scientific rigour in qualitative research is well documented by many authors. (187)(188)(189) Various strategies have been suggested to ensure credibility, confirmability, transferability and dependability of the research process. This is essential because the primary contribution of qualitative research is to capture and convey the experiences, meanings and events encountered in the field. (180) I employed multiple strategies to ensure scientific rigour in this study. These strategies included:

3.10.1 Audit trail

An audit trail involves detailing the research process systematically so that other researchers are able to follow the study procedures from a methodological standpoint. (190) This type of documentation is one of the techniques for developing credibility in quantitative research. (189) In order to ensure credibility of this study, I maintained a clear, detailed and traceable documentation of the whole research process. The documentation included the decisions made during participant recruitment, the process of obtaining informed consent, data gathering and data analysis processes.

3.10.2 Reflexivity

Throughout the research process I kept a reflexive journal. I made field journal entries in an A5 exercise book as soon as I returned to my office after conducting an interview with the study participants. Each entry was made on a fresh page and started with the date the interview was conducted and biographical information about the family including the composition of the family unit. I wrote down my reflections about the interview process. I also noted my perceptions about the family dynamics that I had observed during the interview process, as well as my thoughts, feelings, attitudes and reactions to the family units and any notable events in the course of the data gathering process. I noted any information that came up during the informal conversations which I felt was important and needed to be clarified in the follow up interviews. Each entry ended with a record of the key findings pertaining to the family narrative consistent with that my study objectives.

The reflections made on the interview process enabled me to explore methodological issues such as how well I had conducted the interview and what I needed to change in subsequent interviews. The brief analysis at the end of each entry not only informed my future recruitment of participants, but it also became a source of data during the second level of analysis as I conducted the interpretive process within case and between cases. This process contributed to the credibility, dependability, confirmability and transferability of the findings.

Morrow (190) highlighted the importance of researchers acknowledging their active and influential participation in knowledge construction processes. It was therefore necessary for me to reflect on my own background as an occupational therapist. As a researcher I acknowledged

my position as an occupational therapist, educator, and clinical practitioner in mental health, family member and mother and was careful not to impose my own values in the judgements and decisions on what was right or wrong. I remained focused on understanding the participants' experiences of staying with a family member with a substance use disorder.

3.10.3 Peer debriefing

Peer debriefing is one of the recommended strategies for establishing credibility and dependability in qualitative research. (187)(190)(192) Loh (192) highlighted the importance of seeking validation from researchers working in a similar field as they would be able to provide some new perspectives with regard to the interpretation of data. The researcher and academic supervisors independently reviewed the narratives generated from the first level of data and discussed their respective conclusions. The research supervisors therefore acted as co-researchers and offered alternative views to the whole research process. This not only allowed me to make aspects of the research process explicit, which would have remained unspoken in my mind, but also prevented premature closure of the data analysis process as their contributions stimulated further exploration of the participant narratives.

3.10.4 Prolonged engagement

Participants often provide sensitive information during narrative interviews once rapport has been established with the researcher. (191)(193) As suggested by various authors, credibility of the gathered data depends on adequate submersion in the research setting to enable the researcher to establish rapport with the participants. (127)(189)(192) I maintained contact with the participating family units from the time they agreed to participate in the study up to the time when the final report was written and presented to them. This enabled me to make further

appointments for the second interviews. The clarifications I asked for during the follow up interviews allowed me to better understand the family dynamics thereby identifying facilitators and barriers to the family involvement in the rehabilitation process of a family member on the recovery journey from substance use disorders.

3.10.5 Member checking of transcripts

Member checking refers to a process of involving the participants in the data analysis process as it unfolds. This provides an opportunity for the participants to confirm the accuracy and to validate the researcher's interpretive process and to determine whether participants' are able to "hear their voices." (174)(180)(192) After the initial analysis I took the narratives back to the family units and reconvened the family members who had been involved in the initial interview. It was important to reconvene the family members who had been present in the initial interview because the narratives that had been generated captured the multiple voices of all the family members who had contributed to the data generating process. I explained the data analysis process and asked them to read and confirm the accuracy of the narratives. This process also provided me with the opportunity to correct or clarify any of the information and observations I had noted earlier as well as to discuss issues that had come up in the small talk that happened at the end of the initial interview.

3.10.6 Triangulation

Triangulation is a process of comparing data from multiple sources. This process involves "corroborating evidence from different sources to shed light on a perspective". (p. 8)(158) This strategy was used to establish credibility and dependability of the data. In this study the process of triangulation involved generating data from index participants, affected family members and

observation made in the field by the researcher. This process was aimed at producing a multiple viewer perspective of the data thereby producing a stronger account of the findings.

3.11 Ethics

There are a number of ethical principles that guide research. (194) For this study I sought ethical approval from the Stellenbosch University Ethics Committee (HREC Ref S15/05/104), ethical review boards at Parirenyatwa and Harare Central hospitals (JREC Ref 229/15) and Medical research council of Zimbabwe (MRCZ Ref A/2028). I also adhered to the ethical principles of autonomy, respect for persons, beneficence, informed consent, privacy and confidentiality.

3.11.1 Autonomy

Heads of the selected family units were contacted by phone a day after they had been approached by the research assistants to make appointments to meet their families for data collection. During the initial contact I explained the purpose and nature of the study to the head of the family. I then emphasised the need to discuss the informed consent form that had been given to the families by the research assistants with the rest of the family and negotiated for a date, place and time for the interview. The heads of the family units were allowed time to discuss with the rest of the family and a second phone call was made a day before the agreed appointment to make sure that the participants were still available and willing to participate in the study. All of the participants who had been approached by the research assistants agreed to participate in the study.

There was also need to protect autonomy of the family. This was achieved by discussing informed consent with all the family members who participated in the interview. On the day of the interview, when all the family members had convened for the interviews, I explained the

study and its purpose to the entire family unit before asking them to seek clarifications about what was involved in the research process. Once it was clear that the family had understood what was involved in the research and expressed their willingness to proceed with the interview, I asked the head of the family unit to sign the informed consent form on behalf of the family unit. The same process was repeated when follow up interviews were conducted as part of member checking.

Participation in the study was voluntary and I took measures to ensure that there was no physical or psychological coercion. These measures included emphasising that the index participant would not be denied access to any treatment services that he/she required to access from the hospital because of the family's decision not to participate in the study. No incentives were offered to participants. I also explained to the participants that they were allowed to withdraw from the study whenever they felt they were no longer comfortable participating in the study. One family unit was allowed to withdraw from the study during the follow up interview after the index participant expressed his discomfort with the way the family narrative had been constructed. The narrative that had been generated for this family unit was not considered during analysis.

3.11.2 Respect for persons

This is one of the most basic ethical principles. Respect denotes that “human beings must be respected in terms of their right to self-determination.” (180) In observing this principle in my own research, the nature and purpose of the study and the participants rights were explained to in their first language before the heads of the family units were asked to sign a written consent form.

The research participants were informed that they had a right to:

- Know why the research was being done
- Seek clarifications about the research process at any time
- Know what was expected of them during the research process
- Know the risks and benefits of the study
- Know how the information they were giving to the researcher would be kept safe and confidential
- Decide whether or not to participate
- Withdraw from the study at any point
- Keep a copy of the consent form
- Know whom to contact to ask questions or express concerns about the research

The above information was given to the study participants in order to ensure that all of them understood what participation in the research entailed. This informed consent process continued to be negotiated in follow up interviews with all the participants.

3.11.3 Beneficence

This principle requires that research minimises risks and maximises potential benefits to the participants. (188)(180)(195) It was anticipated that participants in this study might become distressed by emotions stirred by their storytelling. The researcher used empathetic listening skills during the interview and looked out for any signs of distress as the interviews progressed. Participants were asked how they felt at the conclusion of each interview. All of the participants expressed their appreciation of the entire interview process as it was the first time they had ever discussed their experiences of living with a family member with a substance use disorder as a family. Based on the positive responses by the participants to the interview process, I concluded that none of the participants showed any obvious signs of distress.

If any of the participants had become distressed by the emotions stimulated by the storytelling to the point of failing to continue with the interviews, the interviews were to be terminated and such participants would have been referred to a psychologist at the respective hospitals where they were accessing other treatment services for substance use disorders for further management.

3.11.4 Privacy and confidentiality

All identifying information including names and addresses of study participants were removed from the recorded interviews and field-notes. Pseudonyms were used to refer to the index participant and the affected family members. The recorded information was transcribed and stored onto the computer. Electronic copies of the transcripts were password protected and the paper copies were stored in a locked cabinet. Paper copies of the transcripts and field-notes were destroyed at the end of the study.

3.12 Conclusion

In this chapter, I provided details about the narrative inquiry that was used as a method for data gathering and analysis in this study. The detailed description of the research process including the critical decisions that were made during participant recruitment, sampling, data analysis and data management stages provided insights into the strength of the narrative approach as a research method. The whole research process required the researcher to be flexible. The description of the methodology offered useful insight into the use of qualitative research approaches, in particular narrative approaches in occupational therapy research.

Chapter 4: First level of analysis

4.1 Introduction

In this chapter I present the complete narratives that emerged from the first level of analysis. Each of the narratives is presented in its entirety to enable the reader to have an understanding of the experiences. These narratives provide insights into the second and third levels of data analysis. The narratives will be presented in the sequence outlined below.

Shumba`s Narrative: I am not ready for change

Nzou`s narrative: We have come a long way

Zuva`s narrative: It was not an easy journey but I just stayed on

Ndakaziva`s narrative: The experiment that went wrong

Chipo`s narrative: We don`t know how it started but we just want it to end

Danai`s narrative: I want to stop but I have nothing else to do

Themba`s narrative: The ball is in your court my son

Dadirai`s narrative: The bottle is always there when I need to relieve stress

Tatenda`s narrative: I know I can change

Gandiwa`s narrative: It`s not easy to quit when there are drugs everywhere

Gamuchirayi`s narrative: Just give me more time and I will change

Hazviperi`s narrative: There is no light at the end of the tunnel

Tapera`s narrative: Lost opportunities

Nhamo`s narrative: I need a fresh start

Shumba's story: I am not ready to change

Living in denial

My son, Shumba, the third born of four children, is 22 years old. I stay with Shumba, his younger brother and maternal cousin. My husband and I are qualified nurses. My husband works in Nyanga⁵ and comes home whenever he can. I'm not sure when Shumba's substance abuse problem started. He went to a boarding school from primary level and only came home after finishing his advanced level. I suspect the problem started at boarding school. Neither Shumba's father nor I noticed it at the time because he only came home during school holidays.

In his first year at university, we began suspecting a substance abuse problem. However, we minimized it. In his second year at university we noticed that he was drinking and getting into fights more frequently. We decided to talk to him about his drinking. He told us he started drinking in high school. He seemed like such a good child, but quietly he had already started drinking.

He used to be a brilliant student but failed one of his subjects at advanced level. I strongly suspect it was because of his drinking. He was willing to retake the failed examination. We looked for a reputable college in town that could provide extra tuition, but he failed again. Now I realize that he probably did not attend any lessons. While at university, we assumed he was attending lectures as he would leave home every morning during semester time. Once his sister's friend told her she saw him regularly at a nearby bottle store. On one occasion, he was involved in a fight at the bar and ended up being hospitalised due to injuries sustained. Shumba once told

⁵ Small town in a province 400 kilometres from Harare

me that one of his lecturers had asked him if he had problems at home because his grades were deteriorating. We still did not think there was a big problem. Maybe we were in denial.

After Shumba`s graduation, we realized how big the substance use problem was. His father and I tried *counselling*⁶ him because he now picked fights with his cousin and sisters. Whenever we talked to him about the effect of his drinking on the family he would apologise, but soon after he`d start drinking again. We continued *counselling* him, thinking the substance use would just stop. We were still in denial.

Bad influence from friends

Later, we realised that his friends might be a bad influence. He associated with rank marshals⁷, touts⁸ and school dropouts, these are the people known to abuse alcohol and drugs. They take *mbanje* (cannabis). These friends came to look for him, as if they didn`t want to lose him. He would promise to change, only to go back to his friends. I think the friends must have somehow benefitted from making him drunk. I wonder why they enjoyed seeing him like that and what they gave him that made him so drunk that he forgot what happened. I still don`t trust them. The “problem behaviour” only occurs when he`s drunk.

We bought him at least five expensive smart phones that he lost. Every time he went to the bar, he came back without his phone. We don`t know if they were stolen when he was drunk or if he sold them for liquor money. We realised that the problem had escalated. He started staying out

⁶ This process was different from professional counselling. It involved finding immediate family members, extended family members, pastors or neighbours who could talk the individual out of using substances. The process was different for each family unit.

⁷ Refers to individuals who control traffic flow at the public transport (commuter omnibus) parking bays

⁸ Individuals who facilitate boarding of passengers and direct the movement of public transport users (commuters) by shouting the route and destination for each of the commuter omnibuses that will be loading passengers

all night and coming home drunk in the morning. He would not remember anything. We do not even know how he got home.

Once, the neighbours reported that he was behaving strangely at the bar. I asked his cousin (*present at the interview*) to come with me to fetch him. When we arrived at the bar, we saw him grabbing other people`s beer and drinking it. We managed to take him home. He was violent, fighting with his brother and sister who had come home for the weekend and with me too. We took him to the police station. I had to leave him there because I was travelling the following day and couldn`t leave him alone in that state. I gave the police officers money to buy him food.

The next day, I was informed by the police that Shumba had escaped during the night. They didn`t know where he was and neither did we, because he did not come home. Later that day, the police found him loitering near the police station. I collected him after returning from my journey. The police officer in charge was angry with him and wanted to keep him detained. He said he did not expect such behaviour from a 35-year old. He assumed Shumba to be 35 years old, yet he was only 22 at the time. He looks much older due to the alcohol abuse. During one period he refused to bath. He looked scruffy. There were a lot of incidents that we ascribed to his drunkenness. After the incident at the police station, I discussed the problem with his father and we agreed that he should go to the mental health unit.

We tried to avoid giving him extra cash so that he would not have spending money, but it didn`t work. We also locked him up, especially when I saw his friends coming. Shumba got paid for a temporary teaching job he did for two weeks, but I withheld the money because I was afraid he would go out with his friends to fund their habits. Shumba is not serious about life. I don`t think he realises that he has a problem. If he leaves his friends, he will be able to quit. I don`t know

how to help him to see that they are contributing to the problem. Whenever I walk with him in the neighbourhood and we meet some of his friends, they communicate in a very suspicious way. They are not people any parent would want their child to associate with. I would not be worried if he was associating with friends from church or school who are good people.

We have tried giving him various business and study ideas, but he is not interested. He says he wants to study for a master's degree in psychology. I don't think it will be possible as he did not do psychology as a first degree. All I want is for my son to be able say no to substances. Shumba has not yet proved to me that he can stand on his own. He once told me that he is still craving for *mbanje*.

The moment of truth

When I was at university, I had only two days of lectures per week. Initially, on the other days, I moved around campus (*kurocka rocka*) with my friends from university and we would buy beer and cigarettes at the bar near the university. We took turns to buy cheap spirits after lectures. I did not see a problem with it because I was not missing any lectures. During my first year at university I drank a lot and got involved in arguments. There were conflicts of ideas. Some people think that what a drunk person says does not make sense, but a person may have brilliant ideas despite being drunk. So whenever one is drunk, conflicts will arise with those who are sober.

Later, I started spending lecture-free days in the neighbourhood. I would look for my friend *Dread*⁹ and we would go and buy *mbanje* from suppliers in the neighbouring suburb. We would

⁹A street name for anyone with dreadlocks

smoke *mbanje* and drink *zvibhodhoro*¹⁰ such as blue diamond, *zvimacrango*¹¹ and Chateaux. Sometimes we bought these from shops licensed to sell beer and sometimes from illegal traders. We didn't need a lot of money as there are little packs of *mbanje* available for only 10 cents. One friend bought alcohol and *mbanje* for me when I had no money.

I used to tell everyone at home that I was going to university. They believed me because I dressed smartly. My mother did not suspect anything because I left home every day as if going to school. I would go to the bar and start drinking. I wanted to relieve my mind from the stress of school work because I used to work very hard.

I have no plans for my future yet

I'm not in a hurry to make future plans. I'll do so when I start thinking clearly. I'm not sure what I want to do with my life. I worry about my mental wellbeing. I want to see if I am fit to go to work every day. My mind may not be able to cope. I am different from the rest of my family. They are used to working, I am not. I am afraid of losing my freedom. That is why I ask my family to give me time, perhaps next year I will have decided. There are no jobs in this country. According to the news, the unemployment rate is high, especially for someone with my qualifications. I was just lucky to get a temporary teaching job; however, two weeks after I started, the government announced that they are no longer hiring temporary teachers and I wasn't even paid for the work.

I am now more aware of myself and what others think about me and what I think about myself. I cannot yet tell if it is a good or bad thing. I think I see things clearly now and that I am better than when I was admitted. I'm trying to make new friends, but I'm struggling to let go of the bar

¹⁰ A street name for cheap alcoholic beverages that are sold in small bottles

¹¹ A type of illicit alcoholic beverage

environment, not the drinking, just the setting. That is where people talk about what is happening locally, all the news you cannot get in a newspaper.

They used to lock me up at home, but I escaped through the roof because the house had no ceiling. I have changed. Now I just spend the whole day at home. I was banned from the bar and the owner does not want to see me there. I spend the day at home watching the same movies repeatedly. Sometimes I do gardening, or I go to the shops, although I am not allowed to, just go to see what is happening. I think my family needs to give me some space to do my own thing. They can even give me some money so that I can look for a job.

Nzou`s story: We have come a long way

Loss after loss

I am Mr Mwedzi and this is my wife (Nzou`s stepmother) and our son, Nzou, who experienced a mental health problem due to substance abuse. Nzou is 19 years old and has two older brothers and three younger siblings. His older brothers live on their own and my wife and I live with Nzou and his younger siblings.

Nzou was 3 years old when his mother passed away. He was taken in by his maternal grandmother who stayed in Soweto, South Africa. When she passed away, he moved in with his maternal aunt and stayed with her and her family until he returned to Zimbabwe two years ago. His aunt`s husband passed away too, and his aunt was frequently admitted to hospital due to ill health. I could not visit Nzou in South Africa because I do not have a passport, but I communicated with his aunt.

His aunt used to tell me that Nzou was mischievous and, thinking it was innocent mischief, I would tell her to discipline him with a beating. When Nzou`s relatives started phoning more frequently, my wife advised me to bring him home. Initially I refused because I thought it would be hard for him to adjust in Zimbabwe, but when his relatives informed me that they were locking him indoors all day due to “strange behaviour”, I agreed he should come home.

If I had known

When I collected him at the bus station, I was shocked by his vagrant-like appearance. I regretted sending him to South Africa. I thought his relatives might have neglected him because he was not their biological child. When I asked Nzou about the substance abuse, he said it started when he was eight years old because he was stressed. He was constantly reminded that his father had

abandoned him when he did something wrong. When his uncle died, he feared he would be left alone. His aunt was often sick and Nzou was home alone with his cousins. The only way he could relieve his stress was by taking alcohol and *mbanje*. He told me it had become difficult for him to stop.

Seeing is believing

I strongly suspect Nzou's relatives had taken him to hospital for treatment before putting him on the bus because he was calm, and we wondered why they sent him back. We didn't notice any problems initially and thought they might have lied to get rid of him. But one day my wife saw him dancing whilst looking at his shadow. At first, I didn't believe it. Then my sister-in-law witnessed a similar incident. We began observing his actions and realized they were strange. Some people said he was possessed by evil spirits from South Africa and recommended taking him to traditional healers.

Initially we didn't see any signs that he was smoking. Then, one day, I saw him smoking. When he accompanied me to part time jobs, he would frequently excuse himself for a few minutes. I discovered that he was going to the *base*¹². He would come back quietly and continue working. He seemed like a good person but was quietly abusing substances. He had easy access to the substances and ended up using openly, asking me to buy him cigarettes.

We then started noticing strange behaviour when Nzou had abused substances. He started burning his clothes and sewing new clothes. I think I would have taken him to hospital earlier if I knew more about the symptoms of substance use disorders. My wife once saw him holding a

¹² A place where people meet to smoke cigarettes and cannabis and drink alcohol

cooking stick and a teapot and asked him what he was doing. He said, “I want to cook *sadza*¹³.” Sometimes he would take leftovers of *sadza*, add cooking oil, salt and cold water and mix it before eating it. He started demanding to smoke before meals. Sometimes he sang whilst eating.

Nzou started lying about everything, including his whereabouts. This continued for some time and I knew I had to do something. My neighbours suggested visiting traditional healers or prophets, but it didn’t work. I tried to tell him to stop smoking. I was ashamed and pleaded with God to help us. I knew he needed professional help. I asked for a referral to any facility for people with substance abuse problems and was informed that in Zimbabwe there were only private rehabilitation centres available at about US\$1500 per month. I couldn’t afford it. Sometimes I’d go to work with tears flowing down my cheeks, but I’d pretend everything was well because I was ashamed. I cried because I couldn’t help Nzou.

The problem escalated. Nzou got involved in fights, stole and burned properties. We had to use money that was meant to cover our living expenses to pay for damages. I used to get angry, but I realised that it would not solve the problem. He was now mixing substances, including cigarettes, *mbanje*, illicit and licit alcohol. He constantly talked to himself, sometimes laughing. He stayed up late and woke up very early. He became threatening and violent when I did not give him money to buy substances. He was now hiding weapons like screwdrivers when he was going out. He became paranoid, not sleeping and believing that there were people trying to kill him. Extended family members and people from the neighbourhood accused me of all sorts of

¹³ The staple food in Zimbabwe which is prepared using mealie meal and water

bad things, such as *kuromba*¹⁴ so that I would get rich. Most people did not understand that he had a substance abuse problem. They didn't know his history.

After two trying years, a neighbour advised us to take Nzou to the mental health unit at one of the referral hospitals, telling us that consultation services for mental health were free. We had to force him to go. Initially, he did not respond to the medication. After adjusting his medication, we began seeing a positive change.

The morning after his discharge, I secretly followed him when he left the house and saw that he was going back to the *base*. When I got there, he was already smoking *mbanje*. I was sad and disappointed. I told his friends that I would report them to the police. They promised they wouldn't give him *mbanje* again.

The future for Nzou is uncertain

My wife has been very supportive, even though Nzou is a stepchild. She would help me take care of him and did everything that a mother would do. We helped each other until we managed to bring him here. Regarding future plans, we are uncertain. My wish is for Nzou to get a job and become financially independent, but I am concerned that he'll use the money for *mbanje*. I do not have the capital to help him to start his own brick moulding business and I cannot get a loan from the bank. So at the moment Nzou just sits here the whole day, with nothing productive to structure his day. I am afraid if he continues like this for long he might be tempted to start abusing substances again

¹⁴Acquiring a goblin for the purposes of accumulating wealth using supernatural powers. These supernatural powers are believed to result in physical and mental illness as well as deaths of family members

Zuva`s narrative: It was not an easy journey but I just stayed on

It was not an easy journey

Mr Zuva and I have been married for 22 years. We have four children. The firstborn stays alone, two are going to school and the lastborn is not yet at school. We run a tuckshop business. My husband started drinking after our first son was born. He was friends with a neighbour who drank, often inviting him along. At the time, my husband was employed as a security guard and would only drink on his off days. He started a tuckshop business to supplement his salary. I ran the tuckshop when he was at work. On his off days he would go to the wholesalers to buy stock and then come back to run the tuckshop.

Eventually, he left his job as he was earning more from the tuckshop. This is when his drinking became a problem. He started to drink more frequently. He would drink the opaque beer that we sold in the tuckshop. He started going out to drink and coming home very drunk. He began taking money from the tuckshop to buy alcohol. He stopped drinking the opaque beer and instead bought spirits and other illicit alcoholic beverages.

I had to run the tuckshop on my own as he would spend most of his time with his friends. He would take all the money from the tuckshop sales to sponsor his drinking. This impacted heavily on our family income. Our children would sometimes be sent away from school because of non-payment of fees. My husband could no longer afford to send money for his mother`s upkeep. This continued for almost four years.

...And then it got worse

He started becoming very aggressive when I refused to give him money from the tuckshop. To “maintain peace”, I would let him have his way. The children became afraid of him. At first, I

didn't do anything to help them, just accepting the situation. Later, I tried talking to my husband about the impact of his drinking on our family, but the problem just worsened. He would stay out all night, going for days without food. He would start drinking early in the morning: *musombodiya, broncleer, and zed*¹⁵, anything alcoholic. He couldn't control himself and his friends added to the problem by bringing alcohol to our house.

His drinking got even worse, with the aggressive behaviour occurring almost daily. I became depressed. My oldest son asked me if we could move away from his father. My youngest child would start crying or run away to our neighbour's house whenever he saw him. I felt helpless but had nowhere to go.

We tried to open a second tuckshop in a nearby residential area, but my husband would use all the money. Sometimes people would come and demand money for alcohol he drank on credit. He started selling his clothes to get more money.

I repeatedly threatened to leave my husband, but he didn't change. He was losing a lot of weight. I tried to force feed him, but he would spill the food and shout at me. He would go for days without taking a bath and did not even have the strength to take the bucket of water to the bathroom. It was not easy staying with him.

The neighbours started gossiping, accusing us of performing black magic to make the tuckshop successful (*kuromba*). They thought my husband was mentally ill because of this. After drinking some home-brewed "alcoholic concoction" sold in our neighbourhood, my husband became more aggressive, not wanting anyone to make noise in the house. He would laugh alone, talk to himself and stay awake the whole night. He seemed to be hallucinating. I told my mother-in-law

¹⁵ types of illicit alcoholic beverages that are sold in Zimbabwe

what was happening to my husband. When she arrived and saw what was happening, she suggested that we consult traditional and faith healers. They said it was witchcraft and wanted a lot of money to perform a cleansing ceremony. We could not afford it. We continued to monitor the situation at home for almost a week, taking turns to sleep to make sure he would not run away. My maternal uncle who works in a pharmacy came to visit us. He referred us to the psychiatric unit at one of the central hospitals. That was when my husband was admitted for the first time.

At first it was just social drinking

At first, I only drank to socialise. I did not realise that my drinking spiralled out of control. I also started smoking cannabis and gambling. I spent most of my money on alcohol rather than taking care of my family. When I could no longer afford “real alcohol”, I started buying cheap illicit alcohol. It affected my mental wellbeing to a point where I needed alcohol to function.

Before the tuckshop business, I used to drink responsibly. There were consequences for not reporting for duty or drinking alcohol whilst on duty. The other reason why I had to limit my drinking was because I only had a salary at the end of the month, so I did not have extra cash. However, with the tuckshop I was handling cash daily. Through gambling, I would sometimes win a lot of money and could afford to buy even more alcohol. On bad days I would lose a lot of money and end up in debt. I started taking money from the tuckshop, selling household property and my own clothes to clear the debt. I could no longer control my drinking. I was not myself anymore.

The future is uncertain

I am grateful that my wife has stood by me for all these years. Since I got discharged, I have been trying to stop drinking and smoking. I have not taken any alcohol or smoked for the past

two months. I now spend most of my time at home; often sleeping the whole day. I am not sure how to spend my time and I am already starting to get bored. Currently, business is very slow because there is not much to sell.

Ndakaziva's story: The experiment that went wrong

We never saw it coming

I stay here with my wife (Ndakaziva's mother), Ndakaziva and her younger sister. We have four children and Ndakaziva is the third-born. Before our daughter got sick, she was a professional football player, playing for the national female team. She used to be cheerful and would always tell us what was happening in her life. When she was in form two, we started noticing that Ndakaziva was isolating herself. Initially we thought she was just going through adolescence. Her mother also thought maybe she got used to being alone, because when they went for practise camps or travelled for away matches they stayed in single rooms. She started coming back home very late from practise sessions. When we reprimanded her, she started coming home early again, but only for a while. Then she started coming late again, also refusing to eat. Everything about her had changed, but when we asked her about it she said she was fine. When Ndakaziva passed only three subjects when she wrote her ordinary levels we were shocked, she used to be intelligent.

Her football coach informed us that he had noticed some changes in Ndakaziva and her team mates were complaining about her behaviour. She had become unpredictable. Some days she would be very aggressive; other days she would be withdrawn and disinterested. Her coach advised us that she might need professional help. We decided that her mother would try talking to her. Again, she said there was nothing wrong. We did not see it coming. We never saw her drunk or suspected she could be using drugs.

Confused and desperate

The situation worsened when she finished writing her ordinary level examinations. She would not come home after football practise. When we phoned, she would say she had gone to her

friend's house for a sleepover. We could not get to the root of the problem, we continued watching her, helpless. When she was at home, she would stay up late watching TV, saying she could not sleep. When her mother asked her if she was smoking cannabis, she denied it. She was losing weight but refusing to eat. She was more withdrawn and had lost interest in many things, but she continued to tell us there was nothing wrong. Her mother tried to beat her to force her to open up, but it did not help.

We discovered that she was selling her personal belongings. She would hide them in her backpack or wait for times when she was alone at home. We would see neighbours wearing her clothes. We approached a few of them, asking them to return the clothes but they told us they had paid for the things. Ndakaziva used to get paid every fortnight during the soccer season. She'd always show us that she had received her salary and spend it wisely, helping the family. We let her manage her own finances. She travelled to a lot of countries in Africa for soccer matches and would buy herself clothes and electrical gadgets. When she started selling all these things and we asked her about it she'd say, "I am donating to the poor". I think we let her manage her finances when she was still too young and immature.

When she was 19 years old, we noticed a big change. Neighbours told us they had seen her roaming the streets as if she "had lost her mind". One of the neighbours brought her home one day, telling us that Ndakaziva had almost been knocked down by several cars. She advised us to seek help. I had been retrenched from work, so I was spending most of my time at home. I started following her and noticed that she would not pay attention to oncoming cars, crossing the road as if she was drunk.

On one occasion I followed her to a certain house in the neighbourhood. I thought she was visiting a friend, so I waited, but she did not come out. After several hours I entered the yard,

finding a lot of youngsters drinking alcohol and smoking cannabis. I asked to see the owner and when she came, I confronted her, but she was rude and arrogant. I was told that the owner is well connected with the police and would not get arrested.

We were advised to seek help from prophets and traditional healers, but this did not help. I suggested to my wife that we seek medical treatment. On the day we went to hospital she became violent and tried to escape but the security guards helped us, and she was admitted for three weeks. After three days, she began to stabilise. She was referred to a psychologist. Eventually she confessed to us that she was using drugs. She was smoking cannabis, drinking *broncho* and other illicit beverages. She told us where she was hiding drugs in her room and that she wanted to quit. We asked her if she was serious and she said she was ready because of what she went through and what she had seen in the ward.

At first it was an experiment

I started abusing drugs in form two. At that time, I had been selected to play football for the junior female team at national level. I would hear my peers talking about their experiences after smoking cannabis as if it was so great and I felt I was missing out. One day I decided to buy my own cigarette just to experiment. I had seen some of my friends on drugs become very slow responding to situations (commonly known as “kusticker”). Others became overconfident or arrogant. However, I did not experience any of this and thought I could try more.

My friends encouraged me to take *broncho*, saying it would make me feel good and no one would notice that I was drunk. At first, I refused, but eventually I gave in. It made me feel good. The following day I told my friends that I was hearing voices and seeing things, but they assured me that is how it works. I kept on increasing the amount of *broncho*. I was also introduced to *Histalics* (cough mixture). We were like a big family who were abusing substances, looking out

for one another, sharing whatever we had, and telling one another where the substances were available at cheaper prices. When I could not afford to drink and smoke as often as I wanted to, I stopped buying groceries and started selling my belongings. The neighbours would pay in instalments, so I had some money coming in every day.

Then the experiment went wrong

The substance use started affecting me during training. I needed to drink alcohol to function. I would get overly aggressive towards my team mates. My coach tried to talk to me but I did not pay attention. At one point I tried to quit but my friends persuaded me otherwise. Everyone in my team knew I was abusing drugs. I would go anywhere I could find something that made me “high”. I became stubborn, even at home. There was a house in my neighbourhood selling drugs and at times the police would come to search the house, but we would be locked inside until they left.

During soccer season I would make money from soccer matches, but in between seasons I had no income, so we started making counterfeit money. We started with the smaller notes and eventually we were making US\$100 notes. We used these counterfeit notes mostly at “tuckshops” or street vendors and then used the change to buy cannabis and illicit alcohol. After nearly being caught, I stopped dealing in counterfeit notes. I changed the place where I would hang out, but my friends followed me and offered to buy drugs for me. They introduced me to pills which they said were a bit cheaper since I no longer had money. We would put the pills in yoghurt or juice. When I was too drunk, I did not go home but rather visited more places where I would get more drugs and spend the night. I would send messages to my parents, saying we were camping for training. I deleted my coach’s phone number from my parents’ mobile phones, so they could not check with the coach.

We went from one “base” to another. I was introduced to ‘*Passa Passa*’, a street dance party where drugs are sold openly for as little as 10 cents. I used all the money that I had and then asked my friends for more. Sometimes I became unconscious, but my friends would take care of me until I regained consciousness and we would continue abusing drugs. I wanted to feel what happens when I keep on abusing drugs. I wanted to prove that those who got mental illness due to drug abuse were just naturally prone to mental illness.

On one occasion I did not regain consciousness and my friends brought me home to my parents, saying they didn’t know what was wrong with me. I could hear what they were saying but was too weak to respond. From then onwards I did not understand what was happening to me. I began avoiding relatives. I did not want to be questioned because I knew I would respond arrogantly. I even avoided my younger sister whom I used to be close to. This was my strategy to make sure no one would find out that I was abusing drugs.

I now realise that I wasted my time. I lost many opportunities due to substance abuse. Most of my team mates who were not abusing drugs are still playing soccer professionally. Both the police and the national army wanted to recruit me based on my football talent, but I was afraid they would find out about my substance abuse. I changed my mobile number so that they couldn’t get in touch with me.

I realise that I need to stop using drugs and regain my life. I have started playing football again at club level. I hope I will be selected for the national team because I have “re-gained my momentum”. We train throughout the year, but only for an hour per day. I hope to use the rest of my time to prepare for the examinations I intend to re-write. Eventually, I hope to advance my football career and become a coach. I want to help prevent other young girls from abusing drugs.

I am a Christian now, and even if my friends ask me to re-engage in drug abuse I will refuse. I repented while in hospital. During the time I became stable but was still admitted, I saw new patients with substance use disorders. I don't want to go back to such a state. My parents' pastors also visited me in hospital, encouraging me to repent and stop abusing drugs. I think I will ask my parents to help me with financial planning until I am responsible enough.

Chipo`s story: We don`t know how it started but we just want it to stop

We didn`t know what to do

As per Shona culture, both my sister and I are mothers to Chipo since she is our sister`s daughter; however, her biological mother is in Canada. Chipo has stayed with both me and my sister. She was once married but got divorced. First, she lost her baby, and then her husband left her. After her husband left, Chipo stayed with a friend who told me that she was drinking heavily. Her ex -husband later informed us that she`d been evicted by her landlord for not paying rent. She then came to stay with me. I don`t know when the problem started, perhaps at school. We knew that she drank alcohol excessively, but she wouldn`t share the problems that were causing her to drink.

We don`t know how to help our daughter

When staying with me or my sister, Chipo would go away for several days without informing us. We had no way of communicating with her. We looked for jobs for her, but she failed to keep any of them because of her drinking. Sometimes she would stay at home with either me or my sister; other times she stayed with friends. We`ve always been there for Chipo, we`d forgive her and give her more chances to start over again, but she wouldn`t open up about her problems.

Currently, Chipo is staying with my younger sister who is a counsellor at her church. She has tried counselling Chipo, without any success. My brother tried taking her to his pastor but Chipo refused to go back because she said the pastor asked her about issues she didn`t want to talk about. Chipo has a very pleasant personality when she`s sober, but when she is drunk she behaves as if “possessed by a demon”. She becomes overly talkative and quarrelsome. Chipo tends to steal, so most of her other relatives don`t want her to stay with them. This has been an

ongoing problem, even at work and with friends. We reported her to the police once. She was beaten, and we regretted reporting her. She steals to buy alcohol.

Chipo's mother and I have been arranging for her to go to Canada. Her mother was in the process of gathering documents for her student's Visa. We had agreed that she would first go to South Africa for rehabilitation and then apply for a Canadian visa. We looked for a rehabilitation clinic in South Africa and paid US\$4 000. She was supposed to have 25 sessions.

When she came back after the first ten sessions she had made good progress. She would go for ten more sessions and then return to have the medical examinations for the Canadian Visa before completing the remaining five sessions. When she came home after the 20th session, Chipo was very drunk. We were shocked. We were hopeful that she would successfully complete her rehabilitation. She was dismissed from the rehabilitation clinic until she was ready to stop drinking. We stayed with her at home and she continued stealing and getting drunk.

We have no way of raising another \$4000 for her to go back to the rehabilitation clinic. Maybe if we can identify a cheaper place locally, it will be possible to start the process all over. I don't think any of my siblings are still willing to contribute towards her rehabilitation.

The day after she came home for her second visit, she had an appointment for medical examinations for her Visa application that she missed. We have stopped the whole application process. We have not told her mother because we are not sure how she is going to react. Chipo cannot go to Canada until she recovers.

When I took Chipo in the last time, my husband felt her father was not taking enough responsibility. I had explained that she'd just stay a few months whilst preparing to go to Canada. It's becoming increasingly difficult for me to allow her to stay with us. My husband

keeps asking when her father is going to take over the responsibility of looking after her, but he seems to be ignoring her. She has stayed with my brother before, but he won't accommodate her again. Her paternal relatives are not willing to help her either. It's up to Chipo to decide if she really wants to be helped.

Another chance

I started drinking excessively when I was 22 years old. I had no stable home. My parents divorced, and my father remarried when I was in primary school. I stayed with my father and stepmother. When I had completed secondary school, my father left me with my stepmother to stay with another woman. After my father's third marriage, my stepmother asked me to leave. I stayed briefly with my father and his new wife. He had not told her about me, so it was difficult for me. Sometimes she would be nice but most of the time she was too harsh. When I told my mother about the situation, she asked her eldest sister to take me in.

I felt alone at my aunt's place. I moved out to stay with my friend and her family. We had been friends for a long time, so her mum treated me like a daughter. I stayed there for more than a year. I worked for 2 years at various restaurants and a hair salon, changing jobs 5 times during that period. When I got married, my situation changed briefly. I was happy, but it did not even last two years. I was over-excited when I got pregnant, but I had a miscarriage. I also discovered that I am HIV positive and was devastated. The atmosphere at home became tense. It was my first pregnancy and when I lost the baby everything fell apart.

My marriage broke down when I found out my husband had married a third wife. I was his second wife. I was drinking a lot. We used to drink together but I would do it in excess. I was so stressed when my husband left me. I don't know how to express myself when I face challenging

situations, I keep it to myself. However, I managed to call my mum in Canada and explained my situation but talking alone was not enough. I started drinking alcohol so that I could sleep and forget about everything. After leaving, my husband supported me financially for a while but eventually stopped. I started buying and selling perfumes and the drinking continued. I don't want to be a burden to either of my mothers. It gives me hope that they care for me, and I am sorry I have hurt them so many times. I am willing to change. I want people to see my good side. I am not a bad person but when I drink I don't know what happens.

Danai`s story: I want to stop but I have nothing else to do

I had no idea what was happening

I`m a single mother of two. I stay with my 24-year old son, Danai, who has a substance use disorder and his younger sister. I divorced my husband in 2006 because he married a second wife. Since then I have been staying with my children. I used to rent two rooms in the urban areas while working at a local seed company, but I was retrenched last year. I managed to buy a residential stand here in Goromonzi¹⁶ where I now stay with my children. I was the breadwinner for our family. We now survive on the \$50 child support that I receive from my ex-husband and the money I make from my small business as a cross-border trader.

My son must have started abusing substances around grade 7, and the habit just continued. He was at a boarding school and we did not know that`s what he was doing, as we would only see him briefly during school holidays. At first, we didn`t notice anything. Later, he would openly smoke cannabis. He has always been a difficult child, but he got worse after his father left.

He used to quarrel with his father and would run away from home and stay next door. At the time I thought his father was being too harsh, but when I look back I think maybe his father had already noticed that he was abusing substances. I didn`t know he was abusing substances or that he would end up with a psychiatric problem and unable to work.

The harsh reality

It breaks my heart to see my son in this state. At first, I didn`t know what to do. I shared the problem with his paternal aunts and with my sisters. We all tried to talk to him but there was no change. I took him to hospital for the first time in 2012, assisted by the police who handcuffed

¹⁶ Peri-urban residential area 25km from Harare

him because he was so violent. Since then he has been admitted five times. Each time he gets home, he starts abusing substances again and we're back where we started. Sometimes when he has smoked *mbanje*, he becomes violent and quarrelsome, doesn't eat, and burns his belongings. Without a male guardian, it is difficult. He refused to go to the traditional healers and faith healers or even to church. I cannot force him because I am afraid he will get violent.

He used to go to church but stopped. He started taking substances while still attending church. The pastor noticed the problem and asked me if Danai could stay with him for a while. I agreed, and he stayed there for two months, while the pastor tried counselling him. Eventually, the pastor told me he was afraid Danai would influence the other children who were staying at his house, as he was now bringing *mbanje* home, so he was sent away. Since then he has not gone back to church.

Danai worked for road Construction Company. He had his first psychotic episode whilst at work in another city, 400km from home. He had burnt all his clothes and blankets whilst drunk and I was called by his supervisors. When I arrived, I went to his room with his supervisor and we found empty bottles of *broncho* in his room. He was not suspended. His supervisor thought he was possessed by a demon. He asked me to consult a traditional or faith healer and allowed him to come back to work. When we got home I took him to the psychiatric ward for his second admission. After he had recovered, he went back to work but was transferred to another station in a different district. A few months later he got suspended for reporting to work drunk and missing work. His supervisor now knew about his substance use problem and thought the suspension would be a wake-up call. He told me that if he was able to stop abusing substances, the suspension would be lifted. The supervisor told me Danai was keeping *mbanje* in his room. He would drink with his workmates and smoke *mbanje* when he was alone. His workmates drank

responsibly and would report for duty the next day but Danai would either turn up late or not at all.

No lasting solution yet

Danai usually spends the whole day at the shopping centre with his friends. Jobs are scarce, so most young men just hang around, doing nothing productive. Danai wakes up around 10am, eats, goes out, and comes home in the early morning hours. I have seen him several times with his friends when I go shopping. I suspect they are smoking *mbanje* and drinking *broncho*. I once saw a *blue diamond tablet* in his wallet; I suspect he takes that too. I find it very difficult to confront his friends about how they are influencing my son. I don't know if it's possible to get medication to stop his cravings for substances so that he can be more productive.

Each time we discuss the disadvantages of substance abuse Danai promises to quit, but never does. When he has smoked cannabis, his eyes turn red and he is filled with rage. Sometimes my daughter and I will leave and stay out until he calms down and falls asleep. Sometimes I do not go to bed until I am sure he is asleep, worrying that he'll burn the house down. He is now mixing the substances, so I don't know what or how much he has taken and how it will affect him.

I think it might help if Danai stayed with his father, but he doesn't want to hear anything about Danai. Since Danai's last admission his father has not visited or even phoned. I also tried involving his paternal relatives, but they too have lost interest. In my neighbourhood there are mainly ladies who can't really help if he becomes violent. The police have helped me a lot in the past. I have the telephone numbers for the local police station. Whenever he becomes violent I call them for assistance.

I want to stop but I have nothing else to do

I was introduced to substances by my school friends when I was in grade 7. Other students brought cannabis and gave it to us for free, teaching us how to make a “twist”. Before long I could make my own twist and started enjoying the way I felt after smoking. When we had finished smoking, we would return to class to do our homework. After smoking *mbanje* I would find it difficult to concentrate on my schoolwork so I just did not hand in my homework. Initially the teachers would punish me but eventually they just started ignoring me. I would sometimes miss school and no one would ask me. When I failed my Ordinary level examinations, my father helped me to get a job at the road construction company where he works as a human resources manager.

I really enjoyed my previous job. At the workers’ compound, each person had a single room. After work I would be alone in my room, doing chores, listening to music or watching movies on my laptop. Occasionally I would go out to the shopping centre with my colleagues. Usually we just sat at the botte store drinking alcohol. I never smoked cannabis in public; only when I was alone in my room.

I was suspended for arriving late at work. I usually drank *broncho* and *zed* when I was alone, so I would oversleep and be late for work. Since the suspension, I have been staying at home. I am not lazy but there isn’t much to do at home. We do not have any livestock. Our yard is not fenced so we cannot even start a vegetable garden because the cattle and goats from the neighbourhood will destroy it. We are new in the area, so I don’t have friends in the neighbourhood. I go to the shopping centre to socialise with peers. I can’t stay at home doing nothing every day. I want to stop associating with friends who abuse substances. I want to be able to say no when I am offered cannabis or alcohol. I want to go to work.

Themba`s story: The ball is in your court

We have tried everything to help

I am Themba`s mother. I have lost interest in Themba`s alcohol problem. The entire family has given up on him, that`s why they are not here for the interview. He drinks anything alcoholic and smokes too. If there is no alcohol, he even sniffs methylated spirits. He always finds a way. He will steal money for alcohol or borrow from neighbours, telling them that he wants to buy airtime for an urgent call.

We have stopped giving him money and locked him inside the house to prevent him from getting drugs. We have looked for employment for him, but he can`t keep a job. My friends have also talked to him. When he is sober, he agrees to everything, but then he just gets drunk again. I have also encouraged him to join his father at our farm to gain experience, but he is not interested. I even started a poultry project for him at home, but he took all the money we made to buy alcohol. Even his work salary he would spend on alcohol.

He doesn`t have any friends, he drinks alone. He buys his beer at local shops, drinks in his room, then sleeps. I always encourage him to socialise with young people at church, rather than isolating himself. I have gone with him to church several times so that he could meet friends and perhaps a life partner, but he complains that I am forcing him.

If God`s timing comes for him to change he will change. We have tried *counselling*, talking to him, beating him, and sending him for rehabilitation in South Africa. After realising the extent of his problem, we sent him to a rehabilitation centre in South Africa for 3 weeks. After his discharge, we phoned him. He sounded remorseful and told us he had quit drinking. We asked his paternal cousin to stay with him until he found a job, but he was chased away after two weeks

because he stole money to buy alcohol. Then his uncle took him in. He managed to find a job, but his drinking didn't stop. His uncle also chased him away, accusing him not only of abusing alcohol, but also of sexually abusing his son.

We begged his cousin to take him in again whilst we were raising money for him to be re-admitted at the rehabilitation centre. His father was working in Tanzania and needed time to raise the money. His cousin agreed, but he stole money again and then came back home. His father found him a job at a hotel in Tanzania. After a month, he started complaining that he didn't like the job and wasn't earning enough. He didn't like starting at the basic level and doing manual work. He started reporting for duty drunk and missing work. Eventually, he was fired. His drinking escalated, and his father sent him home.

My son lacks discipline

His father wants him to quit both drinking and smoking, but I have told him that quitting is a process and he should do it step by step. We have agreed that he should work on quitting alcohol first, then smoking. Smoking doesn't interfere with work like drinking. His father has completely given up on him. I am also frustrated. Themba sleeps all day and has no initiative. At 34 years I'm still providing and doing everything for him. What frustrates me the most is that we did our best for him to get a better future, sending him to the most expensive private schools and an expensive South African university. I wonder if this was God's plan for my son or if he made wrong choices.

I think my son lacks self-discipline. He can go for up to a month without drinking, but when he starts, he drinks heavily, as if compensating for the days he missed. It's now almost a trend that every month he drinks heavily for a week and stays sober for the other three. Instead of being

grateful, Themba blames us and complains. I guess he needs psychological help. He needs to work extra hard to regain everyone`s trust. He wanted to go back to South Africa, but I told him he couldn`t go until he has proven that he has changed.

I think I was depressed

I went to South Africa in 2002 to study Organisational Psychology at a Cape Town university. I was already drinking beer when I left for university, but my parents didn`t know. The drinking got worse at university because I had lots of friends who drank. It affected my school performance. I took five years to complete the three-year programme. I think I was depressed. I was involved in a series of bad relationships, ending in bad breakups.

I lost my part-time job as restaurant manager in South Africa because of the drinking. I had constant bad reports and missed work. Since I could not afford to stay in South Africa whilst looking for another job, I returned home. When I got home, my parents realised how bad my drinking was and sent me for rehabilitation in South Africa.

I then went to Tanzania where my father was working. I got a job at a hotel but lost it due to the drinking. My Dad was angry and sent me home. I got another job in Harare but started missing work each time I got paid. I would go out with friends and drink until I had no money left. I knew if I went to work with a doctor`s letter I would not get in trouble. I would report to the doctor saying I was sick and get the letter. However, the Doctor started enquiring about my drinking habits. I eventually opened up to him and he referred me to a psychiatrist. The people at work were talking about my drinking problem. I resigned on personal grounds.

My problems are my secrets

I have two sisters. I'm the middle child. My older sister works at a local law firm. She is divorced, so we stay together at my parents' house. My younger sister works in a bank in a small mining town but comes home some weekends. My parents are both retired but my father spends most of his time at the farm, so I'm usually with my mother, my sister, and my nephew and niece. I'm not close to my parents or siblings because I spent a longer time at boarding school than at home. After boarding school, I left for South Africa. I am not used to sharing my problems with them. I learnt to internalise my problems at boarding school. There was a lot of bullying and other stuff I can't mention, and no proper channels for sharing one's problems. I always had to pretend that I was strong and that everything was normal.

I think my parents have done their share and it's now up to me to change. I don't want my mother to tell people about my drinking problem, especially not strangers. I know she is angry and upset with me because of my substance abuse problem, but sometimes I feel that she is too harsh. I just remain quiet and sometimes I end up drinking. Daddy is more flexible and open-minded and mum is the complete opposite

I am taking it one step at a time

I just completed a post-graduate course in project management. I am now doing another short course in occupational health and safety. I want to quit alcohol. I just need a support structure to start a business. I also want to look for volunteer work to fill idle time and do something that makes me feel good. I want to build my confidence and learn to love myself and look after myself. Since I resigned from my last job, I'm hoping to re-apply. I don't want to work at the farm. I want a paying job that will allow me to be financially independent. I am taking it one step at a time and I know eventually I will be able to achieve my life goals.

Dadirai`s story: The bottle is always there when I need to relieve stress

I never knew alcohol could be that bad

Dadirai`s and I got married in December 2015. We don`t have children yet. We live in a medium-density suburb, 10km from the city centre. Before we got married, Dadirai used to drink alcohol and I didn`t mind, but when we got married, her drinking started bothering me. She started drinking more and was sometimes drunk for days. She works continuously for one month and is off duty for the next month. When she is off duty she will drink alcohol daily until she becomes unable to function for at least two days. Sometimes she goes to overnight parties and when she returns she can hardly do anything. She will just sleep, not even waking to take a bath or cook for me. When I return from work, I find the house just as I left it in the morning.

I don`t know how to help

I have talked to her repeatedly about how her drinking is affecting our marriage, but she doesn`t seem to understand. I have tried beating her up when she comes home drunk, but it did not help. Everything in our relationship has become a potential source of conflict. She will shout at me when things don`t go her way. I work for the local authority that has not been able to pay salaries for eight months, which has worsened the situation. She is angry because I can`t contribute to the household. She no longer welcomes me like she used to when I get home from work. Either she`ll be too drunk, or she`ll be chatting on WhatsApp with friends. Whenever we have a conflict, she threatens to break up with me and stay at the single quarters at her work place.

She lies so about her drinking, denying that she`s drunk, even when it`s obvious. I don`t know how much she drinks at home; she hides the alcohol from me. I do everything for her when she is drunk, because she becomes dysfunctional. I tried to stop her from hanging out with her friends who encourage her to drink, I have tried to make sure she does not carry a lot of money, I tried

hiding the car keys when I leave her home alone at so that she can't go and buy alcohol. However, she will call a cab and go and buy alcohol before I come home. She spends US\$50 to US\$60 on alcohol. She buys and drinks the alcohol when I am at work, so I don't know how much she has taken. I used to keep her ATM card, but she on one occasion she became angry because I used it to pay a hospital bill when I had to rush her there due to alcohol-induced unconsciousness. Now I let her keep her own ATM card.

Her drinking is affecting her job, sometimes she is unable to go to work. Then I cover up for her. When I call the doctors at the staff clinic at her workplace to tell them that she is sick, she becomes angry and she accuses me of exposing her, but I only do it because I don't want her to be fired. She has been given several warnings because of her drinking problem. The social workers from her company may visit an employee's home. My worst fear is that they will come here and find her in a drunken state and that she might be fired. If I keep on admitting her to psychiatric hospital, she might be dismissed from work on medical grounds, so when I'm travelling and won't be home for several days, I leave her at her brother's house. This doesn't help much because he and his wife are both employed and therefore mostly not home.

She tries to minimise her drinking problem, even lying to the psychiatrist. When I told him the truth, she was angry. I don't want her to be dismissed from work but at the same time I cannot lie, because I want her to get help.

Failing to adapt

I run a small car sale business, so I sometimes travel to Tanzania to buy second hand cars. Before we got married, our economy was not as bad as now. I would get a lot of orders and travel to Tanzania every other week, often taking Dadirai along. Nowadays I get very few orders. At that time, I could negotiate for at least a week away from work. Now I can only be away from work for a maximum of three days in a month, so I have to travel to Tanzania by air and return by road. Sometimes I cannot do this because I will have used some of my days off to take care of her when she gets drunk.

The bottle is always there when I need to relieve stress

I used to drink alcohol for fun with my friends. However, I started drinking in excess after getting married. I've been admitted to the mental health unit four times in the past year because of substance use disorder. The first admission was after a psychotic episode at work. The other three times I was taken to hospital by my brother and my husband.

Before I got married I stayed in the company accommodation free of charge and could afford to look after myself and my siblings. I was used to my independence. I would go out with friends almost every weekend, we would drink alcohol almost every day because there was a bar at the staff quarters. When I got married, everything changed. I am not coping. My husband comes from a Christian background and doesn't approve of my lifestyle or my friends. Therefore, I cannot invite them over whenever I want. I have more responsibilities now. Sometimes my husband has no money to pay rent because his company has been struggling financially and they sometimes go for three or four months without getting a salary. When that happens, I have to pay the rent. I can no longer afford to send money to my parents. I started drinking more and more on my own to relieve my stress.

After I moved in with my husband, I felt like he was neglecting me, so I drank more to “drown my sorrow”. Whenever I was drunk, I felt better. Before we got married, we travelled together but he no longer takes me along. When he is away I feel lonely and I drink the whole day. When I moved out of the company accommodation, the only person I knew in my neighbourhood was my husband. I have a brother who stays in Harare with his family, but I don’t always want to go to his place when my husband is away. My husband has three siblings who stay in Harare, but I am not close to them. When I’m off duty I am mostly alone.

I am also worried that I might not be able to have children. A few months before we got married I had an emergency appendix-removal. When I returned from theatre, I was informed that they had removed one of my fallopian tubes (laparotomy). The doctors did not explain why, or which tube was removed. Since then I’ve been depressed. I want to know if I will be able to have children because we’ve been trying to conceive for almost a year now.

I want to quit but it is not easy

I work for the uniformed forces, so when I’m sick I have to go to the staff clinic. The first time I had a psychotic episode I was taken to the staff clinic before being referred to a psychiatrist. Now I feel as if the social workers at work are prying into my social life I’m not comfortable discussing the issues that worry me with the medical team at work.

I am trying to quit but it is difficult. I used to take part in sports after work, but I’m no longer engaging in this because we stay far away from the sporting facilities. I was also involved with a catering company. Now, when I’m off duty and spend a whole month at home, I don’t have much to do. If I find something to do during my free time, I will not drink so much.

Tatenda`s story: I know I can change

We had no idea what was happening

I am Tatenda`s mother. I spend most of my time at our farm and Tatenda stays with his father and younger brother. We have two tenants who oversee our house when we are away. My son started showing signs of mental illness due to substance use two years ago. I`m not sure when he started using substances, but according to him it began in grade seven. He abused substances for almost seven years without my knowledge. During the school term, Tatenda stayed with his father in the urban area. At the time, his father was employed as a soldier, working long hours. I stayed at the farm. It was his younger brother who showed me a cigarette stump that he`d found in Tatenda`s bag. Tatenda was repeating form four at the time. I asked him if he was smoking and he denied it. I told his father who promised to keep an eye on him.

The first time Tatenda wrote his ordinary levels he failed all the subjects. We agreed that he would rewrite his examinations. After failing a second time, he came to the farm. One of my neighbours told me that he`d seen Tatenda at the farm compound smoking *mbanje* with some of the boys who stayed there. I confronted Tatenda and he confessed that he`d started smoking cannabis in grade 7 and it was very difficult for him to stop. He would smoke at school and when his father got home, he`d stay in his room, pretending to do homework.

In search of solutions

I started monitoring Tatenda`s movements. He used to go to the farm compound to buy cannabis. He`d leave the house without informing us. I tried asking the neighbours who sold the cannabis to stop selling to him, but they didn`t because that is their income. His father tried beating him, but it didn`t help. His father even beat up the supplier and threatened to report him to the police

but still Tatenda sneaked out to go and buy cannabis. When he smoked, his eyes were red. We agreed to move him back to our house in the urban areas. His father had now retired and was also at the farm. We asked the tenants to keep an eye on him and we'd occasionally visit him. His younger brother had started high school at a boarding school but during the holidays he stayed with Tatenda because we thought at the farm he might also start abusing cannabis. Tatenda ran a tuckshop business in our neighbourhood and made a good profit.

We thought our son had been bewitched

One of our tenants then informed me that Tatenda had become violent and aggressive, always fighting with his younger brother. My husband asked me to go and assess the situation. I was shocked when I saw Tatenda. He was filthy, his clothes were very dirty, he was talking to himself, but we didn't understand what he was saying. We thought he was possessed by an evil spirit, so we took him to a faith healer. I stayed there with him for almost two weeks whilst the faith healer prayed for him and gave him "holy water" to bathe in. It seemed like the problem had stopped and we went home. I thought my son had recovered, so I stayed with him for a few days and then returned to the farm. However, this was a bad decision because he just reconnected with his friends and continued smoking and drinking.

Barely a month after leaving my son at our urban home, our tenant phoned again. This time Tatenda was being violent and aggressive. He had stopped going to the tuckshop and would spend the whole day drinking and smoking. I called the pastor from our church to come and pray for him, but it didn't help. He suggested that we take Tatenda to a mental health unit. That's when we took him to hospital for the first time. He was admitted and stayed for about three weeks.

After he was discharged, I thought he might spend less time with his friends if he had something more demanding to do. We enrolled him for a three-month course in operating mining equipment. I stayed with him to monitor him and accompany him to the hospital for the doctor's reviews and psychologist's sessions. During this time, he reduced his smoking and drinking, and I hardly saw his friends. He successfully completed the course and started looking for a job. I thought he had fully recovered so I went back to the farm. We had asked for two months' supply of medication at the hospital, so I knew he had enough to last him. One tenant called to tell me Tatenda was missing from home. Our other tenant was a *mukorokoza*¹⁷ and had introduced Tatenda to illegal mining. Initially, my son was working for this tenant, so they went home together in the evenings, but Tatenda later moved to a different illegal mining field and had not returned home for several days.

We tried to look for him but there were a lot of illegal mining fields and it was common for miners to move from one field to another. We didn't know where to look. The police were not very helpful. We informed the neighbours, members from our church, and even went on radio. We consulted various faith healers, some of whom told us that he had died. I remained hopeful that we would find him. Six months after his disappearance, one of our church members who sold clothes at the illegal mining fields saw Tatenda at one of the illegal mining fields and she informed me.

I went to the mining area where he was staying. What I saw there was unbelievable. They used ropes to descend into illegal pits, some about 100 metres deep. They would dig for gold from

¹⁷ Illegal miner

early morning until late evening. When I got there, Tatenda had already gone down for his shift, so I had to wait the whole day.

While I was waiting for Tatenda, I was informed by some of the illegal miners that each illegal mine had a primary owner who employed other people. Tatenda was one of the workers, working an eight hour shift every day. The mine workers spent the whole day underground, digging for soil with gold, then sieving it and sending it to the gold mill. Sometimes they would not be paid because the soil would not contain any gold.

At around 4pm Tatenda surfaced from the mining pits, he looked so tired and tattered. I think just staying in such an environment would predispose anyone to using substances. I was hurt to think my son ran away from home, choosing to stay under such harsh conditions. We got to the makeshift house where he stayed; there was nothing but a plastic bag with his meagre belongings. He used a cardboard box as a mattress. I took him home, and the next day I took him back to hospital. After an assessment, the doctor just prescribed the same medication as before and referred him for counselling.

Currently I have no money to sponsor him to start any income-generating project because the school and examination fees for his brother are due. His father is now a pensioner and only gets US\$100/month. We are mostly dependent on income from the farm but this year our harvest was poor.

I am afraid that, even if I give him money, he will just buy cannabis. I know he is still getting cannabis from his friends, but less than before because he does not have money. I know Tatenda enjoys buying and selling, but I am afraid of giving him money to restart his tuckshop business.

I also don't know where he should stay. He knows every place where cannabis is sold in our urban neighbourhood and at the farm our neighbours give him cannabis. He does not enjoy farming, so even if I force him to come and stay at the farm, he won't be productive. I can't keep staying here just to make sure he is not smoking. If I do that, we will be unable to pay for his younger brother's education.

I hoped Tatenda could stay with relatives, but none of them are willing to accommodate him. I think there are evil spirits behind his habit. I have visited several prophets but have now given up. I doubt this will ever stop.

I kept wanting more and more

I started drinking and smoking at my grade seven school farewell party. My friends and I brought food to cook and eat together to celebrate the end of primary school. Everyone volunteered something. One friend didn't have any food but arrived with money and asked us to accompany him to the shops to buy cigarettes and alcohol. He asked some older boys at the bottle store to buy the alcohol and cigarettes on his behalf. We went back to the school grounds and started cooking our food. Afterwards, my friend taught us how to smoke cannabis and cigarettes, and we also drank the alcohol. That was my first experience of drinking and smoking. When I got home I wasn't feeling well, so I went straight to bed. However, the next day my friend brought more cannabis and we smoked again. This time I did not get sick.

The problem worsened when I went to boarding school. There was a small garden behind the laundry area where some of the seniors had planted cannabis, so we would go there, take the cannabis and sundry it. At the end of form one, I complained to my parents that there wasn't enough food at boarding school, so I became a day scholar at a local school. The truth was that I

was starting to miss my friends from primary school with whom I used to smoke and drink. I reconnected with them and continued smoking cannabis. I became a heavy smoker. We would arrive at school around 06:00 am and start smoking heavily. There were seven of us; we would smoke cannabis and drink alcoholic spirits before school. We would do it again at break time and at lunch time. One of our peers supplied us with both cannabis and alcohol; we just gave him money. I had no time to study, so I was not surprised when I failed my ordinary level examinations.

I know I can stop

When I completed my course in operating mining equipment, I tried to get a job at the mine but there were no jobs. I thought I would work at the illegal mines whilst searching for a proper job. I had reduced my alcohol and cannabis intake, but I had stopped taking the medication because it was making me weak and drowsy. When I got paid the first time, I opened a tuckshop at the illegal mining fields. I made a lot of money, but when I got too drunk one evening all my money was stolen. That's when I decided to go to another mining field where I had heard they would pay me after a day's work. However, we were only given \$2/day to buy food. I had to wait for the gold to be sold to get paid. I started drinking and smoking more. The conditions there were tough, all my belongings were stolen. I had to buy a blanket on credit. I just wanted to earn enough to restart my tuckshop business. I need to be independent. I wanted to learn to look after myself just like everyone else at the mining field.

The doctors recommended that I stop using cannabis because it is dangerous for my health but it's difficult to stop. I was diagnosed with Bipolar Affective Disorder. When I feel down, I smoke to feel better. I need to earn my own income. If I have something to occupy me, I will not

smoke. I can manage my addiction by reducing the quantities gradually. I have tried it before, I know it can work.

Gandiwa's story: Quitting is not easy when there are drugs everywhere

My cry for help

I'm a single mother of three sons. Gandiwa, aged 23 years, and his younger brother, aged 20, both abuse substances; however, only Gandiwa has a mental disorder. My youngest is only 8 months old. My first husband, the father of my two older sons, died seventeen years ago. I remarried two years ago after we dated for almost ten years, but my second husband left me just before I gave birth to my lastborn, because of Gandiwa's behaviour.

My oldest has been sick because of substance abuse. He takes *mbanje*, smoking it or boiling the fresh leaves for "cannabis tea" when he is home alone. He also drinks illegal alcoholic beverages and sometimes takes small white pills. Gandiwa finished his ordinary levels in 2011, failing all his subjects. I couldn't afford for him to rewrite the examinations because his younger brother was also starting form one. He stayed at home doing nothing for 2 years and then I managed to send him to a driving school and he got his driving license. I hoped he would get a job as a long-distance truck driver, but most truck owners wanted someone older. His uncle found him a job as petrol attendant. He worked there for 18 months before his contract was terminated, then returned home. At that time some neighbours told me about a company hiring casual workers on contract. Gandiwa seemed interested, so I gave him transport money every day for almost a month to try and get a job at the company. He used the money to buy *mbanje*. Gandiwa lied and became physically aggressive towards me, my husband and his younger brother. He accused his stepfather of wanting to take over the house. After some time, my husband moved out. I couldn't leave my children because of the love for a man. That was the end of my second marriage.

I have tried everything

Initially, we would call the police, they would arrest Gandiwa, and he would sleep in the cells for a night. He was arrested for the same offence several times before a case was opened. The court ruled that that I should get a peace order and that Gandiwa should move out, since he was old enough to be independent. I didn't get the peace order because I was afraid he would be homeless.

Gandiwa continued taking cannabis after my husband left and started gambling too. He sold most of his clothes. I run a small peanut butter business and he would steal the money I made and use it for gambling and buying substances. I used to be a cross border trader, reselling blankets from South Africa. However, since giving birth to my youngest I have not been able to go to South Africa as he doesn't have a passport yet. Now I rely on the money from the peanut butter business. When I confronted Gandiwa about stealing my money, he became violent and aggressive. On some days I'd just leave home and go to my friend's house and come back in the morning.

I consulted various prophets, hoping for a solution. They would give him some ¹⁸*muteuro* claiming his behaviour was caused by evil spirits from his father's family. This didn't help, the situation worsened. He was now getting so drunk that he would collapse and sleep anywhere, even at the roadside. I would ask help from neighbours to take him home. I asked him to go to the hospital, but he refused. Gandiwa started having seizures. He was very weak; his whole body was inflamed, and he couldn't walk. I was afraid that one day he would just die, because he refused to eat. I have a neighbour who sells diazepam pills, but she refused to give me any,

¹⁸ Holy water which is prescribed by prophets for spiritual cleansing purposes

because she said Gandiwa would tell everyone that she sells pills illegally. I approached a nurse who advised me to urgently seek medical attention.

Nowhere to hide

Many young adults in the neighbourhood abuse substances. There have been several deaths. Many of them suffer from drug-induced mental illness. Most of those who show signs of mental illness do not go to hospital; they go to the drug dealers who also sell medication to reverse such effects. It is expensive to buy medication at pharmacies, but the same drugs are readily available on the streets at cheap prices. Who is taking these drugs to the streets? It is those in authority. Drugs are everywhere. The policemen buy *mbanje*, so to whom do you report it to? Most parents just watch their children's lives being destroyed, they are just as helpless as I am. Drug dealers are never arrested; instead, the police are involved too.

Gandiwa is old enough to make his own choices. I have invited him to come with me to church, but he refuses. He refuses to take his psychiatric medication, complaining that it makes him drowsy. I hoped he would start making peanut butter to sell, but he is not interested; neither does he want to help with my other sales. There isn't much to do here. He spends most of his time sleeping. We have a small yard with no room for a garden. Various people have tried to find a job for him, but he is not interested. There has been no one to help me since my husband left. Gandiwa's paternal relatives have never helped. I have asked my sister if he could stay with her, but she refused. He went to his cousin's house once but did not stay long because he started abusing drugs again.

I succumbed to peer pressure

I started smoking cannabis in form two. I didn't smoke that much because I was afraid of getting caught. I used transport money to buy cannabis. After high school I stopped using cannabis

because I didn't have money and my friend who used to supply me had moved away. I stayed at home for three years before getting a job in 2015. I started drinking castle lager while working as petrol attendant, mostly when I was not on duty. However, my contract was terminated after 18 months.

I came home and found another job in the public transport industry, initially as a conductor, later as a driver. I started using cannabis again and my drinking increased. We would smoke cannabis during the day when business was slow. After work we would buy cheap illegal alcoholic beverages. I was fired from my job for being late.

I continued drinking and smoking. I also started gambling to get more money to buy alcohol and cannabis. I would wake up and spend the day with other young people who abuse substances. Many of them are school dropouts, others are university graduates who can't get jobs. My drinking escalated. I had nothing else to do.

However, since I returned from hospital, I have not been drinking. The medication makes me drowsy. I haven't been able to do anything. I want to look for another job as a driver, but I don't have any money to go to the rank to look for a job.

Gamuchirayi's story: Just give me more time and I will change

Nineteen years of drinking

I have six children, four boys and two girls. Gamuchirayi is the fourth born. Four of our children are married and stay with their spouses. The lastborn is in his final year at university in South Africa and only comes home occasionally. I stay here with Gamuchirayi and my husband. My husband and I are both pensioners. I'm a retired nurse and he is a retired teacher.

Gamuchirayi began drinking at the age of 18 when he was doing his lower six at a private college. He would drink beer while going to school and we'd get reports from his teacher that he'd missed school. We would discipline him and advise him to stop, but he didn't listen. At school he was punished several times but continued drinking. When he didn't have money to buy alcohol he would sell his school books and the school would ask us to replace them. His school grades dropped, and he didn't do his homework. He failed his Advanced level. We were not surprised.

We thought of sending him back to school but realised it would be a waste of money. In this neighbourhood there are many young men who abuse drugs, so the problem became worse when he finished school. He started selling his clothes to get money for alcohol. He would hang out with other youths who used drugs. His routine was to wake up, have breakfast, and leave home, coming home very late and drunk. He wouldn't even bother to make his bed. He started stealing things from the house to sell. We used to report him to the police and he would get beaten but didn't stop stealing. Once his father got so angry that he reported the matter to the police, asking them to charge him and send him to prison. I had to beg my husband to withdraw the charges. My husband disowned him, no longer wanting anything to do with Gamuchirayi.

We sent him to a vocational skills centre for a course in cell phone repairs and electronics, but he only completed two modules. He would leave home as if attending the centre and would return at the usual time. We discovered that he had stopped attending lessons and was using the transport money to buy alcohol and cannabis. He achieved the best results at the centre for the two modules he completed but the principal told me that he had just stopped attending lessons without any notice.

Many people advised us to consult prophets or traditional healers. However, I had never done so before and was uncomfortable with the idea, so I just kept praying for him. I shared his problem with one of the nurses I used to work with and she referred me to the psychiatric unit but Gamuchirayi refused to go, saying the place was meant for people with mental illness and he did not qualify. We were then referred to a private hospital, but we couldn't afford it. We watched our son drinking increasing amounts, not knowing what to do.

His first hospital admission was in 2009 after a violent outbreak. His father called the police and with their help we managed to get him admitted at the psychiatric unit. He stayed there for almost a month but when he was discharged he continued drinking and did not go for his scheduled review. He also stopped taking his medication.

..And then he got married

When he was about 32 years old, some relatives advised us that maybe if he married, he would change. I asked his maternal uncles to find him a wife in the rural areas. They found a woman eight years younger than him. He seemed to like her, and they dated for a few months before she agreed to marry him. We paid the bridal price and had a traditional wedding ceremony. He

stayed here with his wife. However, nothing changed. He continued to drink. Sometimes his wife followed him, begging him to come home, but he would beat her.

When his wife gave birth, we thought he would change. When my daughter-in-law delivered her son, we sent her back to her parents, as per our culture. She returned when our grandson was six weeks old. Nothing changed, except that Gamuchirayi would not go out to drink, but instead would drink at home. They started to have marital problems. He accused his wife of having extra-marital affairs. We asked relatives to provide marital counselling, but it did not help. He started beating his wife each time she received a call, suspecting it was from a boyfriend. Eventually she left. Their son is now two years old and stays with his mother but visits us sometimes.

After his wife left, I talked to the priest at our church about Gamuchirayi's problem. He suggested a change of environment to separate my son from his friends and offered him a job as housekeeper at church, promising to monitor him. The priest tried to train him to control his drinking by only drinking on weekends, but he would sneak from the premises to go and buy alcohol. Eventually, the priest told me that he was becoming aggressive and could not stay there anymore. He came home, and the situation worsened. Now we just watch him, not knowing what else to do.

I am constantly checking up on my son. I do not want him to be around bad company, so I try to keep him occupied. My wish is for him to have a better life, just like his siblings. I worry about what will happen to him if I should die before him. His siblings are tired of trying to help and seeing no results. My greatest wish is for him to be financially independent and have a supporting wife. We have encouraged him to look for friends who lead more meaningful lives.

I run a chicken project which I asked Gamuchirayi to help me with. Initially, he did his job faithfully, but soon he started taking shortcuts and becoming impatient for money. Now I run the project on my own again.

I am capable of making decisions

My parents try to control me and treat me like a child. My family only see my faults. They don't notice how hard I'm trying to reduce my alcohol intake. It hurts me. I can't just stop drinking overnight but I am trying to reduce both the quantity and frequency of my drinking. I have asked my mother for money to start an income-generating project, but she thinks I'll just buy alcohol. I am motivated to recover, I have a son to take care of. I get frustrated because they do not listen to me. They won't give me a chance to prove that I've changed.

I started drinking in lower six due to peer pressure. Most of my school friends were drinking and I felt left out. On some weekends we would go out to the club and drink. I started drinking more and more until I could no longer stop.

I appreciate what my family, especially my mother, is doing to help me. The idea of finding me a wife was not the best. I didn't know much about her when we got married. Afterwards, I started seeing her weaknesses. She was consulting prophets behind my back. Sometimes I would see bottles of *muteuro* hidden in our house. We are Catholics and do not believe in consulting prophets. Sometimes when she got angry, she would not wash my clothes or cook for me.

When she came back here after giving birth, I discovered that she was communicating with her old boyfriend. I confronted her about text messages I had seen, but she denied it, asking for proof. Eventually, she admitted that she had been communicating with her old boyfriend because

she was unhappy with our marriage and how I treated her. She finally left at the beginning of this year. I last communicated with her about three months ago to find out how our son is doing.

I think my mother also needs counselling. She enjoys working all day and expects me to do the same, but we are different. When I finish my duties, she will always look for something else to keep me busy. I feel as if I am a slave when I am at home because my mother will not allow me to rest.

I love my mother but sometimes she says hurtful things. She has told me that she wished I was dead. She constantly phones me to ask about my whereabouts as though I'm a child. Sometimes I feel as though she doesn't want me here anymore and I end up drinking more.

I want to start my own chicken project to become financially independent and start looking after myself and my son. I also wish to complete the course in cell phone repairs and electronics that I started some years ago.

When I was admitted to hospital, I was told that the medication I was taking was to calm me and reduce withdrawal symptoms. I did not go for the doctor's review because when I finished the initial dose, I was no longer showing any psychotic symptoms and didn't think it was necessary to go back to see the psychiatrist. I am not prepared to continue taking medication for the rest of my life. I know I made many mistakes and my family has been very supportive. I know they are getting frustrated because all their efforts to try and help me stop using substances have not yielded any results. I promise to change. I am trying very hard to quit smoking and taking alcohol, but it's not easy. I have only managed to reduce the quantities I take per day. I want to ask my family not to give up on me. Just give me more time and I will change.

Hazviperi' s story: There is no light at the end of the tunnel

He had a promising future

I stay here with my two youngest children and my husband. I have seven children: three girls and four boys. The five older ones all work in South Africa. Hazviperi is the sixth child. He quit school when he was in form 4 and since then he has been at home.

Hazviperi started smoking cigarettes in high school. We were not aware of it. When he started refusing to go to school during the third term of form three we thought he had been bewitched. He used to be one of the brightest students at his school and his teachers, who were also unaware of his smoking, pleaded with him to go back to school, but he refused. We consulted a faith healer who advised us to move him to a different school. We transferred him from the local college to a rural high school close to my brother`s place. The first time he wrote his ordinary level examinations he failed. We sent him back to school to try again, but he quit and returned home.

Hazviperi would leave the house without informing us where he was going. When asked about his whereabouts, he would become violent and disrespectful. When he was twenty-one years old, we noticed that he was eating abnormally large portions of *sadza*. On some days he would talk to people that only he could see. We did not suspect that any of this could be due to substance abuse. We consulted a faith healer again, but his behaviour only got worse. Once, he cut his own cheeks and was bleeding. I think these were the beginning signs of mental illness, but we didn't realise. Instead, when I accompanied him to the clinic for treatment, I lied that he had fallen.

He is not making enough effort to recover

After this incident he started coming home very drunk and smoking cannabis openly. Whenever we confronted him, he would become aggressive. We decided to seek medical help. However, at the hospital he was just given a sedative injection and sent back the next morning. He continued with his aggressive behaviour until a neighbour advised us to report him to the police. They helped us to get him admitted at the psychiatric unit.

Hazviperi is still receiving treatment as an outpatient but has not been taking his medication. I have to check that he takes his pills, otherwise he throws it away. I monitor everything he does, even checking his eyes to see if he has smoked. Whenever he is given money, all he thinks of is buying cannabis. I keep monitoring him to prevent him from relapsing, but he still leaves the house without informing us. He still seeks the company of his old friends who smoke and drink alcohol. I have asked my neighbours to keep an eye on him too. He complains that I don't give him any space. I keep encouraging him and we engage him in our prayers at home, even though he does not pray. When at church, he sings, prays, and even plays the instruments.

Recently, I was away for a week. I couldn't take Hazviperi along because he was due for a doctor's review. When I returned, I noticed he had been smoking cannabis and found a pack in his room. I wanted to report him to the police so that the dealers could also be arrested, but I realised the police are also corrupt and wouldn't deal with the issue effectively. We have seen police officers arresting cannabis sellers, only to smoke with them later.

What else can we do?

I am hurt. Hazviperi has become a burden and have decided to look for an institution where he can work under strict supervision until he is sober. I tell him to stop associating with bad friends, but he doesn't listen. I have lost hope. If only we could find him something to do during the day,

but as long he has nothing to do he will occupy himself with smoking. He is not improving. He needs to become independent. I realise that he is spoiled, because when we visit others he is well-behaved, but when we are on our own he is arrogant and aggressive.

We have financial constraints that make it difficult for us to send him for vocational skills training. His father, now retired, is diabetic and we are struggling to buy his medication every month. I am self-employed as a tailor, but I developed arthritis, so I can't work like I used to. He can't go to South Africa to work there if he cannot take his medication. His father is refusing to buy any more medication for him because if he does not take it, it is a waste of money. I have sacrificed my own blood pressure medication so that we can buy his and his father's medication, but now I am the one left with the burden.

He should go somewhere where he can't associate with people who smoke. The medication will not be effective while he is abusing substances. He should be sent to Chikurubi Maximum Prison. He needs to be disciplined, even by means of beating. I agreed that we would send him to get a driving licence, but he is not showing any initiative. I got him the book to prepare for the written tests but haven't seen him reading it. I want him to tell me when he is ready to take the test.

I just needed to relieve stress

I started smoking *mbanje* at the age of 16, in form three, due to peer pressure. My friend introduced me to cannabis and alcohol and before I knew it I found myself wanting more and more, and I also had more friends who were abusing drugs. I was stressed about school work. I was worried about what would happen if I failed. I used to get good grades but had developed a bad attitude towards school. I don't think the teachers suspected that I was using drugs, they

were concerned that I might be having problems at home. I decided to quit school. When I was transferred to the rural areas I made friends with some boys at my new school who smoked and drank, so I continued with my habit. My uncle was unaware of it.

After quitting school a second time, I came home. I started smoking more *mbanje*. Whenever I looked in the mirror, I saw a stranger. I had lot of black marks from pimples I had during puberty. I thought if I removed these marks I would look better. I wanted my face to be flawless. I decided to remove the marks with a broken bottle, that's how I cut myself. I think the substance abuse was starting to affect me mentally.

Change is not easy

I want to take my medication, but it is difficult. It makes me feel dizzy. I prefer a method of intervention that does not involve pills. I am trying to reduce my *mbanje* and alcohol intake. I still get cravings, but I have managed to reduce my smoking to 3 days a week. I have a passion for garment making. There is a college not very far from here that offers this course. The only problem is that my parents cannot afford the fees at the moment.

Tapera`s story: Lost opportunities

Bad beginnings

I`m a widow with five children. Tapera is the lastborn and my only son. He is 21years old. We have lived in this neighbourhood since 2005. My son started using drugs in 2013, in form one. While at school he would go out with his friends to look for cannabis and they would smoke. He was once summoned to the school`s disciplinary committee and the headmaster told us that many students were smoking cannabis. He was eventually expelled from school together with his friends, because they would not stop using drugs. The school authorities were worried that they were influencing other children. Tapera was in form three when they were expelled. He refused to go to another school. I advised him to enrol for vocational training, but he keeps procrastinating.

When he started smoking cannabis, his behaviour changed. He became very stubborn and aggressive, especially towards his elder sister. We would report him to the police if he was getting too violent. After several reports, one of the police officers decided to search his room. He found some tablets (Haloperidol), popularly known as *Maragada* and the police officer explained to me that they are prescribed to mentally ill patients. I asked Tapera why he was taking them, and his response was that they made him drunk. Those pills are cheap and readily available. The police officer suggested that we take him to the psychiatric unit. That`s when he was admitted for the first time. He has been admitted six times now for the same problem.

After each admission his behaviour improves, but a few days later he will start smoking again. He now goes to a house in the neighbourhood, known as the “pink house”, to buy and smoke the cannabis. He leaves the house without informing anyone and comes back later very drunk.

His friends are the source of all the problems

I have not met any of his friend`s parents but some of his friends visit him in hospital whenever he is admitted. On his last admission, two of his friends were also admitted.

I had to stop his friends from visiting him at home because they were becoming a problem. Sometimes they would ask for money, claiming Tapera had borrowed it from them. Tapera had sold most of his clothes to buy drugs. He would also steal property from the house. Whenever we leave the house, I ask him to leave too so that we can lock it.

Stealing has become the norm

He has also stolen clothes from the neighbours' washing line. Once, he came home around 04:00 a.m. with a bruised and swollen face. I strongly suspect he was caught trying to steal from someone.

On another occasion, the police called and told me Tapera had been found with a blanket and a DSTV decoder that had been reported stolen by someone from the neighbourhood. The case was taken to court and I had to testify that he was mentally ill and had defaulted treatment. I had to show the police medical records from the psychiatrist. That is what saved him from being convicted.

In 2009, I told his paternal aunt about the problem. I was hoping she would take him for a while and the change of environment and presence of a male figure would help. She tried counselling him, but was not willing to take him in. The police know who are selling drugs, but they are not arrested. The dealers bribe the police officers. Sometimes they arrest them when they are reported, but then they release them immediately.

I always encourage Tapera to go to church with us, but he refuses. He does nothing to help around the house, not even watering the garden. I force him to clean his room, threatening not to feed him until it's done. He just eats at home, spending the rest of his time with friends. I have suggested starting a business, but he was not interested because he would not make any significant profit. He sometimes gets part-time painting and building jobs and you can tell he has been paid, because he will come home late and very drunk. He does not seem to have any future plans. He did not complete high school and doesn't have any formal training. I am worried that this mental illness may affect him to the extent of not caring about his future. I sell clothes. I have offered to involve him in the business, but he's not interested. We can afford to send him to school if he is interested. If he is serious, I will help him.

When his brother came in the 2015, he suggested that we take him to a long-term care institution such as Ngomahuru. Maybe then he will learn to take life seriously. Sometimes people say he is spoilt, but I can't chase him away from home or stop giving him food.

I am failing to quit

In high school I was introduced to cannabis by some friends. We would use lesson time to go and buy and smoke cannabis. When it was time to go home, we'd pretend we were coming from school. My mother didn't suspect anything until I was called for a disciplinary hearing. My school grades were poor, my attendance was erratic, and I was not submitting any homework. I was eventually expelled. I knew I had to stop, but I was already addicted.

I am failing to quit. I have tried staying at home, but I crave the drugs. It is like an evil spirit taking hold of me and telling me to keep on using. I just don't know how to resist it. When I am broke, my friends will give me drugs. I don't spend the whole day doing nothing. I spend the

greater part of my day at the bus stop, helping passengers who need assistance carrying their luggage. I get about \$3 or \$4 per day. Sometimes I get part-time painting or building jobs at \$5 or \$6 a day. This is the money I use to buy *mbanje* and *zed*. I want to do a course in mechanics, but I don't know where to go.

Nhamo's story: I need a fresh start

It all started when his mother passed away

I stay with Nhamo, his grandfather and his younger sister. Nhamo's mother passed away and his dad is a teacher. He (Nhamo's dad) rents a house close to his workplace, only coming here to visit. Initially when Nhamo's mother passed away, he stayed with his maternal aunt. At the time he was preparing to write his ordinary level examinations. When he failed the first time, his grandfather and I decided it was better for him to stay with us. His grandfather was a teacher and could monitor his studies. We suspect Nhamo was introduced to drugs by his maternal cousin. His aunt has told us that her son was also using drugs. Nhamo used to be a bright student and we all thought he was affected by his mother's death.

Nhamo became a tout after writing his Ordinary level examinations for the second time. When we realised that we had destroyed our grandson's life by letting him become a tout, it was too late. It is common knowledge that these touts use drugs, they take *mbanje* at the ranks and they don't even hide it. He was 18 years old then; now he is 26 years old. He would come home late at night, always drunk. He would act as if seeing things that nobody else saw, trying to chase these things away. Even during sleep, he would shout out, unaware of what he was doing. At times he became so violent that could not restrain him. We would call the police to help. When he went to the hospital, they only gave us pills to stabilize him.

He would steal people's cars. He can drive well, but whenever he "saw the unseen", he would have an accident. Once, the police managed to catch him and he was arrested. When the case was taken to court, the judges recommended a psychiatric evaluation. He stayed at the prison hospital for 9 months. The psychiatrist at the prison hospital diagnosed him with a seizure disorder.

After he was released from prison, he went to stay with his maternal grandmother for a while. We sometimes think that there are evil spirits from his mother's family. We had agreed to let him go and stay with his maternal grandmother with the hope that they would conduct the cleansing ritual, but he came back in a worse state.

Currently, Nhamo is not working. We want him to first learn to do house chores. He needs to be disciplined before he can get formal work. He sleeps a lot, we suspect it's an effect of the medication he was given at the hospital. When he wakes up in the late afternoon, he leaves the house without saying where he is going. He spends the whole day just roaming around. We cannot send him anywhere. He needs to change first. He needs to be closely monitored to see if he is not abusing drugs. He needs to become independent. We are providing all his food and at the end of the month his grandfather gives him money to buy clothes. He has to decide to stop using drugs. His grandfather and I are old and might die anytime and he will be left alone. He has no future plans.

When Nhamo is sober he is cheerful, and we enjoy spending time with him, but as soon as he gets drunk his behaviour completely changes. After he was discharged from the prison hospital, we started a business for him. He was selling airtime and we gave him \$50 as starting capital. He ran a loss and spent the starting capital as well. We are thinking of other viable income-generating projects. We can't keep chickens or rabbits because they might attract thieves to the house. He is interested in motor mechanics, but we can't afford something too costly. Nhamo's grandfather and I are retired. Our neighbour repairs cars at his house. He can work under his supervision for a while, learning in the process.

I need a fresh start

What my grandmother said is all true. I started using drugs while repeating my ordinary levels. I would buy drugs outside the school gate. Some fellow students connected me with the sellers. I enjoyed smoking, but I did not have any money, so I would steal money from the house. When I started working as a tout, I would buy *mbanje* every day because I would get paid for my services as a tout every day. Each time I smoked *mbanje* I felt more confident. I needed this confidence so that I could compete against other touts, it was a tough job.

Since I stopped working as a tout, I have been spending most of my time here at home sleeping. There is not much to do here at home. I usually help with cleaning the yard and mowing the lawn, but we do not do this every day. I have not decided what I want to do, but I am interested in motor mechanics or running a tuckshop business. I am not sure if my grandparents can afford to give me the starting capital. Currently I am always drowsy due to taking Carbamazepine. If I was not feeling so weak, I would help around the house more.

4.2 Conclusion

The narratives highlighted the diversity in the experiences of families who were staying with an individual recovering from a substance use disorder. The narratives presented in this chapter shed light on the onset of the substance use disorders, the strategies that affected family members tried in an effort to assist the index participants and the current situation that the families were now facing as result of the impact of substance abuse. All the index participants were at different stages in their recovery journeys from substance use disorders, with some progressing more than others.

Chapter 5: Second level of analysis

5.1 Introduction

The second level of analysis of the findings is presented in this chapter. The narratives presented in the previous chapter were analysed for the fundamental constructs that contributed to an understanding of how involvement of the family culminated into altered occupational trajectories for the adults with substance use disorders. Reference is made to the original narratives presented in Chapter 4 to support the interpretations of findings.

One overarching theme “Reconstructing occupational participation through transactions enacted within the family context” emerged from the second level of analysis. This overarching theme was informed by two subthemes. The two subthemes are i) Occupational disruption from an intrapersonal and interpersonal perspective and ii) The centrality of the family in creating opportunities for participating in occupations. The culmination of these subthemes into the overarching theme will be presented in the subsequent sections of this chapter.

5.2 Overarching theme: Reconstructing occupational participation through transactions enacted within the family context

Dickie et al. (100) proposed a transactional perspective as a holistic alternative theoretical framework for viewing occupations. A transactional perspective to occupation proposes the centrality of human relations and the context in occupational participation. The narratives generated in this study provide evidence of how the index participants interacted with the affected family members within the family context to reconstruct occupational participation which had been disrupted by substance abuse. Other factors within the environment influenced this interaction and these factors became facilitators or barriers to resuming participation in

meaningful occupations following a substance use disorder. This evidence supports the view that is being put forward in this thesis that reconstructing occupational participation during recovery from a substance use disorders is a complex process that may be successfully facilitated through interactions within the family context with appropriate support systems to address the unique family situations. Table 4 provides a representation of this process in the form of an overarching theme and subthemes.

Table 4: Representation of the overarching theme and subthemes

Theme: Reconstructing occupational participation through transactions enacted within the family context		
Subthemes	Categories	
Occupational disruption from an intrapersonal and interpersonal perspective	Changes in occupational participation patterns	Uncertainty over future occupational participation
The centrality of the family in creating opportunities for participating in occupations	Identifying new opportunities for participating in occupations	Availing of occupational resources to facilitate resumption of participation in meaningful occupations

5.3 Occupational disruption from an intrapersonal and interpersonal perspective

This subtheme highlights the intrapersonal and interpersonal effects of substance abuse on the occupational participation patterns of the family units. Occupational patterns facilitate the participation of humans in social life. (196) (197) Findings from this study revealed the effect that substance use by one individual in the family had on the intrapersonal and interpersonal occupational patterns of the entire family. The escalation of the problem of substance use thus resulted in changes in occupational participation patterns for the entire family. Most of the affected family members described how their own occupational patterns had been affected by the substance abuse of the index participants. Two categories contributed to the understanding of how the use of substances resulted in the disruption of occupations for the family units in this study. The process that resulted in the disruption of occupations is summarised in Figure 3.

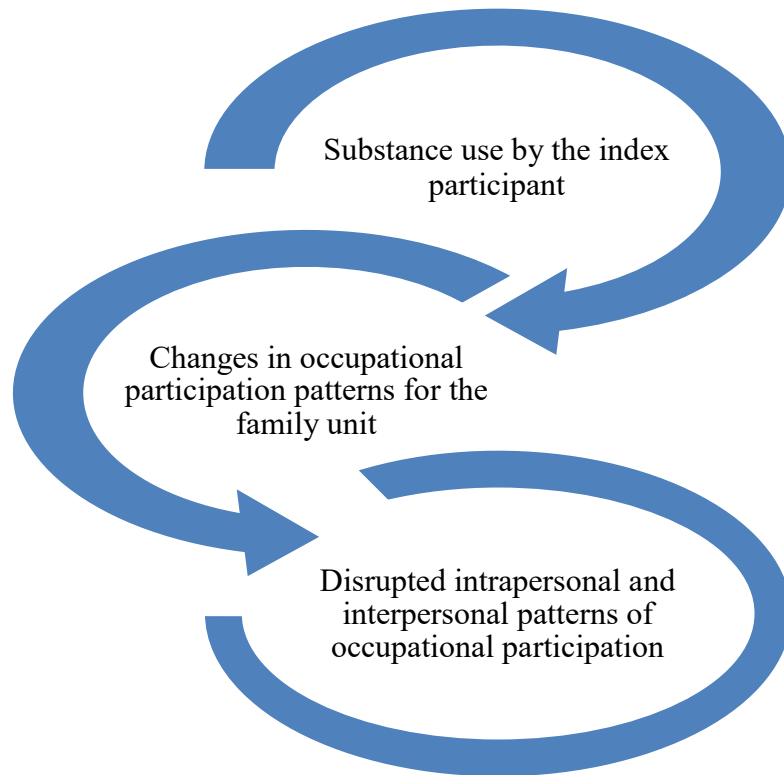


Figure 3 : Representation of the process that resulted in the disruption of intrapersonal and interpersonal occupational participation patterns

5.3.1 Changes in occupational participation patterns

The majority of the index participants were first initiated into substance abuse in the early teenage years. This was the time they were in school. Their occupational participation patterns during this stage were mainly characterised by activities related to the school occupation. In order to illustrate how occupational participation patterns were linked to the dominant occupation of schooling, I will use Ndakaziva's narrative as a case in point. Whilst Ndakaziva was attending school, she participated in another occupation which was football. This occupation of football was somewhat related to the dominant occupation of schooling as her continued participation in football was dependent on her remaining in school. Her occupational

participation patterns during this time were therefore focused on attaining good grades in school. By getting good grades in school, Ndakaziva maintained her participation in football. However as substance use became the dominant occupation, Ndakaziva's activities and occupations were now mostly related to obtaining more substances as exemplified by her attending drug parties or looking for money to buy drugs as illustrated by her involvement in fraudulent activities.

The narratives of the index participants who were initiated into substance abuse during the time they were in school reveal that the onset of substance abuse resulted in an inability to maintain a balance in school related occupations. This was evident in the narratives by Shumba, Nzou, Gamuchirayi, Ndakaziva, Tatenda, Danai, Tapera, Gandiwa, Hazviperi and Nhamo. Tatenda narrated incidences when he failed to concentrate on his homework because of the effects of abusing substances. Similar experiences were evident in all of the narratives of index participants who started abusing substances during the time they were in school. The effects of spending more time on abusing drugs and less time on schoolwork was evident in the poor school grades for most of the index participants who were reported to have been bright students. Shumba and Themba were exceptions as they managed to get good grades in school despite the negative impact of substance abuse on their performance in schoolwork. Even though they both did not perform to the best of their parents' expectations, they managed to proceed to university and Themba went on to attain a masters' degree as well.

On the other hand, Zuva, Chipo and Dadirayi who had started drinking in their adulthood appeared to have been able to maintain a balance between their dominant occupations and other occupations initially as they were able to balance their work and social obligations. They all mentioned that they were social drinkers who drank alcohol during their leisure time as they socialised with their friends and family. However their drinking eventually became uncontrolled

until they could no longer maintain a balance in occupations. Zuva described how going to work had made him drink responsibly. He reflected on how his work obligations acted as a deterrent from severe drinking. He drank responsibly to avoid the consequences of not reporting for work or reporting to work drunk. Zuva's case was an exception as other index participants who were once formally employed did not share the same view.

Regardless of when the substance use was initiated, there was progression from use or experimentation to misuse and finally to abuse or dependency. It was at this juncture that the substance abuse started impacting negatively on the occupations of the affected family members. The affected family members had to take on a new role of caring for the index participants. The caring role included taking care of the basic needs of the index participants, ensuring adherence to the prescribed medication, accompanying them to the mental health unit for any scheduled reviews and keeping an eye on them to ensure that they were not taking substances again. The negative effects were experienced differently by affected family members who were parents, spouses or extended family members to the index participants.

The affected family members who were spouses to the index participants narrated how they experienced significant changes in their occupational participation patterns. To demonstrate the impact of substance abuse on a spouse, I will use Dadirayi's narrative as an example. When Dadirayi's substance use escalated, she stopped participating in her leisure occupation as a part time caterer. She also neglected her culturally ascribed occupations associated with her role as a wife such as cooking and doing laundry for her husband as well as maintaining the home. Dadirayi was also absent from work on many occasions. Her occupational participation patterns were readjusted to meet the demands of substance abuse as the dominant occupation. Continued abuse of substances eventually resulted in occupational dysfunction mostly in the area of work

and social participation. Her husband took over the occupations that were ascribed to Dadirayi's role as a wife. He also had to spend more time at home monitoring Dadirayi's substance use. This resulted in him failing to run his part time car sale business as he had done before Dadirayi experienced a substance use disorder.

Zuva's wife though she was also a spouse to the index participant narrated a different experience. When Zuva's substance abuse escalated, Zuva neglected his roles of providing for the family and he started using resources that were meant for the upkeep of the family to finance his substance abuse habit. Zuva's wife had to take over the role of providing for the family. She became fully responsible for running the tuckshop business. She had to go to the wholesalers to buy stock for the tuckshop as well as spending the day in the tuckshop attending to customers. She also had to perform her usual roles as wife and mother to four children. She reported incidences where she tried to force feed her husband and take care of his other basic self-care occupations.

The experiences of parents of the index participants were different from those described above. What was common across most of the narratives was that mothers took the leading role in caring for their children with substance use disorders. This was regardless of whether these mothers were from a single parent family unit or from a family unit in which both parents were staying together. Most mothers reported how they had to adjust their occupational participation patterns so that they could take on the new occupation of caring for their relatives. This can be illustrated using Tatenda's narrative. Tatenda stayed in the urban areas with his siblings whilst his parents stayed at the family farm where they were involved in commercial farming to sustain the family. When Tatenda experienced a substance use disorder, his mother abandoned her farming occupations so that she could move to their urban house where Tatenda was staying with his

other siblings. Tatenda`s mother cited one incident in which she spent the whole day at an illegal mine field where her son had been located after he been missing for several months. Tatenda`s mother also narrated how she was faced with the dilemma of finding a place where Tatenda would not be influenced into substance abuse. She could not relocate to the family house in the urban areas where Tatenda was staying because she had to work at the farm.

In some family units the fathers took the leading role in caring for the child with a substance use disorder. This is evident in the narratives by Hazviperi, Ndakaziva and Nzou. These fathers explained how they had to sometimes follow their children each time they went out. What was common across these three narratives was that the fathers were more involved in ensuring that their children were not abusing substances again. This complemented the efforts by the mothers` in these family units who were more involved with the other caring roles. In such family units both parents experienced a disruption in their occupational participating patterns. The grand parents who participated in this study played similar roles to those of biological parents. They therefore experienced disruption in occupational participation patterns similar to those shared by most parents.

One family unit in which the index participant was an extended family member narrated a different experience from all the other family units. Chipo`s narrative will be used to illustrate this difference. Initially Chipo stayed with her older maternal aunt, however when she could no longer cope with the caring role she asked Chipo`s uncle to take care of her. Chipo`s uncle then asked another maternal aunt to take care of Chipo. At some point Chipo also stayed with her friend`s family. Chipo`s maternal relatives were now considering sending her to her paternal relatives. One can assume that the extended family members avoided the occupational disruption

that resulted from Chipo`s substance abuse hence they kept moving her from one relative to the other so they could maintain their usual patterns of occupational participation.

The experiences described in this section shed light on how the onset of substance use disorders resulted in changes in occupational participation patterns of the entire family unit. What was common across majority of the narratives is that the index participants prioritised substance abuse and neglected all their other occupations. This resulted in the affected family members sacrificing participation in occupations that were meaningful to them in order to be able to support their relatives who were recovering from substance use disorders.

5.3.2. Uncertainty over future occupational participation

The interruption of previously established occupations before the onset of a substance use disorder prevented the achievement of life goals. Before the onset of the substance use disorders all the index participants were involved in occupations that had clear pathways of progressing from one stage to the other until the attainment of the main goal. For example there was clear progression from primary school through secondary school up to university. However the onset of substance abuse resulted in uncertainty over future occupational participation. Tapera`s narrative demonstrates this uncertainty in future occupational participation. Tapera had started using substances when he was in form two. He eventually got expelled from school and since his expulsion he has been staying at home. Tapera`s dominant occupation at the time of the interview was not well defined. He sometimes assisted public transport passengers with carrying their luggage from the station to their homes. On other times he got temporary contracts to work as a builder`s assistant. His mother suspected he was also involved in stealing clothes from the neighbourhood. Tapera was not sure about his future plans with regard to occupational participation.

The narratives revealed that when the index participants began their recovery journeys they had nothing “to do”. Most participants described a typical day that was now characterised by mostly rest and leisure occupations and very minimal or no productive occupations. Shumba described how he was spending his day watching the same movies. This was similar to what was described by all the index participants with the exception of Ndakaziva who had successfully managed to return to school and had joined a football club so that she could resume her career as a soccer player.

There was need to have clear set goals that would facilitate participation in meaningful occupations during recovery in order to avoid the negative effects of the occupational deficits that resulted from abstaining from substance abuse. Most of the index participants did not clearly articulate their plans for the future with regard to participation in occupations. For Example Danai considered socialising with his friends who were also taking substances as “doing something,” (an alternative to lack of meaningful occupations). Another example is that of Zuva who had managed to stay sober for almost two months but indicated that he was now getting bored of spending the whole day sleeping. He was not sure of his future occupational participation. These examples illustrate the uncertainty that surrounded the plans for the future occupational participation by most of the index participants who had started their recovery journeys. This demonstrates how lack of goals during recovery predisposed the individuals recovering from substance use to relapsing.

5.4. The centrality of the family in creating opportunities for participating in occupations

This subtheme focuses on how family involvement influenced future participation by index participants in meaningful occupations. Findings from this study suggest the importance of the critical role of the family in creating opportunities for future participation in occupations. The family influenced future participation in occupations in two major ways. Firstly, the affected family members facilitated the identification of new occupational opportunities for the index participants. Secondly they availed the required resources that were needed to enable participation in occupations. This was achieved through a continuous process of negotiation between participants as illustrated in Figure 4 below.

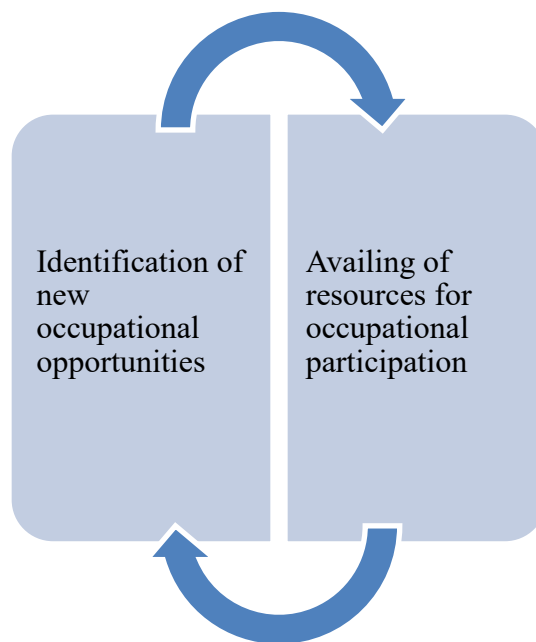


Figure 4: An illustration of the process of facilitating future participation in meaningful occupations

5.4.1 New opportunities for participating in occupations

The index participants had to either identify new occupations or resume the occupations that had been interrupted by the onset of a substance use disorder. As can be seen in Table 5, most of the occupations that the participants identified during recovery were different from the main occupations that they had participated in before the onset of the substance use disorder.

Table 5: Comparison of the dominant occupations before substance use disorder and new occupations identified during recovery

	Dominant occupations before onset of substance use disorder					New occupations identified during recovery			
	Work	School				Work	School	Vocational skills	Income generating projects
		Primary	Ordinary	Advanced	Tertiary				
Shumba		xx	xx	xx	xx				
Nzou		x							x
Zuva	x	xx	xx						x
Ndakaziva		xx	x				x		
Chipo		xx	x				x		
Danai	x	xx	x			x			
Tapera		xx	x			x			
Gandiwa	x	xx	x			x			
Dadirayi	x	xx	xx						x
Tatenda		xx	x			x			
Themba		xx	xx	xx	xx	x			
Hazviperi		xx	x			x		x	
Gamuchirayi		xx	xx	x					x
Nhamo		xx	x					x	

x self-employed x formally employed

x failed to complete level of education xx successfully completed level of education

x identified and currently participating x identified and not currently participating

Only one of the nine participants who were in school when they experienced a substance use disorder wanted to resume this occupation during recovery. The rest of the participants identified new occupations in the area of productivity. Themba, Dadirayi, Danai and Gandiwa were employed formally and wanted to go back to work. However, others like Gamuchirayi had never been formally employed and were considering starting an income generating project as an initial step towards financial independence.

The absence of basic educational qualifications needed for formal employment limited the choices for occupational participation. A comparison of Nzou's and Ndakaziva's narratives illustrates how having no basic education limited the choices for participation in occupations. Nzou dropped out of school before he completed his basic primary school education. Furthermore he had attended school in South Africa where the education system was different from the one in Zimbabwe. He wanted to enrol for vocational skills training but he did not have the prerequisite qualifications for enrolment that is a basic primary education. This limited his choice of alternative occupations. On the other hand when Ndakaziva quit using substances it was easy for her to resume her previously interrupted occupation. She was interested in developing a career in football coaching. The first step was for her to have attained five passes at ordinary level including mathematics. Ndakaziva was able to resume her education so that she could write her mathematics examination as a second attempt and attain the required five ordinary level passes.

In order for the index participants to be able to participate in the new occupations there was need for the families to provide the necessary resources. Most affected families lamented how their previous efforts to provide opportunities to reconstruct occupational participation, mostly

through educational and vocational skills training opportunities had not yielded positive results. Many parents explained that they were now hesitant and uncertain about the outcomes of trying to provide similar opportunities again. The way in which resources were availed is described in the following section.

5.4.2 Availing resources to facilitate resumption of participation in meaningful occupations

When viewing all the research stories it becomes apparent that even though the families were affected negatively by the problem of substance use they had to find solutions to facilitate participation in meaningful occupations. All the family units perceived that participating in new occupations that were not detrimental to health would facilitate the recovery process. Families showed their commitment to availing resources to enable occupational participation. For example Shumba's mother was willing to avail financial resources to allow him to advance his education or to start providing resources for him to start offering private tutorials to high school students who were preparing to write their ordinary level examinations. Most families showed similar commitments to facilitate the resumption of participation in meaningful occupations.

The families availed resources that were needed to facilitate participation in various ways. Most families provided financial resources. Others were willing to teach skills that were required for one to be able to resume participation. For example Nzou's father took him to assist whenever he got building contracts. He was preparing Nzou for his new occupation as a brick moulder. Similarly Gamuchirayi's mother invited him to work on her poultry project. This was done to prepare him to start his own project.

Most affected family members had different circumstances that limited the resources they could avail for the index participants to participate in alternative occupations. In the case of Zuva who

was the head of the family unit, it was difficult for him to get money to restart his tuckshop business. This is because Zuva had spent all the profits from his tuckshop business on alcohol and other illicit substances. His four children who were all still in school needed tuition fees. He also needed to provide food and clothing for the family. His wife was not formally employed and his mother depended on him financially for her general upkeep.

In instances where the parents had to provide the financial resources, the parents had been retrenched from their jobs as was evident in the narratives by Danai and Ndakaziva. Other parents were retired for example Hazviperi, Tapera and Gamuchirayi parents and Nhamo's grandparents. This meant their main source of income was their monthly pension fund. This monthly pension was however not enough to cover their living expenses. Those parents who were self-employed for example Gandiwa's mother and Nzou's father were finding it difficult to provide financial resources for the whole family. These differences in family circumstances provide evidence of how each family had its unique financial struggles that affected the resources available for the index participants to resume participation in occupations.

5.5 Conclusion

The issues discussed above contributed to the understanding of the role that was played by the family during recovery. The participants' narratives illustrated a complex journey from disrupted occupations and occupational imbalance to the creation of new opportunities to participate in meaningful occupations. The themes presented above speak to the way in which the index participants and the affected family members co-constituted one another in the recovery journey. They shed light on how the transactions within the family affected the role of the family in promoting participation in meaningful occupations by the index participants following a substance use disorder.

Chapter 6: Discussion

6.1 Introduction

In this chapter I present a discussion of the findings presented in Chapters 4 and 5. I provide an interpretation of the key factors that shaped the involvement of the family in recovery oriented occupations. I also offer an explanation of how these factors contributed to an understanding of the role played by Zimbabwean families in promoting participation in meaningful occupations by their relatives who were on a recovery journey from a substance use disorder. These explanations are supported by relevant literature from occupational therapy, occupational science, psychology and sociology.

6.2 Factors shaping family involvement in promoting the participation of adults with substance use disorders in meaningful occupation

In discussing the findings, I seek to answer the question “What are the factors shaping family involvement in promoting the participation of adults with substance use disorders in meaningful occupations?” In answering this question, I contend that family involvement in promoting participation of adults recovering from substance use disorders in meaningful occupations was shaped by the family context and opportunities for occupational participation created within the family unit. The interaction of these factors will be presented in the subsequent sections.

6.2.1 The family context and its influence on the family's involvement in promoting the participation of adults with substance use disorders in meaningful occupations

The findings in this study revealed that families who participated in the study provided an essential support system for the individual with a substance use disorder, more-so in an environment where rehabilitation services and post discharge care services are non-existent. While the family offered the much needed psychosocial support, contextual factors within the family unit affected the role played by the families in promoting the participation of adult family members recovering from substance use disorders in meaningful occupations.

In this study, family members who were affected by the substance abuse of an adult relative included spouses, parents, siblings, uncles, aunts and grandparents. Female family members generally took the leading role in caring for family members who were recovering from substance use disorders. This is a common occurrence in most patriarchal societies. (52) However contrary to expectations in a patriarchal society, there were some exceptional cases in which the caring role was assumed by male family members.

The findings revealed that some family members had a negative attitude about the individual with a substance use disorder. This was evident in cases where the index participants were beaten by affected family members and also when some of the affected family members withdrew their support for the index participants. Such a reaction to the family member with a substance use disorder could have been in part due to lack of skills required to support a family member with a substance use disorder. Velleman et al. (105) and Akram et al. (145) proposed that families of individuals with substance use disorders needed to be equipped with parenting skills, substance use related skills and communication skills in order to effectively facilitate recovery of the affected family member. The findings in this study seemed to be consistent with the proposition

by Velleman et al (105) and Akram et al (145) and suggested that equipping Zimbabwean families with parenting and communication skills and educating them about substance abuse could empower them to promote participation in meaningful occupations during recovery.

Lack of family awareness of the extent of substance use by a relative has been reported in literature (198) to contribute to delays in seeking professional help for substance use. The above assertion was found to be true for the family units in this study. In addition, the family units in this study were also not aware of medical services that were available for management of substance use disorders and the possible outcomes of treatment. Therefore there was a gap in service delivery with regards to comprehensive management of substance use disorders as there were no preventative strategies that included family and community education. This gap might be addressed by providing comprehensive occupational therapy services which include family and community substance use disorder awareness programs.

In this study the relationships among family members influenced the way in which affected family members contributed to the recovery process of the individual with a substance use disorder. There was a notable difference between the level of support that was offered by spouses, single parent family units, family units with both parents and extended family units. Extended family members seemed not to assume full responsibility for the caring role as there was a general expectation that other family members would provide that support. Furthermore, in some families there were conflicts between affected family members and index participants. For example Gamuchirayi and his mother had conflicts over how the household chores were to be done and management of the poultry project. These findings were consistent with those by Gilbert et al., (53) Barrett and Turner (115) and Barfield (116) who reported that spouses and families in which both parents were involved in caring for the index participants provided a more

supportive environment compared to single parent families or families in which the caring role was assumed by extended family members. The weakening of the family structure and conflictual family relationships have been reported to result in unsupportive family environment for the recovery process. (199) Gagne and White (112) argued that unsupportive family environments will eventually lead to relapse as individuals recovering from substance use disorders fail to capitalise on the emotional and material resources provided by the family in order to enhance their recovery.

The current findings also revealed that the presence of other support systems such as extended family members, pastors and neighbours provided the affected families with a platform to discuss the challenges that they were facing as a result of substance abuse by a family member. This was the case for example with Danai who once stayed with his pastor and his mother also sought help from his paternal relatives. Most affected family members utilised these support systems when they could no longer cope with staying with a family member with a substance use disorder. This support was in the form of “counselling”. Gupta et al. (73) suggested that family members who receive support in the form of counselling are able to cope with the stress that is associated with living with a family member with a substance use disorder. Even though the indigenous form of counselling that was utilised by family units in this study was different from formal counselling provided by professionally trained counsellors, it provided culturally sensitive approaches to dealing with substance use disorders. Indigenous forms of counselling might therefore be more acceptable to individuals with substance use disorders and their families compared to other forms of counselling.

Cultural beliefs in witchcraft which were found to be prominent among many participants in this study, might contribute to barriers to family involvement in occupational therapy interventions.

This is because definitions of substance use disorders and how they were managed by participants in this study were strongly influenced by these cultural beliefs. This confirms findings from studies that explored the African belief systems and their influence on choice of health care providers. (52)(55) Acknowledging the role of traditional and faith healers in the treatment of individuals with substance use disorders and incorporating them in the interventions might result in adopting a multidisciplinary approach to treatment that is cognisant of the role that is played by traditional and faith healers in the management of substance use disorders in Zimbabwe.

The families who participated in this study demonstrated a lot of resilience in their caring roles. Despite all the negative experiences that came up in their narratives, they were still willing to support their relatives. This was contrary to findings reported by Orford (80) and Orford et al. (133) in which affected family members failed to provide psychosocial support to relatives recovering from substance use disorders due to the stress that was associated with the caring role. It is this resilience which makes the families in Zimbabwe capable of supporting their relatives during the recovery process. Cultural definitions of the role of the family members during illness might have contributed to the family's resilience. In the Zimbabwean culture, families are responsible for caring for their relatives during sickness. This role is usually ascribed to female members of the family and sometimes encompasses the extended family. This cultural imperative is different from that of the Western culture in which adults recovering from substance use disorders rely mostly on community care from professionals. (133) Such positive cultural practises should be integrated in the occupational therapy interventions aimed at promoting participation in meaningful occupations during recovery from substance use disorders.

The majority of the affected family members in this study spent more time ensuring that their relatives were not taking substances to avoid recurrence of substance use disorders. In the absence of rehabilitation facilities dedicated to the management of substance use disorders, the families were now faced with an intricate dilemma of taking care of their relatives regardless of the impact of the relatives' behaviour on the other family members. This supports the notion put forward in literature that families who stay with their relatives with a substance use disorder are compelled to be involved in the recovery process. (198)

Affected family members experienced changes in occupational participation patterns. This corresponds to a large extent to what has been suggested in literature (134) (135) on the effects of caregiving on the occupational participation pattern of the caregiver. In trying to maintain balance in their occupations, the family members had to negotiate their engagement in family occupations, productive occupations, other individual occupations as well as the caring role. The current findings showed that most affected family members prioritised the caring role. The advantage of doing this was that there was constant monitoring of substance use to prevent relapse. However this was likely to impact negatively on the family members' participation in other occupations that had provided structure to their lives. Prioritising the caring occupation over other occupations might not be a sustainable way of supporting individuals recovering from substance use disorders as it affects the balance in the occupations of the family members who take the caring role.

What is evident across all the narratives in this study is that families sought medical treatment to address the pathology that had resulted due to substance use disorder. However the occupational deficits remained and contributed to the limited participation that was experienced by the individuals who were recovering from substance use disorders. Participation in occupations by

individuals recovering from substance use during treatment has been linked to better outcomes and lower relapse rates. (145) The efforts by families to create opportunities for participation are discussed in the next section.

6.2.2 Opportunities for participation in occupations created within the family unit

Although substance abuse has very negative consequences, it can be considered as a primary occupation for individuals with substance use disorders. The findings from this study suggested that substance abuse as a primary occupation for the index participants provided meaning, temporal structure, and opportunities for interaction. This is similar to what was proposed by other scholars. (95)(96) As such its absence had similar consequences as losing primary meaningful and identity engendering occupations. These consequences were experienced as occupational disruption and occupational deficits. In trying to avoid these consequences some index participants went back to abusing substances. The family units had to find ways of addressing these occupational deficits in order to prevent the index participants from relapsing.

Therapeutic approaches to promote health and wellbeing have traditionally been based on the assumption that meaningful occupations contribute to health, wellbeing and quality of life. (60) Accordingly, family units who participated in this study were looking for new occupational opportunities that would replace substance use as an occupation and break the cycle of abuse. These efforts included skills acquisition through vocational skills training and development of income generating projects mostly poultry keeping.

Resuming participation in meaningful occupations after a substance use disorder was a complex process which involved the individual recovering from substance use and the family. The complexity of the process was seen in the way families negotiated before they could agree on a

new occupation. Findings from this study revealed that for most of the family units, the choice of a new occupation was a collective decision made by the family unit. As such, the collaboration between index participants and affected family members was essential in ensuring the successful participation in the new occupation. There was evidence of instances in which there was a mismatch between what the families could afford and what the index participants wanted. This mismatch could act as a barrier to future participation by index participants. This is because meaningfulness is a subjective experience, (39) therefore what is meaningful to the affected family members might not be meaningful to index participants.

Limited participation in meaningful occupations has been reported to result in reduced self-efficacy and mastery. (200) In this current study, the impact of reduced self-efficacy and mastery was noted when individuals who were recovering from substance use disorders were presented with opportunities to identify new occupations by their families. Those who had either quit school or obtained poor results had limited opportunities to resume participation during recovery. They lacked the basic competencies that were required for them to be able to participate in these new occupations. Encouraging participation in family occupations might be the starting point in acquiring competencies for future participation.

Literature suggests that occupational choice is governed by opportunities, personal and social circumstances as well as resources. (201)(202) In this study, limited financial resources deprived some of the index participants from experiencing the benefits of occupational participation. Others however dropped out of occupations that had been provided for them by their families and were now finding it difficult to resume participation in these occupations.

The absence of resources to facilitate participation in meaningful occupations was a common dilemma in many of the family units. As mentioned earlier, this study was conducted against a backdrop of economic challenges which were happening at a national level. These macro-economic challenges contributed to the limited opportunities for participation. The families had many ideas of occupations that could provide opportunities for meaningful participation. However their choices were restricted by the financial resources available to the families.

The findings from this study revealed that all the family units were now considering opportunities for occupational participation that would translate into productive work and allow for financial independence. It is important to note that all the index participants in this study wanted occupational opportunities that would provide structure to their patterns of participation as well having the potential to result in financial independence. Most affected family members expressed their dilemma surrounding the financial independence of the index participants. They were concerned about how having access to money would facilitate access to more drugs. The families had already devised strategies to limit access to financial resources which had not worked. This had implications on how the families were going to support their relatives in order to facilitate participation in meaningful occupations.

Furthermore, the opportunities for occupational participation considered by most of the family units required financial input. Given the financial constraints that most of the families were facing, identifying alternative occupations that were within the family's routines might have been more practical. Ramugondo and Kronenberg (203) highlighted the benefits of utilising the interconnectedness of the individuals and the collective in enhancing participation in occupations. In this regard, utilising family occupations to create opportunities for participation in meaningful occupations might have provided an opportunity for family members to

collectively participate in occupations that were not detrimental to health and wellbeing. These might have been a more sustainable approach to using occupations to facilitate recovery because these everyday occupations would be embedded in the family's routines and therefore would not require additional financial resources. This might also have addressed the feelings of loneliness that were being experienced by the index participants as they started their recovery journeys. Such feelings might have predisposed the index participants to relapse.

6.3 Conclusion

The negative effects of substance use on the affected family members that emerged in this study were consistent with what has been suggested in literature. The difference in this study was that family discourse was dominant, rather than the individual perspective being the focus. The key factors shaping family involvement in promoting participation in meaningful occupations during recovery were highlighted in this discussion. These factors suggested the need to address contextual factors within the family units in order to address the intrapersonal and interpersonal consequences of substance use disorders such as those noted in the current study.

Chapter 7: Conclusion and Recommendations

7.1 Introduction

In this Chapter I present the main conclusion and recommendations of the study in line with the research question and objectives of the study. The critical findings that emerged from the narratives of families living with a family member recovering from substance use disorders and their implications for occupational therapy practice will be highlighted. A proposal for a treatment framework that is contextually relevant to address the factors shaping the family involvement in promoting participation in meaningful occupations during recovery from substance use disorders will be made. This chapter will end by making recommendations to relevant stakeholders. These recommendations are expected to contribute towards the improved management of substance use disorders in Zimbabwe.

7.2 Main findings from the study and their implications for occupational therapy practice

The findings in this study revealed the multifaceted nature of the problem of substance use in Zimbabwe and contribute to the emerging body of knowledge on the critical role that was played by families during the recovery of adults with substance use disorders. Most of the substance use disorders that were observed in adulthood had started as substance misuse in adolescence. However the affected family members were in most cases not aware of the substance abuse until they started seeing signs and symptoms of substance use disorders. Once this occurred the families took their family members to hospital for medical treatment. There were delays in seeking medical intervention because of lack of knowledge of substance use disorders and their management.

The onset of substance use disorders resulted in significant occupational disruption for the individuals who were using substances as well as their families. Most families cared for their family members who had been discharged from hospital without any professional support services. The families demonstrated great resilience and remained supportive despite the negative experiences of living with a family member with a substance use disorder. All the families perceived that participation in meaningful occupations would restructure the occupational participation patterns of their relatives so that they spend less time finding and using substances. In the absence of post discharge support services for the families, most of the families had to look for new occupational opportunities that would promote the participation in meaningful occupations.

Even though the families perceived that participation in meaningful occupation would eventually result in quitting substance use, the majority on these families could only provide limited occupational choices. This was mainly due to financial constraints. However family conflicts and unsupportive socioeconomic and community environments also threatened the sustainability of future participation in meaningful occupations.

In light of these findings, a treatment framework, “the collective occupational reconstruction treatment framework” is recommended. This is a contextually relevant multidisciplinary occupation based framework that would respond to the unique occupational needs of the families in Zimbabwe. Based on the decolonial perspective adopted in this study, I proposed a treatment framework that would be acceptable to the occupational therapists in Zimbabwe ,individuals recovering from substance use disorders and their families as well as acceptable to the policy makers.

7.3 Presentation of the collective occupational reconstruction treatment framework

A multidisciplinary approach to addressing the challenges of substance use in Zimbabwe is essential if families are to successfully promote the participation in meaningful occupations by their relatives recovering from substance use disorders. The gaps in the delivery of services in the management of substance use disorders that were noted in this study provide an opportunity for provision of contextually relevant community occupational therapy services which focus on prevention, early identification and management of substance use disorders. This creates an opportunity for provision of occupational therapy services for substance use disorders from the lowest level of care.

Despite increased calls for a multisector approach to addressing substance use disorders (5), the response in Zimbabwe has remained centred on a medical model of care in which other relevant ministries and government departments, families and communities at large are excluded from the rehabilitation process of individuals with substance use disorders. There is research evidence to support successful treatment outcomes when families were involved in the treatment of family members with substance use disorders. (105)(143)(204)(205) Daley (85) highlighted the importance of a multidisciplinary approach to treatment of substance use disorders and suggested that comprehensive treatment services for substance use disorders should include detoxification, rehabilitation, and counselling, continuing care, substance use monitoring, medication, case management services as well as support groups.

The recommended treatment framework responds to the multifaceted challenges that are faced by families as they play the leading role in providing support to family members recovering from

substance use disorders. Therefore its use will not only facilitate the participation in meaningful occupations by individuals recovering from substance use disorders but will also improve the health and wellbeing of the families affected by substance use disorders. The families who participated in this study played the important role of promoting the establishment of new occupational trajectories for their relatives. In order for these families to successfully promote the participation in meaningful occupations by adult family members, occupational therapists should provide the appropriate support in collaboration with other sectors such as shown in figure 5 below. This is because our findings show that some families had tried to use occupations as a way of making their relatives abstain from the use of substances but this had not yielded results due to complex factors which cannot be addressed by occupational therapy interventions alone. The other sectors involved will therefore assist in the provision of holistic occupational therapy services.

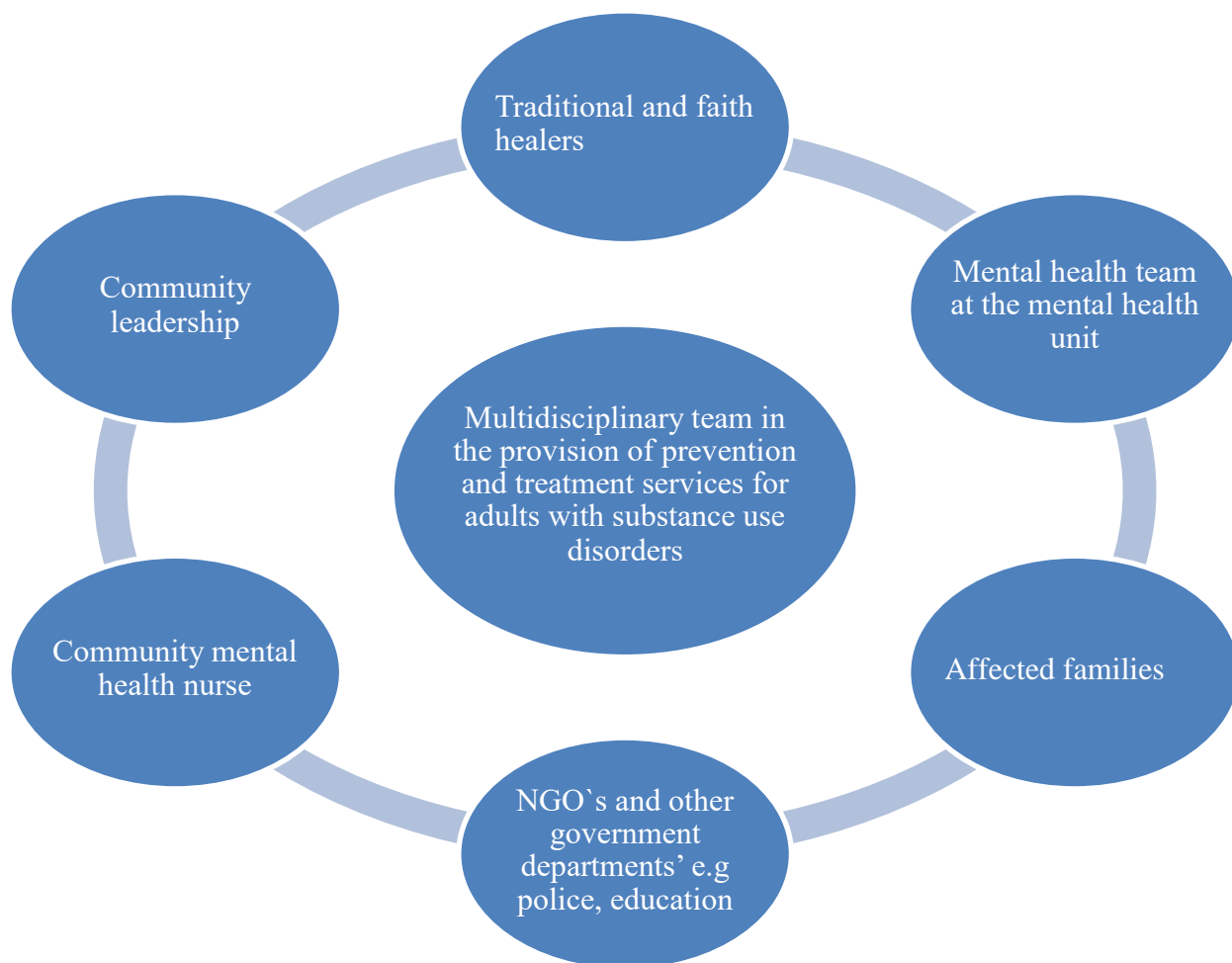


Figure 5: Illustration of the multidisciplinary team required in the provision of services for prevention and treatment of substance use disorders in Zimbabwe

The proposed treatment framework will be guided by the principles of recovery. (142) (206) The concept of recovery and recovery support services has gained impetus in guiding the management of substance use disorders. Within the context of substance use, recovery can be defined as “a process of change through which an individual achieves abstinence and improved health, wellness and quality of life.” (206)(p1) Recovery models propose a comprehensive multi-system client centered approach in order to respond to the changing needs of clients and families

that occur at different stages in the recovery process. The effectiveness of this approach in managing substance use disorders is well documented in literature. (142)(148)(206) (207)

Potential challenges of addressing the problem of substance use emanating from the findings include struggling to find alternative occupations to replace substance use, limited occupational choice and limited resources to enable participation and lack of family support for the recovery process. Gutman (3) suggested that the need to capitalise on the ability of occupational therapy to use real life activities occurring in the natural environments to address the impact of substance use on occupation. Drawing from this suggestion by Gutman, the occupational therapists in Zimbabwe may also capitalise on the available resources and provide interventions that address the real challenges.

7.4 The outline of the collective occupational reconstruction treatment framework

The treatment framework will involve four main stages which are summarised below.

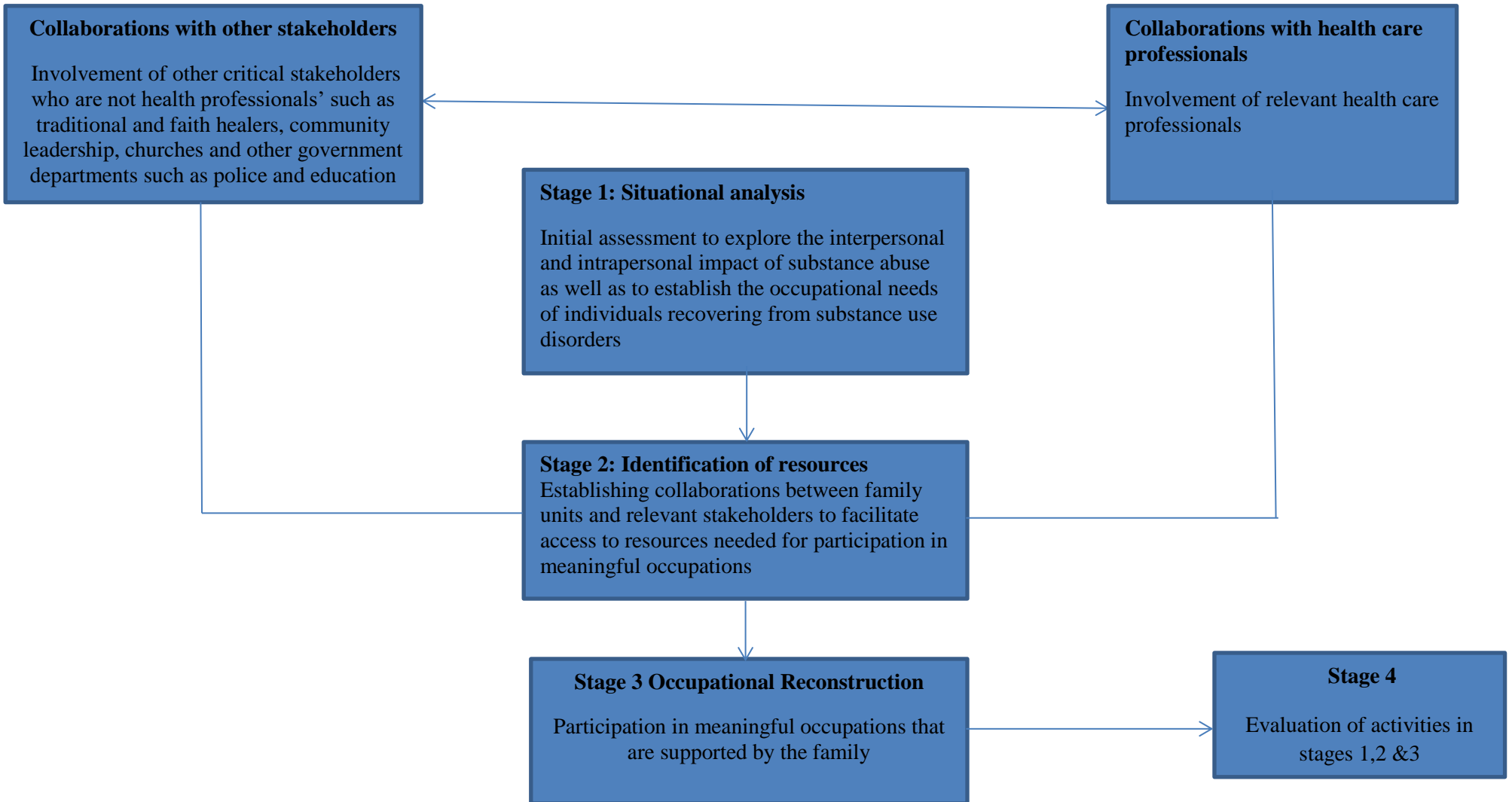


Figure 6: An illustration of the collective occupational reconstruction treatment framework

Stage 1: Situational analysis

This is the initial stage of establishing rapport with the patients and their families when they are referred for occupational therapy during the time of admission for a substance use disorder. Since occupational therapy services in Zimbabwe are mainly available at the tertiary level of care, it is important for the occupational therapist to use this opportunity to explore the families' experiences of staying with family members with a substance use disorder as part of their initial assessment. This can be done when relatives come to attend ward rounds or during visiting times. The narrative interviews that were conducted during this study offered the families a platform to confront the problem of substance use disorders and also opened dialogue between family members on how best to solve the problem. Using the same approach during assessment provides the occupational therapists with information on the unique occupational needs of the individual with a substance use disorder and the support required by the family in order to promote participation in meaningful occupations. Involving the family is a way of promoting and sustaining participation in meaningful occupations.

Stage 2: Identifying resources for occupational reconstruction

This stage involves the identification of new opportunities for occupational participation by the family and the relatives with guidance by the occupational therapists. Opportunities for participation will be explored taking into consideration the resources that are available to the family as well the occupational capabilities of the patient. This stage will provide a platform for discussing the feasibility of the opportunities for occupational participation.

The results from this study revealed the need for a multi sectoral response to the problem of substance use disorders. The occupational therapists will therefore identify all the other important stakeholders that can provide the required resources for reconstructing occupational participation by individuals recovering from substance use disorders. Since the focus of this intervention is occupation based, discussion can be on how these stakeholders can complement the efforts by families to promote participation in meaningful occupations by adults recovering from substance use disorders occupation can be used to prevent substance use.

Stage 3: Occupational reconstruction

During this stage the individuals recovering from substance use disorders reconstruct their occupational participation by either resuming participation in previous occupations before the onset of the substance use disorder or by participating in newly identified occupations. The findings from this study provided evidence that most individuals recovering from substance use disorders experienced occupational deficits when they stopped abusing substances. It is therefore important to provide psychosocial support from relevant stakeholders during this stage to prevent relapsing.

Stage 4: Evaluation

This stage involves ongoing evaluation of the treatment outcomes following the implementation of the occupation based interventions that are identified in stage 1 and supported by activities in stage 2 and 3. This evaluation will be conducted by the occupational therapists and if the interventions have not been successful, the occupational therapists will note the challenges and address them with the assistance of relevant stakeholders. It is important to note that whilst the

treatment framework has been presented in stages, the stages that have been described can occur concurrently.

7.5 Comparison of the proposed collective occupational reconstruction treatment frameworks with existing occupational therapy frameworks

In my evaluation of existing treatment frameworks in occupational therapy that were similar to the approach proposed in this study, I identified the Participatory Occupational Justice Framework (POJF) by Whiteford et al. (208) as being the most similar. This framework is based on theoretical concepts of occupational justice and its main purpose is to facilitate social inclusion by raising awareness and addressing instances of occupational injustice. (209) Occupational justice theorists argue that the individual has the right to exercise inherent capacities to promote health and quality of life. According to Durocher et al. (208) the main focus of social inclusion is ensuring people have opportunities, resources and capabilities to fully participate in life.

The POJF outlines six processes which are similar to the stages proposed in the collective occupational reconstruction treatment framework. (208) Similar to the proposed treatment framework, the six processes of the POJF focus on enablement of skills through a multidisciplinary approach. However unlike the proposed framework where processes are staged in an order that resembles the occupational therapy process, the steps in the POJF can be approached in any order and it is also not clear how these processes were derived. Furthermore, the focus of POJF is occupational justice, while in the proposed framework, the target is identifying new occupations to replace substance use through collective efforts of family members whilst accessing support from other critical stakeholders in the management of substance use disorders.

A review of existing literature (209)(210)(200) indicates that the manifestations of occupational injustice are occupational deprivation, occupational alienation, occupational marginalisation and occupational apartheid. These dimensions of occupational injustice have been defined within the context of marginalised and impoverished populations. However, there is lack of clarity on how occupational injustice can be assessed in a setting where the macro economic situation has resulted in an economic meltdown that has affected occupational participation of the whole nation. Viewing participation of individuals recovering from substance use disorders as an occupational right in the Zimbabwean context will therefore not sufficiently address the factors that contributed to the development of substance use disorders as they are broader than what can be conceptualised using an occupational justice perspective.

7. 6 Recommendations from the study

7.6.1 To occupational therapists

7.6.1.1 Advocate for community occupational therapy services

Most of the affected family members acknowledged the negative impact of substance use by their relative as they narrated their experiences of staying with a relative with a substance use disorder. However they did not access any psychosocial support services. This resulted in some of the family members becoming less involved in the recovery process. Community occupational therapy services will create an opportunity to provide ongoing psychosocial support to the families during the recovery process. There is literature (76) (105)(145) suggesting that families that receive appropriate psychosocial support will create a positive family environment that is conducive to promoting participation in meaning meaningful occupations.

7.6.1.2 Document everyday practices as baseline for future evidence based studies

There is lack of evidence on best practices in the management of substance use disorders. Occupational therapists should document their everyday practices in the form of case studies or short reports. These can then be used as baseline for future studies. The same information can also be used to come up with basic guidelines for managing substance use disorders to enable occupational therapy practitioners to standardise treatment and advocate for more posts in the community.

7.6.1.3 Conduct a feasibility study on the recommended treatment framework

It is important to evaluate whether the proposed treatment framework will work in the Zimbabwean setting. There is therefore need to determine the feasibility of this proposed framework by conducting a feasibility study. Once the feasibility has been established then a decision will be made on how this framework can be adopted as a national framework in the management of substance use disorders.

7.6.2 To the Ministry of health and child care

7.6.2.1 Create community awareness on substance use and its impact on the individuals using substances and their families

The majority of the participants had no knowledge on substance use disorders, how these present and where to access treatment services. As a result most families delayed in seeking treatment. Accessing intervention early is associated with good treatment outcomes.(142) This shows the need to create community awareness on substance use, its prevention and treatment of the substance use disorders that develop if prevention is not successful.

7.6.2.2 Establish a multisector response to the problem of substance use disorders

The findings from this study provide evidence on the complexity of substance use disorders and the factors contributing to increased substance use. This calls for a multisector response to the problem. Involving other government departments will help address some of the factors contributing to the development of substance use disorders, for example involving the ministry of primary and secondary education will address the problem of substance use in schools, the police will address the issue of drugs being sold openly in the community. Such an approach will

comprehensively address the challenges being faced by families as they support their relatives during the recovery process

7.6.2.3 Establish a database for substance use disorders

Most families reported that their relatives had been admitted multiple times due to the same problem. If this information is well captured, these statistics can be analysed and used to justify the need for more resources in the management of substance use disorders.

7.6.3 Lecturers at the University of Zimbabwe

7.6.3.1 Develop research in the prevention and management of substance use disorders

The search for literature revealed that there was paucity of literature on substance use and substance use disorders in Zimbabwe. Since all of the undergraduate programmes at the University have a research component, lecturers from the different departments (nursing, pharmacy, psychiatry, occupational therapy, health promotion, community medicine, psychology) working with clients with substance use disorders could advocate for research in this area. If this is done there is a potential of creating an interdisciplinary research base which can culminate into research evidence for contextually relevant interventions for Zimbabwe.

7.7 Study limitations

The limitations of the study were as follows:

- This study focused on exploring factors shaping family involvement in promoting participation in meaningful occupations during recovery of adult family members with substance use disorders. This focus guided the construction of narratives and subsequent data analysis. As such some useful information in the management of substance use disorders that was revealed during the narrative interviews and was not related to the study focus might have been omitted during the construction of the narratives.
- Study participants sampled in this study stayed within a radius of 60km from the hospitals where they were recruited from. This resulted in a sample with participants from urban and peri-urban areas only. Transferability of findings from this study therefore does not apply to families living in rural areas. Participants from rural settings might have provided different insights into the factors shaping family involvement in promoting participation in meaningful occupations during recovery. Future studies should thus include families living in more rural contexts.
- Participants in this study narrated their experiences based on their memory of events that happened in the past. They might have therefore omitted some critical information which could have contributed to a deeper understanding of factors shaping family involvement in prompting participation in meaningful occupations.
- This study focused on the impact of substance use on occupational participation but did not consider the impact of substance use on executive functioning. Further studies in this

area should investigate this important aspect of the disorder (i.e. the effect of cognitive impairments on participation in occupations).

- Meaningfulness of occupation is considered a fundamental construct in occupational therapy. However, in this study I did not explore whether the alternative occupations that were identified by the family units were meaningful to the index participants. Future research should focus on exploring meaningfulness of occupations that are collectively chosen.

7.8 Conclusion

This chapter highlighted the major findings from a qualitative study which sought to explore the lived experiences of families staying with a relative with a substance use disorder. The findings indicated that the family is extremely important in the management of substance use disorders. Through support from family members, the individuals who were recovering from substance use disorders were able to identify new occupational opportunities and reconstruct occupational participation. The opportunities for occupational participation facilitated future participation in occupations that were health enhancing. These findings provided useful insights into the occupational therapy services that would be contextually relevant for individuals recovering from substance use disorders in Zimbabwe. A treatment framework which is occupation based and initiated by the families was proposed as a sustainable approach to providing post discharge occupational therapy services.

Glossary of Zimbabwean terms used in the study

Term	Definition
Base	Refers to a place where people meet to smoke cannabis and drink alcoholic beverages
Broncho	Street name for Broncleer cough syrup which is one of the commonly abused drugs in Zimbabwe
kuromba	Acquiring goblins for the purposes of accumulating wealth at the expense of your relative`s wellbeing
kusticker	A street name used to refer to “drunken stupor”
Makorokoza	A street name for illegal miners
Maragada	Street name for haloperidol
Mbanje	Shona name for Cannabis
Musombodhiya	An illicit alcohol brew composed of diluted ethanol or methanol. The alcohol content is believed to be 95%
Muteuro	Holy water that is prescribed by faith healers to protect people from being attacked by evil spirits
Rank marshals	Individuals who control traffic flow at public transport parking bays
Sadza	Staple food in Zimbabwe prepared using mealie meal
Passa passa	Street dance party where drugs are openly sold
Touts	Individuals who direct movement of public transport users (commuters) by shouting the route and destinations for each of the commuter omnibus that will be loading passengers at passenger pick up points
Tuckshop	A small grocery selling retailer usually located within the residential areas in Zimbabwe
Zed	An alcoholic spirit abused in Zimbabwe which contains more than the recommended 40% alcohol
zvima crango	Cheap alcoholic beverages with high alcohol content
Zvibhodhoro	Street name for illicit alcoholic beverages that are packed in small bottles

References

1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. American Psychiatric Association; 2013. 1. (DSM Library).
2. WHO . mhGAP Intervention Guide for Substance Use Disorders. .Health Organization; 2010. Available from:
http://apps.who.int/iris/bitstream/10665/44406/1/9789241548069_eng.pdf
3. Gutman SA. Why Addiction Has a Chronic, Relapsing Course. The Neurobiology of Addiction. *Occup Ther Ment Heal* 2006;22(2):1–29.
4. Murphy SA, Lynch KG, Oslin D. Developing adaptive treatment strategies in substance abuse research. *Drug Alcohol Depend*. 2007;88 (2): 24-30.
5. United Nations Office on Drugs and Crime. Education sector responses to the use of alcohol, tobacco and drugs - Good policy and practice in health education, Booklet 10. 2017. 1-69 p. Available from:
<http://unesdoc.unesco.org/images/0024/002475/247509E.pdf>
6. United Nations Office on Drugs and Crime. World Drug Report 2012. New York: United Nations; 2012. Available from : <https://www.undoc.org>
7. World Health Organisation. Public health dimension of the world drug problem. 2016;(May):1–2. Available from:
http://apps.who.int/gb/ebwha/pdf_files/EB138/B138_11-en.pdf?ua=1

8. United Nations Office on Drugs and Crime. *Drugs P. Report world 3*. New York: United Nations; 2017. Available from https://www.unodc.org/wdr2017/field/Booklet_2_HEALTH.pdf
9. Odejide AO. Status of drug use/abuse in Africa: A review. *Int J Ment Health Addict*. 2006;4(2):87–102.
10. World Health Organization, World Health Organization, editors. *mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings: version 1.0*. Geneva: World Health Organization; 2010. Available from: http://apps.who.int/iris/bitstream/10665/44406/1/9789241548069_eng.pdf
11. Matunhu J, Matunhu V. *Drugs and drug control in zimbabwe*. in *Pan African issues in drugs and drug control: An African Perspective*. Klaunta Crumpton, Farnham, Surrey Ashgate. 2015.
12. United Nations Office On Drugs and Crime. *World drug report 2015*. Place of publication not identified: United Nations Pubns; 2015. Available from: https://www.unodc.org/documents/wdr2015/World_Drug_Report_2015.pdf
13. Van Ginneken N , Maheedhariah MS, Ghani S. Human resources and models of mental healthcare integration into primary and community care in India : Case studies of 72 programmes. 2017;1–25. Available from: <http://dx.doi.org/10.1371/journal.pone.0178954>
14. Tharyan P, Lewin S, Gn R, Sm M, Pian J. Non-specialist health worker interventions for the care of mental , neurological and substance-abuse disorders in low- and middle-income countries (Review). 2013;(11).

15. Rane A, Church S, Bhatia U, Orford J, Velleman R, Nadkarni A. Psychosocial interventions for addiction-affected families in Low and Middle Income Countries: A systematic review. *Addict Behav.* 2017;74(May):1–8.
16. Wilcock AA. Occupation and health: Are they one and the same? *J Occup Sci.* 2007;14(1):3–8.
17. Hammell KW. Dimensions of meaning in the occupations of daily life. *Can J Occup Ther.* 2004;71(5):296–305.
18. Matuska kathleen M, Christiansen Charles H. A proposed model of lifestyle balance. *J Occup Sci.* 2008 Apr;15(1):12–9.
19. WFOT. Definitions of occupational therapy from member organizations. *World Fed Occup Ther.* 2013. Available from www.wfot.org
20. Westhorp P. Exploring balance as a concept in occupational science. *J Occup Sci.* 2003;10(2):99–106.
21. Stewart KE, Fischer TM. Rethinking occupation: Use and addiction. *Br J Occup Ther.* 2015;78(7):460–1.
22. Stoffel VC, Moyers PA. An Evidence-Based and Occupational Perspective of Interventions for Persons With Substance-Use Disorders. *Am J Occup Ther.* 2004;58(5):570–86.
23. Wasmuth S, Pritchard K, Kaneshiro K. Occupation-Based Intervention for Addictive Disorders: A Systematic Review. *J Subst Abuse Treat.* 2016;32(6):1-12.

24. Wagman P, Håkansson C, Björklund A. Occupational balance as used in occupational therapy: A concept analysis. *Scand J Occup Ther* . 2012 J;19(4):322–7.
25. Hammell KW. Participation and occupation. *Can J Occup Ther*. 2015;82(1):4–5.
26. Hancock N, Honey A, Bundy AC. Sources of meaning derived from occupational engagement for people recovering from mental illness. *Br J Occup Ther*. 2015;78(8):508–15.
27. World Health Organization. International classification of functioning, disability and health ICF. Genève: World Health Organization; 2001. Available from <https://www.who.int/classifications/icf/en/>
28. Law M. Participation in the occupations of every life. *Am J Occup Ther*. 2002;56(6):640–647.
29. Sakiyama M, Josephsson S, Asaba E. What is participation? A story of mental illness, metaphor, & everyday occupation. *J Occup Sci*. 2010 Oct;17(4):224–30.
30. Goldberg B, Brintnell ES. The Relationship Between Engagement in Meaningful Activities and Quality of Life in Persons Disabled by Mental Illness. *Occup Ther Ment Health* 2008; 18(2):17-44.
31. Clarke E, Lecture S, Trombly CA. 1995 Eleanor Clarke Slagle Lecture. *Am J Occup Ther* 1995;49:960–72.
32. W. HK. Dimensions of meaning in the occupations of daily life. *Can J Occup Ther*. 2004;71:296.

33. Hvalsøe B, Josephsson S. Characteristics of meaningful occupations from the perspective of mentally ill people. *Scand J Occup Ther.* 2003;10(2):61–71.
34. Eakman AM. Measurement characteristics of the Engagement in Meaningful Activities Survey in an age-diverse sample. *Am J Occup Ther.* 2012;66(2).
35. Reed KD, Hocking CS, Smythe LA. Exploring the meaning of occupation: The case for phenomenology. *Can J Occup Ther.* 2011;78(5):303–10.
36. Majnemer A. Balancing the boat:Enabling an ocean of possibilities. *Can J Occup Ther.* 2010;77(4):198–208.
37. Persson D, Erlandss LK. Value Dimensions, Meaning, and Complexity in Human Occupation - A Tentative Structure for Analysis. *Scand J Occup Ther.* 2001;8(1):7–18.
38. Leufstadius C, Eklund M, Erlandsson LK. Meaningfulness in work - Experiences among employed individuals with persistent mental illness. *Work.* 2009;34(1):21–32.
39. Ikiugu MN. Meaningfulness of Occupations as an Occupational-Life-Trajectory Attractor. *J Occup Sci.* 2005;12(2):102–9.
40. Tjörnstrand C, Bejerholm U, Eklund M. Participation in day centres for people with psychiatric disabilities - A focus on occupational engagement. *Br J Occup Ther.* 2013;76(3):144–50.
41. Hitch D, Pepin G, Stagnitti K. Engagement in activities and occupations by people who have experienced psychosis: A metasynthesis of lived experience. *Br J Occup Ther.* 2013;76(2):77–86.

42. Ikiugu MN, Hoyme AK, Mueller B, Reinke RR. Difference between meaningful and psychologically rewarding occupations: Findings from two pilot studies. *J Occup Sci.* 2016;23(2):266–77.
43. World Health Organisation. Atlas of substance use disorders . Country Profile :Zimbabwe . 2010;1:1–4. Available from https://www.who.int/substance_abuse/activities/atlas/en/
44. WHO | Joint UNESCO, UNODC and WHO publication on education sector responses to substance use.. Available from:
http://www.who.int/substance_abuse/activities/education_sector/en/
45. Dangerous drugs Act Zimbabwe. 1982;1:13–5. Available from
https://zimlii.org/system/files/legislation/num-act/1956/28/DANGEROUS_DRUGS_ACT_15_02.pdf
46. World Health Organization. Mental health atlas 2014. 2015. Available from:
http://apps.who.int/iris/bitstream/10665/178879/1/9789241565011_eng.pdf
47. Nhunzvi C, Galvaan R, Peters L. Recovery From Substance Abuse Among Zimbabwean Men: An Occupational Transition. *OTJR Occup Particip Heal.* 2017;1-7.
48. Ministry of Health and Child Welfare Z. The National Health Strategy 2016. Available from <http://www.zim.gov.zw/government-ministries/ministry-health-and-child-care>
49. International Labour Organisation. Women in the Informal Economy. Available from https://www.ilo.org/wcmsp5/groups/public/---.../---ro.../wcms_619740.pdf

50. ZIMSTAT. 2014 Labour Force Survey. Available from
<http://socialprotection.org/institutions/zimbabwe-national-statistical-agency>
51. Therborn G. African Families in a Global Context. Nordiska Afrikainstitutet. 2006. 122 p.
Available from: <http://nai.diva-portal.org/smash/get/diva2:240546/FULLTEXT02.pdf>
52. Satyanarayana VA, Hebbani S, Hegde S, Krishnan S. Two sides of a coin : Perpetrators and survivors perspectives on the triad of alcohol , intimate partner violence and mental health in South India. *Asian J Psychiatr.* 2015;15:38–43.
53. Gilbert JM, Oliff H, Sutton D, Bartlett C, Henderson R. Substance Abuse Treatment And Family Therapy. A Treatment Improvement Protocol (TIP) Series 39. *Subst Abus Ment Heal Serv Adm.* 2004; Available from: <https://eric.ed.gov/?id=ED491568>
54. Chirozva C, Mubaya CP and Mukamuri B. The traditional african family in the age of globalization . Literature review report for Centre for Rural Development a Barefoot Education for Afrika Trust (BEAT). Available from www.beatafrica.org/comm.pdf
55. Asare M, Danquah SA. The African Belief System and the Patient ’ s Choice of Treatment from Existing Health Models : The Case of Ghana Choosin. *iMedPub* 2017;1–4.
56. USAID. Zimbabwe Health System Assessment 2010. Available from
https://www.hfgproject.org/wp.../02/Zimbabwe_Health_System_Assessment20101.pdf
57. Mangezi W, Chibanda D. Mental health in Zimbabwe. *Int Psychiatry.* 2010;7(4):93–4.
58. World Health Organization. Mental health atlas 2014.. Available from:
http://apps.who.int/iris/bitstream/10665/178879/1/9789241565011_eng.pdf?ua=1&ua=1

59. Ministry of Health and Child Welfare. Zimbabwe National Strategic Plan for Mental Health Services 2016-20. Available from
https://www.unicef.org/zimbabwe/National_Health_Strategy_for_Zimbabwe_2016-20
60. Hammell, K. R.. Building globally relevant occupational therapy from the strength of our diversity. Final Day Plenary Speech at the 17th World Federation of Occupational Therapy 2018. Available from www.wfot.org
61. Dirette DP. Decoloniality in the Profession : Reflections from WFOT 2018. Available from www.wfot.org
62. Maldonado-Torres N. On the coloniality of being: Contributions to the development of a concept. *Cult Stud.* 2007;21(2–3):240–70.
63. Sonn CC, Arcidiacono C, Dutta U, Kiguwa P, Kloos B, Maldonado Torres N. Beyond disciplinary boundaries: speaking back to critical knowledges, liberation, and community. *South African J Psychol.* 2017;47(4):448–58.
64. De Oliveira Andreotti V. (Towards) decoloniality and diversity in global citizenship education. *Glob Soc Educ.* 2011;9(3–4):381–97.
65. Grosfoguel R. The epistemic decolonial turn: Beyond political-economy paradigms. *Cult Stud.* 2007;21(2–3):211–23.
66. Ramos F. reflections on methodology : dilemmas in a research project about the educational experiences. :1–15. Paper presented at the AARE Conference, Western Australia 2015.
67. Mignolo WD. Epistemic Disobedience, Independent Thought and De-Colonial Freedom.

- Theory Cul Soc 2009;26:1–23.
68. Volkow ND, Wang GJ, Tomasi D, Baler RD. Unbalanced neuronal circuits in addiction. *Curr Opin Neurobiol.* 2013;23(4):639–48.
 69. Mennis J, Stahler GJ, Mason MJ. Risky substance use environments and addiction: A new frontier for environmental justice research. *Int J Environ Res Public Health.* 2016;13(6).
 70. Kim S, Kwok S, Mayes LC, Potenza MN, Rutherford HJV, Strathearn L. Early adverse experience and substance addiction: dopamine, oxytocin, and glucocorticoid pathways. *Ann N Y Acad Sci.* 2017;1394(1):74–91.
 71. Templeton L, Velleman R, Russell C. Psychological interventions with families of alcohol misusers: A systematic review. Vol. 18, *Addiction Research and Theory.* 2010. 616-648 .
 72. Arcidiacono C, Velleman R, Procentese F, Albanesi C, Sommantico M. Impact and coping in Italian families of drug and alcohol users. *Qual Res Psychol.* 2009;6(4):260–80.
 73. Gupta S, Sarpal SS, Kumar D, Kaur T, Arora S. Prevalence, pattern and familial effects of substance use among the male college students-a north Indian study. *J Clin Diagnostic Res.* 2013;7(8):1632–6.
 74. Szapocznik J, Zarate M, Duff J, Muir J. Brief strategic family therapy: Engaging drug using/problem behavior adolescents and their families in treatment. *Soc Work Public Health.* 2013;28(3–4):206–23.
 75. Harrison M, Angarola R, Forsyth K, Irvine L. Defining the environment to support occupational therapy intervention in mental health practice. *Br J Occup Ther.* 2016;79(1):57–9.

76. Amato L, Minozzi S, Vecchi S, Davoli M, Perucci CA. An overview of cochrane systematic reviews of pharmacological and psychosocial treatment of opioid dependence. *World Heal Organ.* 2005;57.
77. Berridge KC. The debate over dopamine's role in reward: The case for incentive salience. *Psychopharmacology (Berl).* 2007;191(3):391–431.
78. Moses N. Ikiugu, Ashley K. Hoyme, Brittany Mueller & Rochelle R. Reinke. Difference between meaningful and psychologically rewarding occupations: Findings from two pilot studies. *J Occup Sci.*2015;1-10.
79. Murphy SA, Lynch KG, Oslin D, McKay JR, TenHave T. Developing adaptive treatment strategies in substance abuse research. *Drug Alcohol Depend.* 2007;88:S24–S30.
80. Orford J. Re-Empowering Family Members Disempowered by Addiction: Support for Individual or Collective Action? *Int Community Psychol.* 2011;163.
81. Gruber KJ, Taylor MF. A Family Perspective for Substance Abuse: Implications from the Literature. *J Soc Work Pract Addict.* 2006;6(1–2):1–29.
82. Orford J, Copello A, Velleman R, Templeton L. Family members affected by a close relative's addiction: The stress-strain-coping-support model. *Drugs Educ Prev Policy.* 2010;17(SUPPL. 1):36–43.
83. Gonzales R, Anglin MD, Glik DC, Zavalza C. Perceptions about recovery needs and drug-avoidance recovery behaviors among youth in substance abuse treatment. *J Psychoactive Drugs.* 2013;45(4):297–303.
84. Shanmugam PK. The Influence of Social Factors in Drug Addiction—A Mini Review of

- Work by Miller & Carroll (2006). *J Alcohol Drug Depend.* 2017;05(04):4–6.
85. Daley DC. Family and social aspects of substance use disorders and treatment. *J Food Drug Anal.* 2013;21(4):S73–6.
 86. Gallagher M, Muldoon OT, Pettigrew J. An integrative review of social and occupational factors influencing health and wellbeing. *Front Psychol.* 2015;6(September):1–11.
 87. Choate PW. Adolescent addiction: What parents need? *Procedia - Soc Behav Sci.* 2011;30:1359–64.
 88. Dutra L, Stathopoulou G, Basden SL, Leyro TM, Powers MB, Ph D, et al. Reviews and Overviews A Meta-Analytic Review of Psychosocial Interventions for Substance Use Disorders. *Am j.* 2008;165:179–87.
 89. Wasmuth S, Crabtree JL, Scott PJ. Exploring Addiction-as-Occupation. *Br J Occup Ther.* 2014;77(12):605–13.
 90. Stone M. Understanding the Impact of Substance Abuse on Occupation Using the Lifestyle History Questionnaire. 2017; Unpublished PhD thesis available from <https://encompass.eku.edu/cgi/viewcontent.cgi?article=1030&context=otdcapstones>
 91. Flesch ME. An occupational approach to substance use disorders within an acute care setting: a program development plan. 2012; Available from: <http://utdr.utoledo.edu/graduate-projects%5Cnhttp://utdr.utoledo.edu/graduate-projects/69>
 92. Rojo-Mota G, Pedrero-Pérez EJ, Huertas-Hoyas E. Systematic review of occupational therapy in the treatment of addiction: Models, practice, and qualitative and quantitative research. *Am J Occup Ther.* 2017;71(5):1–12.

93. Chang E. Drug use as an occupation: Reflecting on Insite, Vancouver's supervised injection site. *OT Now*. 2008;10(3):21–23.
94. Helbig K, McKay E. An exploration of addictive behaviours from an occupational perspective. *J Occup Sci*. 2003;10(3):140–5.
95. Kiepek N, Magalhães L. Addictions and impulse-control disorders as occupation: A selected literature review and synthesis. *J Occup Sci*. 2011;18(3):254–76.
96. Wasmuth S, Brandon-Friedman RA, Olesek K. A Grounded Theory of Veterans' Experiences of Addiction-as-Occupation. *J Occup Sci*. 2016;23(1):128–41.
97. Haltiwanger E, Lazzarini I, Nazeran H. Application of nonlinear dynamics theory to neuro-occupation: a case study of alcoholism. *Br J Occup Ther*. 2007;70(August):349–57.
98. Stewart KE, Fischer TM, Hirji R, Davis JA. Toward the reconceptualization of the relationship between occupation and health and well-being. *Can J Occup Ther*. 2016;83(4):249–59.
99. Aldrich RM. From complexity theory to transactionalism: Moving occupational science forward in theorizing the complexities of behavior. *J Occup Sci*. 2008;15(3):147–56.
100. Dickie V, Cutchin MP, Humphry R. Occupation as transactional experience: A critique of individualism in occupational science. *J Occup Sci*. 2006;13(1):83–93.
101. Kuo A. A transactional view: Occupation as a means to create experiences that matter. *J Occup Sci*. 2011;18(2):131–8.
102. Rudatsikira E, Maposa D, Mukandavire Z, Muula A, Siziya S. Prevalence and predictors

- of illicit drug use among school-going adolescents in Harare, Zimbabwe. *Ann Afr Med.* 2009;8(4):215.
103. Tesfaye G, Derese A, Hambisa MT. Substance Use and Associated Factors among University Students in Ethiopia: A Cross-Sectional Study. *J Addict.* 2014;2014:1–8.
104. Ansari-Moghaddam A, Habybabady RH, Shakiba M, Mirzaei R, Shahriyari F, Aghaei S. Predictors of initiation, continuation and transition of drug use in south-eastern Iran. *J Pak Med Assoc.* 2012;62(7):698–703.
105. Velleman RDB, Templeton LJ, Copello AG. The role of the family in preventing and intervening with substance use and misuse: A comprehensive review of family interventions, with a focus on young people. *Drug Alcohol Rev.* 2005;24(2):93–109.
106. Quinn PD, Harden KP. Differential changes in impulsivity and sensation seeking and the escalation of substance use from adolescence to early adulthood. *Dev Psychopathol.* 2013;25(1):223–39.
107. Okpataku CI, Kwanashie HO, Ejiofor J OVO. Prevalence and socio-demographic risk factors associated with psychoactive substance use in psychiatric out-patients of a tertiary hospital in Nigeria. *Niger Med J.* 2014;55(6):460–4.
108. Osman T, Victor C, Abdulmoneim A, Mohammed H, Abdalla F, Ahmed A, et al. Epidemiology of Substance Use among University Students in Sudan. *J Addict.* 2016;2016:1–8.
109. Price P, Stephenson SM. Learning to promote occupational development through co-occupation. *J Occup Sci.* 2009;16(3):180–6.

110. Hauli KA, Ndetei DM, Jande MB, Kabangila R. The prevalence of substance use among psychiatric patients: The case study of bugando medical centre, mwanza (Northern Tanzania). *Subst Abus.* 2011;32(4):238–41.
111. Bashir N, Sheikh AA, Bilques S and Firdosi MA. Sociodemographic correlates of substance use disorder patients seeking de-addiction services in Kashmir India-A cross sectional study. *BJMP* 2015;8(4):833-845.
112. Chapter 1 Substance Abuse Treatment and Family Therapy - Substance Abuse Treatment and Family Therapy - NCBI Bookshelf. Available from:
<https://www.ncbi.nlm.nih.gov/books/NBK64269/>
113. Pizarro KW, Bustamante I V., Surkan PJ. Family Factors and Adolescent Problem Drinking in a High-Risk Urban Peruvian Neighborhood. *Subst Use Misuse.* 2017;52(2):194–202.
114. Buu A, DiPiazza C, Wang J, Puttler LI, Fitzgerald HE, Zucker RA. Parent, Family, and Neighborhood Effects on the Development of Child Substance Use and Other Psychopathology From Preschool to the Start of Adulthood. *J Stud Alcohol Drugs.* 2009;70(4):489–98.
115. Barrett AE, Turner RJ. Family structure and substance use problems in adolescence and early adulthood: Examining explanations for the relationship. *Addiction.* 2006;101(1):109–20.
116. Barfield-Cottledge T. The Triangulation Effects of Family Structure and Attachment on Adolescent Substance Use. *Crime Delinq.* 2015;61(2):297–320.

117. Crawford L a., Novak KB. Parent Child Relations and Peer Associations as Mediators of the Family Structure Substance Use Relationship. *J Fam Issues*. 2007;29(2):155–84.
118. Fosgate GT, Carpenter TE, Chomel BB, Case JT, DeBess EE, Reilly KF. ContentServer (1).pdf. Vol. 8, Time-space clustering of human Brucellis, California, 1973-1992. 2002. p. 672.
119. Martin MJ, Conger RD, Sitnick SL, Forbes EE, Shaw DS. Pathways to Educational Attainment. 2016;86(6):1719–37.
120. Ryzin MJ Van, Roseth CJ, Fosco GM, Lee Y, Lansing E. HHS Public Access. 2017;72–80.
121. Hicks Brian M., Johnson Wendy, Durbin, Emily, Blonigen DM, Iacono, William G., and McGue M. Delineating Selection and Mediation Effects among Childhood Personality and Environmental Risk Factors in the Development of Adolescent Substance Abuse. 2014;42(5):845–59.
122. Wazen RM, Kuroda S, Nishio C, Sellin K, Brunski JB, Nanci A. NIH Public Access. 2014;8(9):1385–95.
123. Martin LM, Smith M, Rogers J, Wallen T, Boisvert R. Mothers in Recovery: An Occupational Perspective. *Occup Ther Int*. 2011;18(3):152–61.
124. Brenner AB, Bauermeister JA, Zimmerman MA. Neighborhood Variation in Adolescent Alcohol Use: Examination of Socioecological and Social Disorganization Theories*. *J Stud Alcohol Drugs*. 2011;72(4):651–9.
125. Galea S, Ahern J, Tracy M, Vlahov D. Neighborhood Income and Income Distribution

- and the Use of Cigarettes, Alcohol, and Marijuana. *Am J Prev Med.* 2007;32(6):195–202.
126. Boyd-Ball AJ. A Culturally Responsive, Family-Enhanced Intervention Model: Alcohol Clin Exp Res. 2003;27(8):1356–60.
127. Arcidiacono C, Velleman R, Procentese F, Berti P, Albanesi C, Sommantico M, et al. Italian families living with relatives with alcohol or drugs problems. *Drugs Educ Prev Policy.* 2010;17(6):659–80.
128. Orford J, Velleman R, Haters L. Addiction in the Family Is a Major But Neglected. *Soc Sci Med.* 2013;78(Feb):70-7.
129. Kelly JF, Fallah-Sohy N, Cristello J, Bergman B. Coping with the enduring unpredictability of opioid addiction: An investigation of a novel family-focused peer-support organization. *J Subst Abuse Treat.* 2017;77:193–200.
130. Martin LM, Bliven M, Boisvert R. Occupational Performance, Self-Esteem, and Quality of Life in Substance Addictions Recovery. *OTJR Occup Particip Heal.* 2008;28(2):81–8.
131. Kourgiantakis T, Ashcroft R. Family-focused practices in addictions: A scoping review protocol. *Br J Occup Ther.* 2018;8(1):1–5.
132. Davits R, Cameron J. Self-identified occupational competencies, limitations and priorities for change in the occupational lives of people with drug misuse problems. *Br J Occup Ther.* 2010;73(6):251–60.
133. Orford J, Velleman R, Copello A, Templeton L, Ibanga A. The experiences of affected family members: A summary of two decades of qualitative research. *Drugs Educ Prev policy.* 2010;17(sup1):44–62.

134. Hodgetts S, McConnell D, Zwaigenbaum L, Nicholas D. The impact of autism services on mothers' psychological wellbeing. *Child Care Health Dev.* 2017;43(1):18–30.
135. McGuire BK, Crowe TK, Law M, Vanleit B. Occupational Concerns and Solutions. :54–64.
136. Bechara A. Decision making, impulse control and loss of willpower to resist drugs: A neurocognitive perspective. *Nat Neurosci.* 2005;8(11):1458–63.
137. Morales M, Pickel VM. Insights to drug addiction derived from ultrastructural views of the mesocorticolimbic system. *Ann N Y Acad Sci.* 2012;1248(1):71–88.
138. Squeglia LM, Jacobus J, Tapert SF. The influence of substance use on adolescent brain development. *Clin EEG Neurosci.* 2009;40(1):31–8.
139. Reay JL, Hamilton C, Kennedy DO, Scholey AB. MDMA polydrug users show process-specific central executive impairments coupled with impaired social and emotional judgement processes. *J Psychopharmacol.* 2006;20(3):385–8.
140. Colzato LS, van den Wildenberg WPM, Hommel B. Reduced attentional scope in cocaine polydrug users. *PLoS One.* 2009;4(6):2–7.
141. Crean RD, Crane NA, Mason BJ. An evidence-based review of acute and long-term effects of cannabis use on executive cognitive functions. *J Addict Med.* 2011;5(1):1–8.
142. Substance Abuse and Mental Health Services Administration (SAMHSA). Supporting principles of recovery and systems of care elements guiding principles and elements of recovery-oriented systems of care: What do we know from the research ? *Subst Abus.* 2009;(August):1–61.

143. Sprenkle DH. Intervention Research in Couple and Family Therapy: A Methodological and Substantive Review and an Introduction to the Special Issue. *J Marital Fam Ther.* 2012;38(1):3–29.
144. Eassom E, Giacco D, Dirik A, Priebe S. Implementing family involvement in the treatment of patients with psychosis: A systematic review of facilitating and hindering factors. *Br J Occup Ther.* 2014;4(10):1–11.
145. Akram Y, Copello A, Moore D. Family-based interventions for substance misuse: A systematic review of systematic reviews-protocol. *Syst Rev.* 2014;3(1):1–6.
146. Das JK, Salam RA, Arshad A, Finkelstein Y, Bhutta ZA. Interventions for Adolescent Substance Abuse: An Overview of Systematic Reviews. *J Adolesc Heal.* 2016;59(2):S61–75.
147. Leppard A, Ramsay M, Duncan A, Malachowski C, Davis JA. Interventions for Women With Substance Abuse Issues : A Scoping Review. 2018.
148. Peloquin SM, Ciro CA. Self-development groups among women in recovery: Client perceptions of satisfaction and engagement. *Am J Occup Ther.* 2013;67(1):82–90.
149. Creswell, J.W. (2007). *Qualitative inquiry and research design: Choosing among ve approaches* (2nd ed.). Thousand Oaks, CA: Sage. 2007.
150. Frank G, Polkinghorne D. Qualitative Research in Occupational Therapy: from the First to the Second Generation. *OTJR Occup Particip Heal.* 2010;30(2):51–7.
151. Hollway W, Jefferson T. *Doing qualitative research differently: free association, narrative and the interview method.* London ; Thousand Oaks, Calif: SAGE; 2000.

152. Yin RK. *Qualitative Research from Start to Finish*. Guilford Press; 2011.
153. Denzin NK, Lincoln YS. *The SAGE Handbook of Qualitative Research*. SAGE; 2011. 785 p.
154. Jovchelovitch S, Bauer MW. Narrative interviewing. *Qual Res with text, image sound*. 2000];57–74.
155. Wicks A, Whiteford G. Conceptual and practical issues in qualitative research: Reflections on a life-history study. *Scand J Occup Ther*. 2006;13(2):94–100.
156. Kathard H. Sharing Stories: Life History Narratives in Stuttering Research. *Int J Lang Commun Disord*. 2001;36:52.
157. Molineux M, Richard W. Storied Approaches to Understanding Occupation. *J Occu Sci*. 2003;10(1):52-60.
158. Moen T. Reflections on the Narrative Research Approach. *Int J Qual Methods*. 2008;5(4):56–69.
159. Riessman CK. Strategic uses of narrative in the presentation of self and illness: A research note. *Soc Sci Med*. 1990;30(11):1195–1200.
160. Polkinghorne DE. Narrative configuration in qualitative analysis. *Int J Qual Stud Educ*. 1995 J;8(1):5–23.
161. Muylaert CJ, Sarubbi Jr V, Gallo PR, Neto MLR, Reis AOA. Narrative interviews: an important resource in qualitative research. *Rev da Esc Enferm da USP*. 2014 Dec;48(2):184–9.

162. Clandinin D, Clandinin DJ, Rosiek J. Mapping a Landscape of Narrative Inquiry: Borderland Spaces and Tensions. In 2455 Teller Road, Thousand Oaks California 91320 United States: SAGE Publications, Inc.; 2007.
163. Lieblich A, Tuval-Mashiach R, Zilber T. Narrative Research [Internet]. 2455 Teller Road, Thousand Oaks California 91320 United States of America: SAGE Publications, Inc.; 1998.
164. Elwyn G, Gwyn R. Narrative based medicine: stories we hear and stories we tell: analysing talk in clinical practice. *Br Med J.* 1999;318(7177):186.
165. Hatch JA, Wisniewski R. Life history and narrative: introduction. *Life Hist Narrat.* 2002;1:1. Available from:
<https://books.google.com/books?hl=en&lr=&id=UzuQAqAAQBAJ&oi=fnd&pg=PA1&dq=%22visibility+of+life+history+and+narrative+work+has+increased,+and+its+importance+has+been%22+%22lead+chapter,+%22Narrative+configuration+in+qualitative+analysis%22+by+Donald+Polkinghorne>
166. Clandinin D. Handbook of Narrative Inquiry: Mapping a Methodology [Internet]. 2455 Teller Road, Thousand Oaks California 91320 United States: SAGE Publications, Inc; 2007.
167. Plummer K. Life Story Research. *Rethinking Methods in Psychology.* 1995. 48-63 p.
168. Mattingly C, Garro LC, editors. Narrative and the cultural construction of illness and healing. Berkeley: University of California Press; 2000.
169. Polkinghorne DE. Explorations of narrative identity. *Psychol Inq.* 1996;7(4):363–367.

170. Savin-Baden M, Niekerk L Van. Narrative Inquiry: Theory and Practice. *J Geogr High Educ.* 2007 Sep;31(3):459–72.
171. Polkinghorne DE. Transformative narratives: From victimic to agentic life plots. *Am J Occup Ther.* 1996;50(4):299–305.
172. Taylor J. Expressing care in narratives about occupations. *Br J Occup Ther.* 2015;78(10):606–13.
173. Clandinin & Connelly - Stories of Experience and Narrative Inquiry | Narrative | Social Sciences.. Available from: <https://www.scribd.com/doc/52186680/Clandinin-Connelly-Stories-of-Experience-and-Narrative-Inquiry>
174. Clandinin D, Josselson R. The Ethical Attitude in Narrative Research: Principles and Practicalities. In 2455 Teller Road, Thousand Oaks California 91320 United States: SAGE Publications, Inc.; 2007.
175. Caine V, Estefan A, Clandinin DJ. A Return to Methodological Commitment: Reflections on Narrative Inquiry. *Scand J Educ Res.* 2013;57(6):574–86.
176. McCance T V., McKenna HP, Boore JR. Exploring caring using narrative methodology: an analysis of the approach. *J Adv Nurs.* 2001;33(3):350–356.
177. Polkinghorne DE. Language and meaning: Data collection in qualitative research. *J Couns Psychol.* 2005;52(2):137–45.
178. Clandinin D, Clandinin DJ, Murphy MS. Looking Ahead: Conversations with Elliot Mishler, Don Polkinghorne, and Amia Lieblich. In 2455 Teller Road, Thousand Oaks California 91320 United States: SAGE Publications, Inc; 2007.

179. Wicks A, Whiteford G. Value of life stories in occupation-based research. *Aust Occup Ther J.* 2003;50(2):86–91.
180. Kielhofner G. *Research in occupational therapy: methods of inquiry for enhancing practice.* Philadelphia: F.A. Davis; 2006.
181. Bleakley A. Stories as data, data as stories: making sense of narrative inquiry in clinical education*. *Med Educ.* 2005;39(5):534–40.
182. Huot S, Rudman DL. Extending beyond qualitative interviewing to illuminate the tacit nature of everyday occupation: Occupational mapping and participatory occupation methods. *OTJR Occup Particip Heal.* 2015;35(3):142–50.
183. Van Nes F, Abma T, Jonsson H, Deeg D. Language differences in qualitative research: Is meaning lost in translation? *Eur J Ageing.* 2010;7(4):313–6.
184. Smith HJ, Chen J, Liu X. Language and rigour in qualitative research: Problems and principles in analyzing data collected in Mandarin. *BMC Med Res Methodol.* 2008;8(1):44.
185. Muylaert CJ, Sarubbi Jr V, Gallo PR, Neto MLR, Reis AOA. Narrative interviews: an important resource in qualitative research. *Rev da Esc Enferm da USP.* 2014;48(spe2):184–9.
186. Gubrium JF, Holstein JA, Morse JM. 16 *Interviewing The Ill.* In 2455 Teller Road, Thousand Oaks California 91320 United States of America: SAGE Publications, Inc.; 2001.
187. Rolfe G. *Validity, trustworthiness and rigor: quality and the idea of qualitative research.*


- Methodol issues Nurs Res. 2006;53(3):304–10.
188. Bradbury-Jones C. Enhancing rigour in qualitative health research: exploring subjectivity through Peshkin's I's. *J Adv Nurs*. 2007 A;59(3):290–8.
189. Barusch A, Gringeri C, George M. Rigor in qualitative social work research: A review of strategies used in published articles. *Soc Work Res*. 2011;35(1):11–19.
190. Morrow SL. Quality and trustworthiness in qualitative research in counseling psychology. *J Couns Psychol*. 2005;52(2):250–60.
191. Whittemore R, Chase SK, Mandle CL. Validity in qualitative research. *Qual Health Res*. 2001;11(4):522–537.
192. Loh J. Inquiry into issues of trustworthiness and quality in narrative studies: A perspective. *Qual Rep*. 2013;18(33):1-12.
193. Angen MJ. Evaluating interpretive inquiry: Reviewing the validity debate and opening the dialogue. *Qual Health Res*. 2000;10(3):378–395.
194. Margareth A. Rigor and ethics : challenges in qualitative research. *Ciência & Saúde Coletiva* 2008;13(2):312-328.
195. Heggen K, Guillemin M. Protecting Participants ' Confidentiality using a Situated Research. *SAGE Handb Interview Res Complex Cr*. 2014;465–76.
196. Bendixen HJ, Kroksmark U, Magnus E, Jakobsen K, Alsaker S, Nordell K. Occupational Pattern: A Renewed Definition of the Concept. *J Occup Sci*. 2006;13(1):3–10.
197. Holthe T, Thorsen K, Josephsson S. Occupational patterns of people with dementia in

- residential care: An ethnographic study. *Scand J Occup Ther.* 2007;14(2):96–107.
198. Green AE, Bekman NM, Miller EA, Perrott JA, Brown SA, Aarons GA. Parental awareness of substance use among youths in public service sectors. *J Stud Alcohol Drugs.* 2011;72(1):44–52.
199. Austin AM, Macgowan MJ, Wagner EF. Effective family-based interventions for adolescents with substance use problems: A systematic review. *Res Soc Work Pract.* 2005;15(2):67–83.
200. Townsend EA, Polatajko HJ. *Advancing an occupational therapy vision for health, well-being, and justice through occupation.* Ottawa, CAOT Publ. 2007.
201. Kennedy J, Davis JA. Clarifying the construct of occupational engagement for occupational therapy practice. *OTJR Occup Particip Heal.* 2017;37(2):98–108.
202. Hemmingsson H, Borell L, Gustavsson A. Participation in school : School assistants creating opportunities and obstacles *OTJR; Occup Particip Heal* 2003; 23(3):88-98.
203. Ramugondo EL, Kronenberg F. Explaining collective occupations from a human relations perspective: Bridging the individual-collective dichotomy. *J Occup Sci.* 2015;22(1):3–16.
204. Edwards MA, Millard P, Praskac LA, Wisniewski PA. Occupational therapy and early intervention: a family-centred approach. *Occup Ther Int.* 2003;10(4):239–252.
205. Rusnáková M. Codependency of the Members of a Family of an Alcohol Addict. *Procedia - Soc Behav Sci.* 2014;132:647–53.
206. Laudet AB, Humphreys K. Promoting recovery in an evolving policy context: What do we

- know and what do we need to know about recovery support services? *J Subst Abuse Treat.* 2013;45(1):126–33.
207. Henwood BF, Padgett DK, Smith BT, Tiderington E. Substance Abuse Recovery After Experiencing Homelessness and Mental Illness: Case Studies of Change Over Time. *J Dual Diagn.* 2012;8(3):238–46.
208. Whiteford G, Jones K, Rahal C, Suleman A. The Participatory Occupational Justice Framework as a tool for change: Three contrasting case narratives. *J Occup Sci.* 2018;7591.
209. Durocher E, Gibson BE, Rappolt S. Occupational justice: A conceptual review. *J Occup Sci.* 2014;21(4):418–30. 210. Durocher E, Gibson BE, Rappolt S. Occupational justice: A conceptual review. *J Occup Sci [Internet].* 2014;21(4):418–30. Available from: <http://dx.doi.org/10.1080/14427591.2013.775692>

Appendices

Appendix 1: HREC approval


UNIVERSITEIT-STELLENBOSCH-UNIVERSITY
Jou kennisvermooi - your knowledge partner

Approval Notice
Response to Modifications- (New Application)

04-Nov-2015
Chikwaha, Theodora TM

Ethics Reference #: S15/05/104
Title: Exploring factors shaping family involvement in promoting the participation of adults with substance use disorders in meaningful occupations.

Dear Ms Theodora Chikwaha,

The Response to Modifications - (New Application) received on 25-Sep-2015, was reviewed by members of **Health Research Ethics Committee 2** via Expedited review procedures on 16-Oct-2015 and was approved.
Please note the following information about your approved research protocol:

Protocol Approval Period: 16-Oct-2015 - 16-Oct-2016

Please remember to use your **protocol number** (S15/05/104) on any documents or correspondence with the HREC concerning your research protocol.

Please note that the HREC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

After Ethical Review:
Please note a template of the progress report is obtainable on www.sun.ac.za/ethics and should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit.
Translation of the consent document to the language applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372
Institutional Review Board (IRB) Number: IRB0005239

The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Provincial and City of Cape Town Approval

Please note that for research at a primary or secondary healthcare facility permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health (healthres@gpw.gov.za Tel: +27 21 481 9907) and Dr Helene Visser at City Health (Helene.Visser@capetown.gov.za Tel: +27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

We wish you the best as you conduct your research.
For standard HREC forms and documents please visit: www.sun.ac.za/ethics

If you have any questions or need further assistance, please contact the HREC office at 219389819.

Included Documents:
Protocol Synopsis
MOD_Protocol
Interview Guide

Appendix 2: MRCZ approval

Telephone: 791792/791193
 Telefax: (263) - 4 - 790715
 E-mail: mrcz@mrcz.org.zw
 Website: <http://www.mrcz.org.zw>



Medical Research Council of Zimbabwe
 Josiah Tongogara / Mazoe Street
 P. O. Box CY 573
 Causeway
 Harare

APPROVAL

REF: MRCZA/2028 08 April 2016

Theodora Chikwanha
 University of Zimbabwe
 College of Health Sciences
 P.O Box A 178
 Avondale
 Harare

RE:- Exploring factors shaping family involvement in promoting the participation of adults with substance abuse disorders in meaningful occupations.

Thank you for the application for review of Research Activity that you submitted to the Medical Research Council of Zimbabwe (MRCZ). Please be advised that the Medical Research Council of Zimbabwe has **reviewed and approved** your application to conduct the above titled study.

This approval is based on the review and approval of the following documents that were submitted to MRCZ for review:-

- Full proposal
- Informed Consent Form (English and Shona)
- Interview guide (English and Shona)

•APPROVAL NUMBER : MRCZA/2028
 This number should be used on all correspondence, consent forms and documents as appropriate.

- **TYPE OF MEETING** : Full Board
- **EFFECTIVE APPROVAL DATE** : 08 April 2016
- **EXPIRATION DATE** : 07 April 2017

After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the MRCZ Offices should be submitted three months before the expiration date for continuing review.

•SERIOUS ADVERSE EVENT REPORTING: All serious problems having to do with subject safety must be reported to the Institutional Ethical Review Committee (IERC) as well as the MRCZ within 3 working days using standard forms obtainable from the MRCZ Offices or website.

•MODIFICATIONS: Prior MRCZ and IERC approval using standard forms obtainable from the MRCZ Offices is required before implementing any changes in the Protocol (including changes in the consent documents).

•TERMINATION OF STUDY: On termination of a study, a report has to be submitted to the MRCZ using standard forms obtainable from the MRCZ Offices or website.

•QUESTIONS: Please contact the MRCZ on Telephone No. (04) 791792, 791193 or by e-mail on mrcz@mrcz.org.zw

Other

- Please be reminded to send in copies of your research results for our records as well as for Health Research Database.
- You're also encouraged to submit electronic copies of your publications in peer-reviewed journals that may emanate from this study.

Yours Faithfully

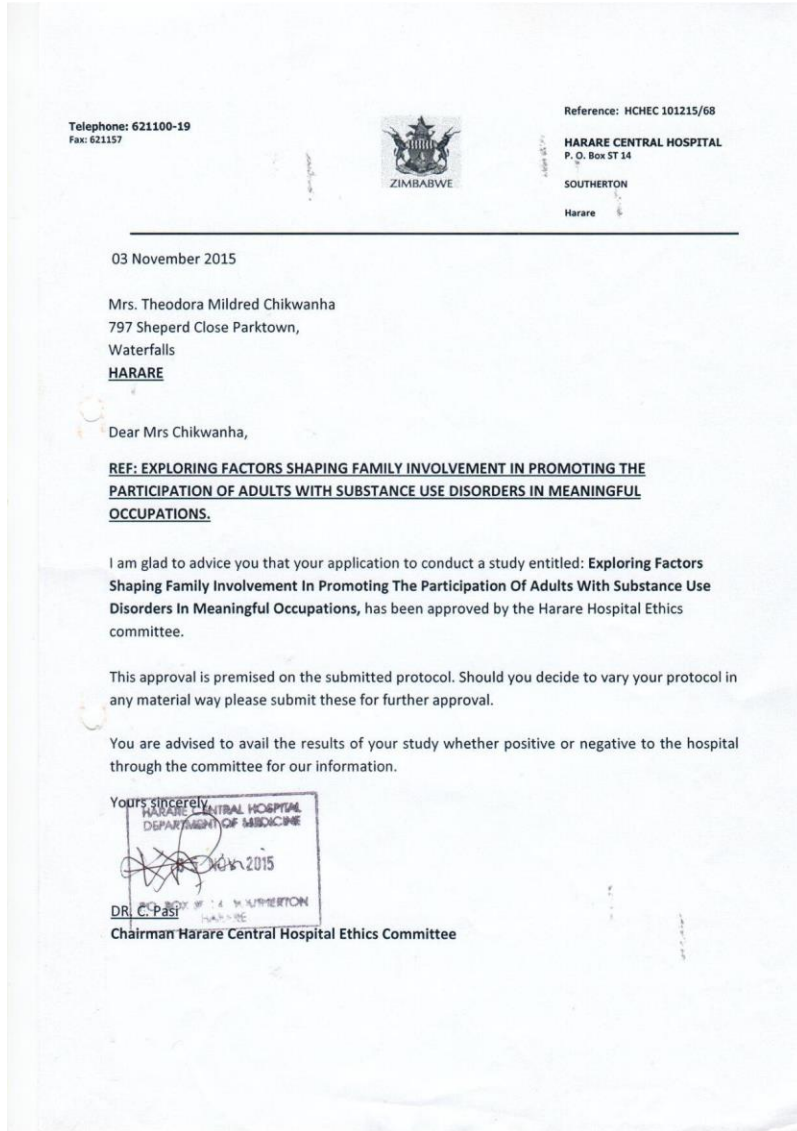


**MRCZ SECRETARIAT
 FOR CHAIRPERSON
 MEDICAL RESEARCH COUNCIL OF ZIMBABWE**





PROMOTING THE ETHICAL CONDUCT OF HEALTH RESEARCH

Appendix 3: Harare Central Hospital approval



Appendix 4: JREC approval

 **FOR THE University of Zimbabwe,
College of Health Sciences and
Parirenyatwa Group of Hospitals** 

Parirenyatwa Group of Hospitals JREC Office No. 4, 5th Floor College of Health Sciences Building
Telephone: +263 4 798140/ 791631 Exts 2241/2242
Email: jrec.office@gmail.com/jrec@medsch.uz.ac.zw, website: www.jrec.uz.ac.zw University of Zimbabwe
College of Health Sciences

APPROVAL LETTER

Date: 25th November 2015 **JREC Ref: 229/15**

Name of Researcher: Mildred Theodora Chikwanha
Address: University of Zimbabwe, Department of Rehabilitation

Re: Exploring Factors Shaping Family Involvement In Promoting The Participation Of Adults With Substance Use Disorders In Meaningful Occupations

Thank you for your application for ethical review of the above mentioned research to the Joint Research Ethics Committee. Please be advised that the Joint Research Ethics Committee has reviewed and approved your application to conduct the above named study. You are still required to obtain MRCZ approval and if required by the nature of your study, RCZ approval as well, before you commence the study.

- **APPROVAL NUMBER** JREC/229/15
- **APPROVAL DATE:** 25th November 2015
- **EXPIRY DATE:** 24th November 2016

This approval is based on the review and approval of the following documents that were submitted to the Joint Ethics Committee:

- a) Completed application form
- b) Full Study Protocol
- c) Informed Consent in English and/or appropriate local language
- d) Data Collection tool.

After this date the study may only continue upon renewal. For purposes of renewal please submit a completed renewal form (obtainable from the JREC office) and the following documents before the expiry date:

- a. A Progress report
- b. A Summary of adverse events.
- c. A DSMB report

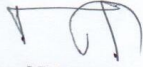
OHRP IRB Number: IORG 00008914
PARIRENYATWA GROUP OF HOSPITALS FWA: 00019350

Prior approval is required before implementing any changes in the protocol including changes in the informed consent.

- **TERMINATION OF STUDY:**

On termination of the study you are required to submit a completed request for termination form and a summary of the research findings/ results.

Yours sincerely,



Professor MM Chidzonga
JREC Chairman

Appendix 5: MRCZ Renewal

Telefax: (263) - 4 - 790715
 E-mail: mrcz@mrcz.org.zw
 Website: <http://www.mrcz.org.zw>



Medical Research Council of Zimbabwe
 Josiah Tongogara / Mazoe Street
 P. O. Box CY 573
 Causeway
 Harare

CONTINUING APPROVAL

REF: MRCZ/A/2028

30 March 2017

Theodora Chikwanha
 University of Zimbabwe
 College of Health Sciences
 P.O Box A 178
 Avondale
 Harare

RE:- Exploring factors shaping family involvement in promoting the participation of adults with substance abuse disorders in meaningful occupations.

Thank you for the application for review of Research Activity that you submitted to the Medical Research Council of Zimbabwe (MRCZ). Please be advised that the Medical Research Council of Zimbabwe has **reviewed** and **approved** your application to conduct the above titled study.

This approval is based on the review and approval of the following documents that were submitted to MRCZ for review:-

- a) MRCZ form 102

• **APPROVAL NUMBER** : MRCZ/A/2028

This number should be used on all correspondence, consent forms and documents as appropriate.

- **TYPE OF MEETING** : Full Board
- **EFFECTIVE APPROVAL DATE** : 08 April 2017
- **EXPIRATION DATE** : 07 April 2018

After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the MRCZ Offices should be submitted three months before the expiration date for continuing review.

- **SERIOUS ADVERSE EVENT REPORTING:** All serious problems having to do with subject safety must be reported to the Institutional Ethical Review Committee (IERC) as well as the MRCZ within 3 working days using standard forms obtainable from the MRCZ Offices or website.
- **MODIFICATIONS:** Prior MRCZ and IERC approval using standard forms obtainable from the MRCZ Offices is required before implementing any changes in the Protocol (including changes in the consent documents).
- **TERMINATION OF STUDY:** On termination of a study, a report has to be submitted to the MRCZ using standard forms obtainable from the MRCZ Offices or website.
- **QUESTIONS:** Please contact the MRCZ on Telephone No. (04) 791792, 791193 or by e-mail on mrcz@mrcz.org.zw

Other

- Please be reminded to send in copies of your research results for our records as well as for Health Research Database.
- You're also encouraged to submit electronic copies of your publications in peer-reviewed journals that may emanate from this study.

Yours Faithfully





**MRCZ SECRETARIAT
 FOR CHAIRPERSON
 MEDICAL RESEARCH COUNCIL OF ZIMBABWE**



PROMOTING THE ETHICAL CONDUCT OF HEALTH RESEARCH

Appendix 6: JREC renewal

 **Joint Research Ethics Committee**
For The University of Zimbabwe,
College of Health Sciences and
Parirenyatwa Group of Hospitals 

Parirenyatwa Group of Hospitals
JREC Office No. 4, 5th Floor College of Health Sciences Building
Telephone: +263 4 798140/ 791631 Exts 2241/2242
Email: jrec.office@gmail.com/jrec@medsch.uz.ac.zw, website: www.jrec.uz.ac.zw
University of Zimbabwe
College of Health Sciences

RENEWAL LETTER

Date: 24th November 2016 **JREC Ref:** 229/15

Name of Researcher: Chikwana Theodora Mildred
Address: University of Zimbabwe, Department of Rehabilitation

RE: EXPLORING FACTORS SHAPING FAMILY INVOLVEMENT IN PROMOTING THE PARTICIPATION OF ADULTS WITH SUBSTANCE USE DISORDERS IN MEANINGFUL OCCUPATIONS.

Thank you for your application for renewal of the authority to carry on your research project. The Joint Research Ethics Committee has granted you renewal to continue conducting the above named study.

- **APPROVAL NUMBER:** JREC/229/15 (Renewal)
- **APPROVAL DATE:** 24th November 2016
- **EXPIRY DATE:** 23rd November 2017

This approval is based on the information you provided on the JREC Annual Review Form dated 21st November 2016 submitted to JREC Office on 21st November 2016.

After the expiry date the study may only continue upon further renewal. Renewal must be processed before the expiry date and the following documents (where applicable) must be submitted:

- a) A completed renewal form (Obtainable from the JREC Office)
- b) A Progress report
- c) A Summary of adverse events.
- d) A DSMB report

OHRP IRB Number: IORG 00008914
PARIRENYATWA GROUP OF HOSPITALS FWA: 00019350

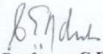
- **MODIFICATIONS:**

Prior approval is required before implementing any changes in the protocol including changes in the informed consent.

- **TERMINATION OF STUDY**

On termination of the study you are required to submit a completed request for termination form and a summary of the research findings/results.

Yours sincerely



Professor C.E. Ndhlovu
Acting JREC Chairman

Appendix 7: Sociodemographic data abstraction form

Institution: Harare [] Parirenyatwa [] Participant number

Hospital number					
Age					
Gender	Male	Female			
Place of residence					
Employment status	Employed	Unemployed	Retired	Self employed	
Marital status	Married	Single	Widowed	Divorced	Cohabiting
Level of Education	Primary	Second	tertiary	None	
Monthly income	<300	300-600	601-900	>900	
Previous admissions	Dg Adm Rx disc	Dg Adm Rx dis	Dg Adm Rx dis	Dg Adm Rx dis	
Date of current admission					
diagnosis					
Other underlying conditions	HIV	Mood Disorders (specify)	Schizophrenia	Other (s	
Smoking	Yes	No	Alcohol intake	Yes	no

Signature of Research Assistant

Appendix 8: Original English interview guide

TITLE: Exploring factors shaping family involvement in promoting the participation of adults with substance use disorders in meaningful occupations

Participant ID:

Venue:

Date of interview:

Introduction

We are conducting this study to explore how families can participate in the rehabilitation endeavors aimed at helping family members recover from substance use disorders. We are also interested in identifying the factors that makes it easy or difficult for families of adults recovering from substance use to help their relative participate in meaningful occupations.

Directed to the whole family

1 Tell me about your family?

Probe

- a) Who is the head?
- b) Is there family history of substance abuse

2. What has been your experience staying with a family member with a substance use disorder?

Probe

- a) How did the problem of substance abuse start?
- b) How has the problem affected his /her occupational patterns as well as those of other family members in your family in any way?

3. Have you tried to assist your relative in any way?

- a) Explain how you have tried to help

4. How can you as a family, contribute towards the rehabilitation process directed at helping your relative recover substance use disorder?

a) What would make it easy or difficult for your family to participate in the rehabilitation programmes?

Directed to the family member with a substance use disorder

5. How has your family tried to help you?

6. Do you feel your family should be included in the in the rehabilitation endeavors aimed at helping you recover from substance use disorder?

7. How would you like your family to help you in the future as you continue on your recovery journey?

Directed to the whole family

8. Do you have anything else you would want us to discuss or any questions you might want to ask?

Thank the client and conclude the interview

Appendix 9: Original Shona interview guide

Mibvunzo yenhaurirano

Tsvakiridzo pamusoro pezvinoita kuti mhuri dzirerukirwe kana kuomerwa nekubatsira hama dzinorwara nechirwere chepfungwa zvichikonzerwa nekushandisa zvinodhaka

Participant ID: -----

Nzvimbo yenhaurirano: -----

Zuva renhaurirano: -----

Nhanganyaya

Tsvakiridzo iyi iri pamusoro pezvinoita kuti mhuri dzirerukirwe kana kuomerwa nekubatsira hama dzinorwara nechirwere chepfungwa zvichikonzerwa nekushandisa zvinodhaka. Tine tarisiro yekuti zvichabuda mutsakiridzo iyi zvichabatsira chikamu chinoongorora zvekushanda kwemitezo nepfungwa cheoccupational therapy kuti chiwane nzira dzekuti mhuri dzikwanise kubatsira hama kupedza dambudziko rekushandisa zvinodhaka

Mibvunzo kumhuri yose

1. Ndiudzeiwo nezvemhuri yenyu?

Mibvunzo yekubatsira

- c) Ndiani musoro wemba mumhuri yenyu?
 - d) Mune mumwe here mumhuri yenyu akamboita dambudziko rekurwara nepfungwa mushure mekushandisa zvinodhaka?
2. Mungatsanangurawo here magagriro amurikuita nehama yenyu ine dambudziko rekurwara nepfungwa zvichikonzerwa nekushandisa zvinodhaka?

Mibvunzo yekubatsira

- a) Dambudziko iri rakatang a sei?
- c) Dambudziko iri rakanganisa sei mabatiro emabasa anotarisirwa kuti hama yenyu kana kuti imi munge muchiita mazuva ose?
3. Makamboedza here kubatsira hama yenyu padambudziko iri?
 - a) nyatsotsanangurai zvamakaedza zvacho?

4 Imi semhiri Mungabatsira sei padambudziko iri?

a) zvii zvingaomesa kana kurerutsa mabatsiro amuchaita hama iyi?

Mubvunzo kune munhu ane dambudziko nezvinodhaka

5. nderupi rubatsiro rwawakawana kubva kumhuri ?

6. ungada kuramba uchiwana rumwe rubatsiro here kubva kumhuri yako?

7. tsanangura mabatsiro aungada kuramba uchiitwa?

Kumhuri yese

8. mune mibvunzo yakanangana nezvatanga tichikurukura here?

Tenda mhuri wopeta hurukuro

Appendix 10: Revised English interview guide

TITLE: Exploring factors shaping family involvement in promoting the participation of adults with substance use disorders in meaningful occupations

Participant ID: -----

Venue: -----

Date of interview: -----

Introduction

This study is being conducted to explore how families can participate in the rehabilitation endeavors aimed at helping family members recover from substance use disorders. It is anticipated that findings from this study will help occupational therapists understand the factors that make it easy or difficult for families of adults recovering from substance use to help their relative during the rehabilitation phase of management of the substance use disorders.

Directed to the head of the family

1 Tell me about your family?

Probe

- e) Who is the head?
- f) Is there family history of substance abuse

Directed to the whole family

2. What has been your experience staying with a family member with a substance use disorder?

Probe

- a) How did the problem of substance abuse start?
 - d) How has the problem affected his /her occupational patterns as well as those of other family members in your family in any way?
3. Have you tried to assist your relative in any way?
- a) Explain
 - b) What would make it easy or difficult for you to help your relative recover

Directed to the family member with a substance use disorder

5. How has your family tried to help you?

Probe

a) What worked

b) What did not work

a) What would make it easy or difficult for your family to continue helping you

Closing remarks

Do you have anything else you would want us to discuss or any questions you might want to ask?

Thank the client and conclude the interview

Appendix 11: Revised Shona interview guide

Mibvunzo yenhaurirano

Tsvakiridzo pamusoro pezvinoita kuti mhuri dzirerukirwe kana kuomerwa nekubatsira hama dzinorwara nechirwere chepfungwa zvichikonzerwa nekushandisa zvinodhaka

Participant ID: -----

Nzvimbo yenhaurirano: -----

Zuva renhaurirano: -----

Nhanganyaya

Tsvakiridzo iyi iri pamusoro pezvinoita kuti mhuri dzirerukirwe kana kuomerwa nekubatsira hama dzinorwara nechirwere chepfungwa zvichikonzerwa nekushandisa zvinodhaka. Tine tarisiro yekuti zvichabuda mutsakiridzo iyi zvichabatsira chikamu chinoongorora zvekushanda kwemitezo nepfungwa cheOccupational therapy kuti chiwane nzira dzekuti mhuri dzikwanise kubatsira hama kupedza dambudziko rekushandisa zvinodhaka.

Mibvunzo kumhuri yose

3. Ndiudzeiwo nezvemhuri yenyu?

Mibvunzo yekubatsira kunyatsonzwisisa

- a) Ndiani musoro wemba mumhuri yenyu?
 - b) Mune mumwe here mumhuri yenyu akamboita dambudziko rekurwara nepfungwa mushure mekushandisa zvinodhaka?
4. Mungatsanangurawo here magagriro amurikuita nehama yenyu ine dambudziko rekurwara nepfungwa zvichikonzerwa nekushandisa zvinodhaka?

Mibvunzo yekubatsira kunyatsonzwisisa

- a) Dambudziko iri rakatang a sei?
 - b) Dambudziko iri rakanganisa sei mabatiro emabasa anotarisirwa kuti hama yenyu kana kuti imi munge muchiita mazuva ose?
3. Makamboedza here kubatsira hama yenyu padambudziko iri?

Mubvunzo wekubatsira

- a) nyatsotsanangurai zvamakaedza zvacho?

4. Imi semhuri mungabatsira sei pakurapwa kwedambudziko rine hama yenyu?

a) Ndezvipi zvingaite kuti rubatsiro rwenyu mukurapwa kwehama yenyu rwureruke kana kuoma?

Mibvunzo kuhama ine dambudziko rekushandisa zvinodhaka

5. Mhuri yenyu yakamboedzawo zvipi kukubatsirai padambudzio ramuinaro?

6. Munofungawo kuti mhuri yenyu inofanira kupinda munezvamunenge manzi muite mukurapwa kwenyu here?

7. Mungade kuti mhuri yenyu ikubatsirei sei?

Mibvunzo kumhuri yose

8. Mune zvimwewo zvamungade kutaura here?

Tendai mhuri mobva mavhara nhaurirano

Appendix 12: English informed consent form

Informed consent for families living with a family member with a substance use disorder

Principal Investigator: Chikwanha Theodora Mildred

Phone number(s): +263 772 212 921

What you should know about this research study:

- We give you this consent so that you may read about the purpose, risks, and benefits of this research study.
- Routine care is based upon the best known treatment and is provided with the main goal of helping the individual patient. The main goal of research studies is to gain knowledge that may help future patients.
- We cannot promise that this research will benefit you. Just like regular care, this research can have side effects that can be serious or minor.
- You have the right to refuse to take part, or agree to take part now and change your mind later.
- Whatever you decide, it will not affect your regular care.
- Please review this consent form carefully. Ask any questions before you make a decision.
- Your participation is voluntary.

My name is Chikwanha Theodora Mildred and I am a lecturer in occupational Therapy in the department of Rehabilitation at the University of Zimbabwe. I am conducting a study on Exploring factors shaping family involvement in promoting the participation of adults with substance use disorders in meaningful occupation. You are being invited to take part in this research study. This study has been approved by the Health Research Ethics Committee at Stellenbosch University, Clinical Directors of Harare and Parirenyatwa Hospitals and by the Medical Research Council of Zimbabwe.

Purpose of the study

The purpose of this study is to find out what makes it easy or difficult for families of adults recovering from substance use related disorders to participate in the occupational therapy intervention programmes for their relatives who are on a recovery journey from substance use disorders. Information obtained from this study will not benefit you now but it will be used to develop family based occupational therapy interventions in the Zimbabwean context. It is anticipated that such interventions will reduce the number of times that individuals are admitted for substance use disorders.

Participant Selection

Participants for this study will be recruited from Parirenyatwa Hospital Annexe and Harare Central Hospital Psychiatric Unit. A total of twenty families living with a family member recovering from substance use disorders will participate in this study. These families have been selected because it is anticipated that their varied experiences of living with family members with substance use disorders will contribute much to our understanding of how easy or difficult it is for family members to be involved in the rehabilitation process of a family member recovering from substance use related disorders.

Procedures involved in the study

Upon accepting to participate in the study, you will be asked to sign an informed consent form. The interview will be approximately one hour long. If you do not wish to answer any of the questions during the interview, you may say so and the interviewer will move on to the next question.

You will be interviewed either in the Occupational Therapy departments at the hospital where your family member is receiving the other treatment services for the substance use disorder or any other place you will feel comfortable narrating your experiences of staying with family members with substance use disorders. You may be asked to participate in follow up interviews in future to ensure that the researcher has interpreted the information accurately and to further explore issues that will be raised in the initial interviews. The entire interview will be tape-recorded, but no-one will be identified by name on the tape. The information recorded is confidential, and no one else except the research team will have access to the information documented during your interview.

Risks and Discomforts

You will be asked to share some very personal experiences of living with an adult family member with a substance use disorder and you may feel uncomfortable talking about some of these experiences. In the event that you do not wish to continue narrating your experiences the interview will be terminated. If you or the researcher feels that you need counseling, a referral will be made appropriately.

Benefits and/ Compensation

There is no remuneration for taking part in this study. However if you decide to have the interview away from your home, all your transport costs will be covered. Refreshments will be served after the interviews.

Voluntary Participation

You may stop participating in the research at any time that you wish and you will not be forced to give an explanation. Your relative will not be denied access to any treatment services that he/she needs to access from the hospital because of your decision not to participate in the study.

Confidentiality

Information recorded from the interviews will be used solely for academic purposes and will not be shared with anyone outside of the research team. The information that we collect from this research project will be kept private and confidential. A numerical unique identifier will be used to identify the recording instead of your names. Only the researchers will know what your number is and will keep this information in a secure location.

Contact Details

If you have any questions, you can ask them now or later. If you wish to ask questions later, you may contact any of the following:

The Researcher: Chikwanha Theodora Mildred

Cell phone number: +263 772 212 921

Address: University of Zimbabwe, College of health sciences
Department of Rehabilitation
Private Bag A178
Avondale, Harare

OR

The Chairperson Joint research Ethics Committee

Office no 4,5th floor College of Health sciences building

Phone: +263 4 708140/791631

AUTHORIZATION

I have understood the purpose of the study and possible risks and benefits of participating in the study. I understand participation is voluntary. I am willing to participate in the study.

I agree to the recording of the interview Yes () No ()

Participant full name (Print): -----

Participant's signature: ----- Date-----

Research's signature: ----- Date-----

Witness' signature: ----- Date-----

Appendix 13: Shona informed consent form

Mukuru wetsvakiridzo: Chikwanha Theodora Mildred

Nhamba dzenharembosha: +263 772 212 921

Zvamunofanira kuziva pamusoro petsvakiridzo ino:

- Tinokupai tsamba ino yekuzivisa kuti muverenge pamusoro pechinangwa chetsvakiridzo ino, zvingagona kukanganisika muri pakati petsvakiridzo uyewo zvamuchawana kubudikidza nekuva mutsvakiridzo ino.
- Rubatsiro rwamunowana rwuri maererano nezvagara zvinozivikanwa pamusoro pemepirwo ezvirwere kana matambudziko amunenge muchisangana nawo. Donzvo guru retsvakiridzo nderekuwedzera ruzivo rwagara rwuripo kuitira kuti tivandudze nzira dzekubatsira nadzo varwere mune ramangwana.
- Hatikwanise kuvimbisa kuti tsvakiridzo ino ichakubatsirai. Sezvinongowanikwawo kana vanhu vachirapwa nenzira dzakasiyana siyana, vamwe vanogona kuzowirwa nematambudziko makuru kana madiki anokzereswa nenzira dzekurapwa dzinenge dzashandiswa.
- Mune kodzero yekuramba kupinda mutsvakiridzo iye zvino, kana kumbobvuma kupinda mozosandura mafungiro moramba pava pamberi.
- Chero zvaminenge masarudza, hazvishandure mabatsirirwo amagara muchiitwa.
- Ndinokumbira kuti munyatsoverenga nekuzwisisa gwaro iri. Sunungukai kubvunza mibvunzo musati maita sarudzo yekuramba kana kubvuma kupinda musarudzo ino.
- Kupinda kwenyu mutsvakiridzo hakumanikidzwe.

Zita rangu ndinonzi Chikwanha Theodora Mildred, ndiri mudzidzisi muchikamu chionoongorora zvekushanda kwemitezo nepfungwa che*Occupational Therapy* PaYunivhesiti yeZimbabwe. Ndirikuita tsvakiridzo pamusoro pezvinoita kuti mhuri dzirerukirwe kana kuomerwa nekubatsira hama dzinorwara nechirwere chepfungwa zvichikonzerwa nekushandisa zvinodhaka. Tsvakiridzo iyi yakabvumirwa nevakuru vekomiti inoongorora tsvakiridzo dzine chekuita nehutano paUnivhesiti yeStellenbosch, vakuru veZvipatara zveHarare neParireyatwa, nevakuru vepaYunivhesiti yeZimbabwe uyezve nekanzuru inoongoorora tsvakiridzo dzine chekuita nehutano hwevanhu muZimbabwe yose.

Chinangwa chetsvakiridzo iyi

Chinangwa chetsvakiridzo iyi, kuti tive nekunzwisisa zvinodiwa kuti mhuri dzirerukirwe nekubatsira hama dzinorwara nechirwere chepfungwa zvichikonzerwa nekushandisa zvinodhaka. Tsvakiridzo iyi inotarisirwa kutipa ruzivo runeudzamu kuchidzidzo che*Occupational Therapy*

uye zvichabatsira kugadzira hwaro rwedzidzo tichitarisa nzira dzekubatsira nadzo varwere vanenge vaakurwara nepamusana pekushandisa zvinodhaka kuti vagobatsirwa kurega tsika yekushandisa zvinodhaka vachiita mamwe mabasa emaoko asingakuvadze hutano hwavo.

Sarudzo yevachave mutsvakiridzo

Vachapinda mutsvakiridzo iyi vachasarudzwa kubva mumhuri dzevarwere vanorapwa chirwere chepfungwa zvichikonzerwa nekushandisa zvinodhaka muzvikamu zvinoongorora nezvehutano hwepfungwa kuzvipatara zveHarare neParirenyatwa. Kuchasarudzwa mhuri makumi maviri. Mhuri idzi dzinokokwa kuti dzipewo ruzivo mutsvakiridzo iyi nekuti takaona kuti ruzivo rwenyu sevanhu vagere nehama dzinorwara nechirwere chepfungwa zvichikonzerwa nekushandisa zvinodhaka runotibatsira chose. Zvamunosangana nazvo mukuchengeta hama dzenyu zvinotibatsira zvakanyanya kuti tive nekunzwisisa pamusoro pezvinoita kuti mhuri dzirerukirwe kana kuomerwa nekubatsira hama dzinorwara nechirwere chepfungwa zvichikonzerwa nekushandisa zvinodhaka.

Nzira Ichashandiswa Pakuita Tsvakiridzo

Mushure mekunge matendera kupinda mutsvakiridzo iyi, muchabvunzwa mibvunzo muchikamu chimwechete. Mibvunzo inotarisirwa kutora pakati pezvidimbu zvitatu zveawa neawa rimwe chete. Kana maona zvakakuomerai kupindura mimwe yemibvunzo yamuchabvunzwa munotenderwa kubuda pachena kuti hamukwanisi kupindura kuitira kuti mubvunzi aenderere mberi. Mhinduro dzamuchapa pamibvunzo yamuchabvunzwa ichachengetwa zvakavandika uye hapana mumwe munhu anotenderwa kuve nemukana wekuona mhinduro dzenyu kunze kwevatsvakiridzi chete. Zvamuchataura muzvikamu zvemibvunzo zvichange zvichitapwa nechivhitivhiti (tape recorder) asi pasina kudomana kwemazita pakutapwa apa uye zvichange zvachengetwa zvakavandika.

Njodzi kana Zvakamanika

Hapana njodzi inofungidzirwa kuti ingakuwirei nekuti maita hurukuro neni. Asi mutsvakiridzo iyi muchave nekubvunzwa uye nekupawo ruzivo rwenyu maerarano nekurarama kwamunoita nehama dzinorwara nechirwere chepfungwa zvichikonzerwa nekushandisa zvinodhaka. Pamwe munogona kuomerwa kana kubatikana zvakanyanya, kukurukura kana kupindura zvimwe zviru muhurukuro yacho, makasununguka kupindura kana kusapindura kana mamanikwa musingape zvikonzero zvinenge zvakutadzisai kupindura. Tikaona muchibatikana zvakanyaya zvekuti mungade rubatsiro tichakuendesai kwamunowana rubatsiro rwakakodzera.

Mubhadharo kana Zviripo

Hapana mubhadharo uripo pakupinda mutsvakiridzo iyi asi kuti kupa ruzivo rwenyu kuchabatsira kuti pave nekunzwisisa kuzere zvinodiwa nemhuri kuti dzikwanise kubatsira hama kusiya tsika yekushandisa zvinodhaka kuti dzigokwanisa kuitawo mamwewo mabasa asingakuvadze utano. Hurukuro yedu inokwanisa kuitirwa kumba kwenyu kana kune imwewo nzvimbo inoita kuti imi musununguke kutaura neni. Kana tisina kuita hurukuro kumba kwenyu, muchapihwa mari yekufambisa kudzokera kumba pamwe nezvenwiwa zvekuti munwe pamunenge muchikurukura nemutsvakiridzi.

Kuve Mutsvakiridzo

Tsvakiridzo iyi haimanikidzwe uye hamutadze kurapwa nokuti maramba kupinda mutsvakiridzo iyi. Munotenderwa kusava mumwe wetsvakiridzo chero panguva yamada uye hamanikidzwi kupa chikonzero.

Zvakavandika

Tinovimbisa kuti hapana kushambadzirwa kwezvamunenge mataura kune vasiri muchikwata chevarikuita tsvakiridzo iyi. Zvese zvichataurwa zvichange zvichizivikanwa nemucherechedzo yechiverengo kwete nemazita enyu. Varidzi vetsvakiridzo ndivo vega vanenge vachiziva chiverengo chako uye zvichawanikwa mutsvakiridzo zvichave zvakachengetwa zvakavandika.

Kwekundiwana

Kana paine mibvunzo, munogona kubvunza iye zvino kana pakufamba kwetsvakiridzo. Kana muchishuwira kuzondibvunza munguva inotevera munogona kuzondibata pakero kana nhamba dzenharembozha dzakapihwa pasi:

Mutsvakiridzi: Chikwanha Theodora Mildred

Nharembozha: +263 772 212 921

Kero : University of Zimbabwe, College of health sciences
Department of Rehabilitation

Private Bag A178

Avondale, Harare

Kana vakuru vangu

The Chairperson Joint research Ethics Committee

Office no 4,5th floor College of Health sciences building

Phone: +263 4 708140/791631

Kupa Mvumo

Ini _____ ndanzwisisa zvinodikanwa kubva kwandiri uye ndawana ndichipindurwa mibvunzo yangu yese. Handisi kunzwa sekunge ndamanikidzwa kupa ruzivo rwangu mutsvakiridzo iyi uye ndirikuuta nekuda kwangu. Ndinoziva kuti ndinogona kungosiya kuve mutsvakiridzo pandinenge ndadira uye kusiya kwangu hakunditadzise kuenderrera mberi nekurapwa.

Ndanzwisisa kuti hurukuro dzetsvakiridzo iyi, dzichange dzichirekodhiwa

Ndinobvuma kurekodhiwa

ndinoramba kurekodhiwa

Siginecha

Abvunzwa

Zuva nenguva

Mutsvakiridzi

Zuva nenguva

Mutsigiri

Zuva nengu