ATTITUDES OF HEALTHCARE PROFESSIONALS TOWARDS SUBSTANCE-DEPENDENT CLIENTS WHO HAVE RELAPSED

By

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Declaration: In accordance with Rule G5.6.3, I hereby declare that the above-mentioned dissertation is my own work and that it has not been submitted for assessment to another university or for another qualification.

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ABSTRACT

Relapse has been identified as a major problem when it comes to substance-dependence. Research focusing on substance-dependence has found that substance users are at risk of relapsing after attending treatment, whether receiving out-patient or in-patient services. Healthcare professionals are seen as playing a crucial role when it comes to assisting substance-dependence clients; hence their attitudes when working with these clients are considered important. This study explored the attitudes of healthcare professionals when it came to working with substance-dependent clients who had relapsed. The study further explored whether the attitudes held by the healthcare professionals affected the treatment interventions or plans implemented. The study adopted the theory of planned behavior as a theoretical framework, and a qualitative research methodology was used. Nine participants (four social workers, one nurse, one drug counsellor, one psychologist and one registered counsellor) made up the research sample. A combination of convenience and purposive sampling techniques was used. Data was transcribed verbatim and analysed using thematic analysis. The findings of the study indicated that healthcare professionals displayed both positive and negatives attitudes when working with substance-dependent clients who had relapsed. The findings of the study showed that although some of the healthcare professionals displayed negative attitudes when clients relapsed, they still believed that their clients could recover and were committed to assisting them. The findings showed that healthcare professionals who worked with substance-dependent clients who had relapsed were influenced by the confidence they had in working with substance-dependence clients, their experiences, the client's attitudes and level of motivation, as well as the client's reasons for relapsing. This study also described the different treatment interventions healthcare professionals implemented when working with relapsed clients. Based on the conclusions made, it is important for healthcare professionals to have the relevant education, knowledge

and experience that is needed to work with substance-dependence and relapse. The importance of healthcare professionals' awareness of their attitudes and how these affect their behavior when working with substance-dependence was noted. It is recommend that similar studies are conducted in provinces or cities that have been identified to have high levels of substance-dependence relapse. Identifying healthcare professionals' attitudes from these regions could result in more knowledge.

TABLE OF CONTENTS

DECLARATION BY CANDIDATE i
ACKNOWLEDGEMENTS ii
ABSTRACT iii
CHAPTER ONE 1
Introduction 1
1.1. Background 1
1.2. Statement of the problem 3
1.3. Purpose of the study 4
1.4. Research questions 4
1.5. Research objectives: 4
1.6. Definition of terms 4
1.7. Procedures 5
1.8. Significance of the study 6
1.9. Limitations of the study 6
1.10. Organisation of the study 7
1.11. Summary of chapter 8
CHAPTER TWO 9
Literature Review 9
2.1. Introduction 9
2.2. Substance-dependence 9
2.3. Substance-dependence relapse 11
2.5. Factors affecting attitudes of healthcare professionals towards substance-dependent clients 20
2.6. Negative attitudes of healthcare workers 23
2.7. Positive attitudes of healthcare professionals 25
2.8. Effects of healthcare professionals attitudes on treatment intervention 26
CHAPTER THREE 31
Theoretical framework 31
3.1. Introduction 31
3.2. Theory of planned behavior background 31
3.3. Determinants of behavior intention 34
3.4. Application of the theory 36
3.5. Criticism and limitations of the theory of planned behavior 38

3.6. Summary of chapter 39

CHAPTER FOUR 40

Methodology 40

4.1. Introduction 40

4.2. Research design 40

4.3. Sampling 41

4.4. Data collection 42

4.5. Research procedure 43

4.6. Data analysis 44

4.7. Strategies ensuring the trustworthiness of this study 46

4.7.1. Credibility 47

4.7.1.1. Negative case analysis 47

4.7.2. Transferability 47

4.7.3. Dependability 48

4.8. Ethical considerations 49

4.8.1. Ethical review 49

4.8.2. Informed consent and confidentiality 49

4.8.3. Respect for persons 50

4.8.4. Beneficence and non-maleficence 51

4.9. Conclusion 51

CHAPTER FIVE 52

Research Findings 52

5.1. Introduction 52

5.2. Description of participants 52

5.3. Themes and sub-themes 53

5.4. THEME 1: Healthcare professionals' attitudes 54

5.4.1. Sub-theme 1A: Positive attitudes 54

5.4.1.1 Non-judgemental attitudes 54

5.4.1.2. Understanding attitudes 58

5.4.1.3. Motivating attitudes and/or supportive attitude 61

5.4.2. Sub-theme 1B: Negative attitudes 63

5.4.2.1. Experiencing relapsed clients as difficult to work with 64

5.4.2.2. Disappointment because of client relapsing 65

5.4.2.3. Labelling of relapsed clients 68

5.5. THEME 2: Factors that influence healthcare professionals' work with substance-dependent clients who had relapsed 71

5.5.1. Sub-theme 2A: Client attitudes and behavior 71

5.5.2. Sub-theme 2B: Reasons for a client's relapse 72

5.5.3. Sub-theme 2C: Healthcare professionals confidence in working with substance-dependent clients 77

5.6. THEME 3: Nature of treatment intervention/ plan implemented............................... 79

5.6.1. Sub-theme 3A: The treatment plans or interventions 79

5.6.2. Sub-theme 3B: Aftercare services.. 83

5.7. Summary of chapter.. 84

CHAPTER SIX **86**

Discussion **86**

6.1. Introduction 86

6.2. Answering the research question.. 86

6.3. Healthcare professionals' attitudes 86

6.3.1. Negative attitudes 88

6.3.2. Positive attitudes 92

6.4. Factors influencing the healthcare professional's intention to work with relapsed clients.. 95

6.4.1. Client's attitudes and behavior 95

6.4.2. Reasons for relapse... 96

6.4.3. Healthcare professional's confidence in working with substance-dependent clients 98

6.5. Treatment interventions or plans implemented 100

6.5.1. Treatment intervention 100

6.5.2. Aftercare services 103

6.6. Summary of chapter.. 105

CHAPTER SEVEN.. **107**

Conclusion and Recommendations.. **107**

7.1. Overview of the study... 107

7.2. Personal reflection of the research process 110

7.3. Strengths and limitations of the study... 111

7.4. Recommendations for future research 111

REFERENCE LIST **113**

LIST OF APPENDICES... **125**

Appendix A: Participant information letter 125

Appendix B: Information letter to gatekeepers... 127

Appendix C: Participant consent form 129

Appendix D: Interview schedule 132
Appendix E: Ethical clearance letter 133

CHAPTER ONE

Introduction

This chapter provides a brief introduction and rationale for the current study. The chapter also includes the research primary aim and the research questions. The research term definitions as well as the study's organisation is also included as part of this chapter.

1.1. Background

Relapse refers to returning to drug use after detoxification and in-patient treatment of at least six to twelve weeks, together with the marked return of behavior associated with substance use (Swanepoel, 2014). Relapse rates have been found to be high both nationally and internationally. According to the statistics in South Africa (Swanepoel, 2014), in 2013, 22% of admissions into treatment centres in SA were re-admissions. The drop-out rates of patients are dependent on whether the facility is in-patient or out-patient, where the facility is located (for example, big city or small town), and the substance that is being used.

Ramlagan, Peltzer and Matseke (2010) indicated that some facilities reported a drop-out rate of 2 to 8% while others had 40% and higher. Higher drop-out rates were recorded at outpatient-based facilities, as substance-dependent clients had a higher chance of being influenced before they had completed their treatment. Key informants stated that relapse rates could be 50% for cannabis, 33% for alcohol and 65% and higher for harder drugs such as cocaine and heroin. The SA statistics that were provided by SACENDU (2008) reported that 24% of the intakes into treatment centres in Gauteng, 22% in Cape Town, 20% in the Northern region, and 32% in Port Elizabeth were not first-time admissions. This led to the conclusion that substance relapse is quite common in South Africa (Swanepoel, 2014).

Addiction programs usually consist of healthcare professionals such as physicians, psychiatrist, nurses, substance-abuse counsellors, social workers and others. These healthcare

professionals often work as an interdisciplinary team to obtain a common goal in providing drug treatment care for substance-dependent clients. The healthcare professionals in these drug-treatment programmes are the first line of staff that clients encounter and continue to interact with throughout their treatment care. According to Rapp, Xu, Carr, Lane, Redko, Wang and Carlson (2007), participation in treatment has been associated with positive outcomes amongst substance abusers. For this to be possible, however, it is necessary for substance-dependent clients to enter treatment in the first place, which becomes a significant problem in many situations. SACENDU (2008) reports from 1998 to 2008 indicated that the overall number of treatment admissions has increased significantly over the past 10 years (Ramlagan et al, 2010).

Substance-dependence is an extremely difficult condition to treat, as clients have to manage their physical and emotional symptoms, the prejudice of society, and still be willing to face their issues and seek help (Birtel, Wood & Kempa, 2017). These reasons can be seen as contributing factors to the high instance of dropout or withdrawal from treatment and subsequent relapse. In drug treatment programmes, the healthcare professionals often develop a particular perspective or view, which can be strengthening or harmful to the client's treatment and care (Gotay, 2014).

Substance-dependent clients are referred to treatment centres or clinics either by their families, friends, financial and legal providers, medical practitioners, and self or workplace referral (Stein, Ellis, Thomas & Meintjie, 2012). However, healthcare professionals are the ones who are crucial in the identification and accessibility to treatment for people with substance-use disorders (Van Boekel, Brouwers, Van Weeghel & Garretsen, 2013). The negative attitudes that healthcare professionals have towards substance-dependent clients may negatively affect healthcare delivery and could result in treatment avoidance or interruption during treatment (Van Boekel et al, 2013). On the other hand, Gotay (2014)

indicated that healthcare professionals displayed positive attitudes owing to the low level of discrimination and a prominent level of acceptance towards their clients. Therefore, as positive attitudes have been shown to have an impact on relapse or recovery, it is important to investigate the attitudes that the healthcare professionals hold towards their clients who have relapsed.

1.2. Statement of the problem

One of the major problems relating to treatment for substance-dependence is the relapse of clients who are attending treatment into hard drug use (Kalula & Nyabadza, 2012). Evidence has indicated that healthcare professionals at times have low regard, less motivation and feelings of dissatisfaction when working with these substance-dependent clients (Van Boekel, Brouwers, Van Weeghel & Garretsen, , 2014).

Substance-dependence relapse is viewed as a significant challenge to treatment and, unfortunately, for a number of clients, relapse is a part of the process of recovery (Garrun, 2011). Research that has been conducted previously seemed to focus on different healthcare professionals attitudes when it came to substance or substance-abusing clients. Healthcare professionals who work with substance-dependent clients commonly deal with the issue of relapse, however, there seems to be a gap in research conducted when it comes to investigating the attitudes that healthcare professionals hold when it comes to working with substance-dependent clients who have relapsed. The negative attitudes that healthcare professionals hold may lead to an increase of drop-out or relapse during treatment interventions (Cornfield, 2018). Therefore, it is seen as important for healthcare professionals to maintain a warm, non-judgemental relationship after a client has relapsed to create the necessary environment for the cycle of change to start again (Hitzeroth & Kramer, 2010).

1.3. Purpose of the study

The purpose of the study was to explore and describe the attitudes that healthcare professionals had towards substance-dependent clients who had relapsed. The study also explored and described how the attitudes that healthcare professionals hold could influence the treatment plan or interventions that were utilised or implemented.

1.4. Research questions

In this study, the following research questions were addressed:

1. What are the attitudes that healthcare professionals have towards substance-dependent clients who have relapsed?
2. In what manner do the attitudes that healthcare professionals have affect the treatment plan or intervention used?

1.5. Research objectives:

The objectives of the study are as follows:

1. To explore and describe the attitudes that healthcare professionals have towards substance-dependent clients who had relapsed.
2. To explore and describe how the attitudes of healthcare professionals towards substance-dependent clients who have relapses influence the treatment plans or interventions that are utilised.

1.6. Definition of terms

Attitudes: An attitude can be defined as a psychological tendency to view a particular object or behavior with a degree of favor or disfavor (Albarracin, Johnson, Zanna & Kumkale, 2005).

Healthcare professionals: In terms of the National Health Act, both healthcare providers and healthcare workers are the healthcare team that provide clinical services for

users or patients, and the administrative staff who support these services. The Act includes healthcare practitioners under the term "healthcare providers" (HPCSA, 2016). For the purpose of this research study, the term healthcare professionals refer to psychologists, nurses, counsellors and social workers.

Relapse: Relapse refers to the return of drug use, after detoxification and in-patient treatment for at least six to twelve weeks, together with the marked return of behaviors associated with drug use (Swanepoel, 2014).

Substance-dependence: This refers to when an individual compulsively and repetitively consumes an illicit drug despite problems related to the consumption of that drug, possible tolerance to the effects of the drug, and possible withdrawal symptoms should the drug be reduced or stopped altogether (American Psychiatric Association, 2000).

1.7. Procedures

Participants that were working or had worked with substance-dependent clients were deemed suitable for this research study. The study consisted of nine participants that worked at in-patient rehabilitation centres, private practice, private hospital as well as an outpatient after care. The sample was made up of four social workers, an auxiliary social worker, a nurse, a drug counsellor, a registered counsellor and a clinical psychologist.

Once the final approval was granted by the FPGSC and REC-H, the researcher started conducting the research. The researcher made contact with the potential participants, and a mutually agreed upon date and time was set for the interviews. Semi-structured individual, face-to-face interviews and a telephonic interview were conducted. The interviews were recorded using an audio-recorder, and transcribed by the researcher. Data saturation was reached once the researcher realised that no new information was emerging from the interviews.

An interview schedule (see Appendix D) was utilised as a tool for collecting data. Open-ended questions were prepared beforehand for the researcher to guide the interview, and additional questions were asked during the interviews.

1.8. Significance of the study

Owing to healthcare professionals being the first staff that clients who had relapsed encountered and continued to interact with throughout their treatment care, the understanding of the dynamics of healthcare professionals' interaction with substance-dependent clients played a crucial role in raising awareness of the healthcare professionals' shortcomings or excellence of care. The investigation of the healthcare professional's attitudes when it came to working with clients who had relapsed played a crucial role in ensuring that clients were treated appropriately when they had accessed treatment.

The attitudes that healthcare professionals hold might influence their behavior towards relapsed clients, and this might promote or prevent substance-dependent clients from returning to treatment. The data collected from the study would contribute further to the body of knowledge that focused on healthcare professionals' attitudes and substance-dependence relapse, as well as other factors that influenced healthcare professionals' behavior. This information could be utilised to inform the training of healthcare professionals.

1.9. Limitations of the study

The researcher had difficulty in scheduling appointments with participants. The participants that were deemed suitable for the research were a population that was found to be unavailable most of the time and this made it difficult to establish times and dates that were suitable to conduct interviews. SACENDU (2008) also identified Cape Town, Gauteng and the Northern region as having relapse rates that were concerning. Therefore, it was suggested that it would be preferable to conduct similar studies in these areas.

1.10. Organisation of the study

The study is discussed in seven chapters, namely:

- **Chapter One: Introduction**

  This chapter provides a brief introduction and rationale for the current study. The chapter also includes the research primary aim and the research questions. The research term definitions as well as the study's organisation is also included as part of this chapter.

- **Chapter Two: Literature review**

  This chapter reviews literature that investigates substance-dependence as well as substance-dependence relapse. This chapter investigates the role of healthcare workers when it comes to working with substance-dependent clients, and also explores the factors that affect the attitudes of healthcare professionals when it comes to working with substance-dependent clients. This chapter further discusses the negative and positive attitudes of healthcare professionals and how these attitudes influence or affect the treatment interventions implemented by the healthcare professionals.

- **Chapter Three: Theoretical framework**

  This chapter provides information on the theoretical framework that was utilised in this study. The chapter discusses the theory of planned behavior as it related to this research study.

- **Chapter Four: Methodology**

  In this chapter, the researcher outlines the research design of the study. This chapter explains the sampling technique, sampling characteristics, data collection and data analysis. The chapter further details the qualitative techniques applied throughout the research process. The chapter also explores issues of qualitative research credibility and

transferability that ensured the trustworthiness of the study. Lastly, the ethical considerations taken into account during the research process are discussed.

- **Chapter Five: Results**

This chapter describes the results of this study. This chapter presents the dominant themes identified as having an influence on the behavior of healthcare professionals as well as the attitudes of those healthcare professionals. The chapter is divided into sections, and in each section, the researcher discusses each theme and its sub-theme, and attempts to demonstrate links in the summations in each theme.

- **Chapter Six: Discussion**

  In this chapter, the researcher discusses the findings through the lens of the theory of planned behavior, and provides existing literature that supports the findings of the study.

- **Chapter Seven: Conclusion and recommendations**

  This chapter summarises the methodology utilised in the study, the conclusion that is drawn from the summary, the limitation of the study and implications of the conclusions for future research. This chapter also makes recommendations and suggestions for future research.

1.11. Summary of chapter

The current chapter provided a brief introduction and rationale for this study as well as the primary aim and research questions. The chapter included the definition of the research terms as well as the study's organisation. In Chapter Two, the literature that is relevant to the current study is reviewed.

CHAPTER TWO

Literature Review

2.1. Introduction

This chapter commences with reviewing literature that investigates the challenge of substance-dependence as well as the issue of substance-dependence relapse. It then proceeds to explore the role played by healthcare professional when it comes to working with substance-dependent clients. Before discussing the literature on the attitudes of healthcare professionals when working with substance-dependent clients, this chapter explores factors that influence healthcare professionals' attitudes when they are working with this population. The chapter then discusses the negative and positive attitudes that healthcare professionals have when it comes to working with substance-dependent clients. Lastly, the chapter explores the influence of the attitudes held by healthcare professionals on the treatment intervention or plan that they utilised or implemented when working with clients who were substance-dependent.

2.2. Substance-dependence

Substance abuse and substance-dependence are seen as national problems (Smith, 2007). This is a serious global health issue, which is associated with a number of negative personal and societal consequences. Substance-dependent clients suffer numerous deleterious effects, both physically and psychologically, while society suffers from increased crime and a strain associated with public funds (Cornfield, 2018).

South Africa has been highlighted as having social pathology problems that need attention (Ramlagan et al, 2010). The World Mental Health Survey, which included the first nationally-representative epidemiological data on common mental disorders in Africa, supported this view by indicating that South Africa has one of the highest lifetime prevalence

of substance use disorder across the globe (Ellis, Bernichon, Yu, Roberts & Herrell, 2004). This rise in substance-dependence has been associated with increased severity of a range of negative outcomes, both globally and locally. These negative outcomes include other medical and psychiatric disorders, including risky sexual behavior and sexually-transmitted diseases, crime and violence, family dysfunction, and various "accidents", including motor vehicles collisions (Stein et al, 2012).

There has been a growing demand for effective, affordable and accessible substance-dependence treatment, however, structural and attitudinal barriers have been identified as barriers that hamper access to treatment services in South Africa (Myers & Parry, 2005; Stein et al, 2012). The structural barriers include the relative lack of funding for mental health clinicians and the relative lack of accessible facilities for the treatment of substance use disorders. Underlying these barriers are likely to be attitudinal barriers on the part of policy-makers, patients and even clinicians (Stein et al, 2012). Stigma and negative beliefs about treatment were also identified as barriers to treatment use (Myers, Fakier & Louw, 2009).

Perceived stigma such as pessimism towards substance users has been identified as a significant barrier to treatment use, with clients who need help tending to deny or hide that they are substance-dependent owing to fear of being negatively labelled (Myers et al, 2009; Verissimo & Grella, 2017). There is growing evidence that supports the concept that substance-dependence and substance-use disorder are medical disorders, however, these conditions continue to be highly-stigmatised and often fall within the purview of the Department of Social Welfare, rather than Department of Health (Stein et al, 2012).

Substance-dependence and substance-dependent clients often stir up complex responses in society. Stigma, rejection and punitive responses to substance-dependent clients are seen as being common. Substance-dependent clients are perceived as being "weak",

"lacking self-control" and also "mad" (Myers et al, 2009). The views of people on substance-dependence often result in those who are substance-dependent feeling rejected and isolated. This negative view of substance-dependent clients and the lack of treatment seeking by those who are substance-dependent make it difficult for them to recover and be integrated into the community successfully (Au, 2006). The lack of awareness and understanding of substance-dependence has resulted in many substance-dependent individuals remaining undetected and untreated (Au, 2006).

Healthcare professionals are also members of the public and they are likely to be exposed to biased and uninformed beliefs and attitudes, which they assimilate from the larger society (Au, 2006). With the prevalence of substance use disorder in South Africa, its associated morbidity, under-diagnosis and treatment, it is important to therefore focus on the factors that cause these adverse effects (Stein et al, 2012). It is, therefore, important to investigate the attitudes that healthcare professionals have towards substance-dependent clients, because their attitudes could potentially have a negative or positive influence on their work with these clients.

2.3. Substance-dependence relapse

Substance abuse is commonly thought of as a "chronically relapsing condition", with both youth and adults returning to substance abuse at high rates after treatment. Studies estimate that between two-thirds and four-fifths of both adults and adolescents begin using again in the six months after an episode of community- or hospital-based drug and alcohol treatment (Ramo & Brown, 2008). Although the way clients respond to treatment for substance-dependence issues vary, numerous relapse episodes are common among clients who are treated for substance-dependence and are normal to recovery (Panebianco, Gallupe, Carrington & Colozzi, 2015). The South African Community Epidemiology Network on Drug Use (SACENDU, 2008) indicated that 24% of the intakes into treatment centres in

Gauteng, 22% in Cape Town, 20% in Northern Region and 32% in Port Elizabeth were not first-time admissions.

The problem of relapse is undoubtedly one of the most critical challenges facing the field of addictions (Swanepoel, 2014). One of the major problems that have been identified relating to treatment for substance-dependence is the relapse of those under treatment into hard drug use (Kalula & Nyabadza, 2012; Swanepoel, 2014). It has been acknowledged by clinicians and researchers that substance abuse and dependence are chronic disorders that affect treatment and abstinence efforts.

Although there seems to be significant reduction in substance use following treatment, these improvements are often difficult to maintain (Appiah, Danquah, Nyarko, Ofori-Atta & Aziato, 2017). The prognosis over a long period has been seen as not being optimistic, as approximately two-thirds of individuals who have successfully completed treatment programmes for substance-dependence relapse within three months after treatment (Galizio & Maisto, 2013). Research conducted on the short-term effectiveness of treatments for substance abuse suggests that most clients may expect immediate improvement of the problem upon entering a formal treatment program (Galizio & Maisto, 2013). This may be due to the clients expecting to be “fixed” by healthcare professionals. Tang, Wiste, Mao and Hou (2005) argue that substance-dependent clients should also take responsibility for their own behaviors and learn from their faults.

Relapse is seen as the process of becoming dysfunctional in sobriety that leads to renewed alcohol or other drug use, physical or emotional collapse, or even suicide. The relapse process is marked by predictable and identifiable warning signs that begin long before substance use or failure occur (Lewis, Dana & Blevins, 2014). Relapse is considered an integral part of the addictive disease process, and should be seen as a learning opportunity

that can inform the process of change once the client returns to treatment (Hitzeroth & Kramer, 2010). Susbtance-dependence is a double-edged sword with two cutting edges, namely, substance-based symptoms that manifest themselves during active episodes of substance use and sobriety-based symptoms that emerge during periods of abstinence. The sobriety-based symptoms create a tendency towards relapse that is part of the disease itself (Swanepoel, 2014).

When researching the internal and external states preceding relapse, both adults and adolescents were identified as having a combination of internal and external precursors to relapse rather than just one prominent situation that precipitated their relapse. These states include emotional stress and the inability to cope with urges or temptation to use (Ramo & Brown, 2008). Extremely positive and negative emotional experiences are indicated as being high risk in maintaining abstinence among former substance-dependent clients. Emotional responses to these experiences include frustration, anger, anxiety, depression and boredom (Appiah et al, 2017; Chetty, 2011). Unhealthy interpersonal relationships and repellent attitudes including hostility, feeling overwhelmed by intense negative and positive emotions, exposure to traumatic experiences such as loss might also lead to an individual returning to using substances (Appiah et al, 2017). The factors identified were probably previously dealt with through the use of substances (Chetty, 2011).

Ellis et al (2004) indicated that relationships with family members, friends and partners or significant others may play an important part on the likelihood of relapse after treatment. The lack of family support is also seen as a major factor that contributes to substance-dependence clients relapsing (Chetty, 2011). This led to healthcare professionals regarding family involvement as integral to the treatment of substance-dependence (Akinola, 2015). Johnsen and Herringer (1993) found that having families participate in treatment

programmes in combination with regular Alcoholics Anonymous (AA) meetings and aftercare support programmes contributed to greater abstinence (Ellis et al, 2004).

The harmful effect of friends who are still using substances on post-treatment abstinence has been stated by many (Grant, Colaiaco, Motala, Shanman, Booth, Sorbero & Hempel, 2017; Appiah et al, 2017). Research has indicated that relapse was also determined by the negative influence of the client's substance-dependent friends with whom the client was still in contact. Changing the social network by the client including severing ties with heavy users but maintaining or re-establishing ties with family members, predicted better treatment outcomes (Ellis et al, 2004).

Healthcare professionals providing relapse prevention therapy aim at helping the client to identify situations that trigger relapse, and also learn cognitive and behavioral skills to cope with these situations (Grant, et al, 2017). The identification of factors that lead to the substance-dependent clients relapsing is, therefore, deemed important. Alcohol cravings, duration of client's dependence to substances, co-morbid diagnosis (such anxiety or depression) of clients were noted to be possible causes of alcohol relapse (Korlakunta, Chary & Reddy, 2012).

It is clear that among substance-dependent clients, multiple personal and environmental factors influence each relapse. This suggests that relapse prevention portions of substance-abuse treatment programmes should target numerous relapse causes rather than just one primary cause. Additionally, particular attention should be paid to urges as an antecedent among adult users regardless of emotional state or social situation, whereas adolescents might need different relapse prevention support depending on the emotional state that occurs most often, for example, negative versus positive (Ramo & Brown, 2008).

Traditional relapse prevention is based on the theory that certain interactions between the individual and environment, for example, social influences, greater access to substances, along with the inability of the client to cope with craving caused by these interactions, can increase the risk of relapse. Since negative thinking and guilt are factors that have also been associated with relapse, the importance of teaching psychological defence mechanisms is also emphasised (Grant et al, 2017). Research that focuses on precipitants of relapse and its prevention signifies continuing efforts at preventing or reducing relapses (Appiah et al, 2017).

2.4. Healthcare professionals' role in working with substance-dependent clients

The development of comprehensive, effective and sustainable strategies for the prevention and management of substance-dependence requires a multi-sectoral approach, which should involve healthcare professionals, policymakers, psychiatrists and researchers. The array of possible interventions include primary prevention (to ensure that substance abuse does not develop), secondary intervention (involving early identification and effective treatment to prevent escalation) and tertiary intervention (to reduce substance-related harm) (Kalula & Nyabadza, 2012).

Healthcare professionals from both the medical and nursing team have been shown to be knowledgeable when it comes to problematic alcohol consumption. This granted a high level of importance to the identification and treatment of problem drinkers in the primary-care setting (Coloma-Carmona, Carballo & Tirado-Gonzalez, 2017). Primary healthcare professionals are particularly well placed to intervene in excessive drinking owing to the large proportions of the population who access them (Lock, Kaner, Lamont & Bond, 2002).

The ultimate goal of all substance abuse treatment is to enable the susbtance-dependent client to achieve lasting abstinence. Treatment can be distinguished from one

along three broad dimensions, namely, structure, behavioral content and phamarcotherapy (Piasecki, 2006). Treatment structure refers to the manner in which treatments are delivered, including variables such as the number of sessions, their timing, the provider selected to deliver the treatment, the total amount of treatment time and the counselling format (Piasecki, 2006). Service quality and effectiveness varies considerably from service provider to service provider (Myers et al, 2009).

Commonly-used treatment programmes are multi-fold and include outpatient drug-free treatment programmes, which do not include medication, but a variety of strategies such as individual or group counselling (Kasiram & Jeewa, 2008). Positive social support was found to account for clients' confidence that they would not return to substances when facing difficult situations (Schmitt, 2003), and the durations of abstinence was associated with this support (Dennis, Foss & Scott, 2007). Healthcare professionals, therefore, often involved families and significant others as part of the treatment process.

The Matrix treatment programme (Obert, McCann, Marinelli-Casey, Weiner, Minsky, Brethen & Rawson, 2000), which is a Cognitive Behavioral treatment is another intervention used by healthcare professionals working with susbtance-dependence. This programme consists of relapse prevention groups, education groups, social support groups, individual counselling as well as urine and breath-testing delivered in a structured manner over a 16-week period. The treatment focuses on current issues that the client deals with and behavior change (Obert et al, 2000).

There are also a number of self-help programmes, such as a form of aftercare, to assist clients to deal with substance-dependent issues. These are Narcotics Anonymous (NA), a self-help organisation for drug abusers, which is an offshoot of Alcoholics Anonymous (AA), using a group meeting format, group intervention and the 12-Step Programme (Kasiram & Jeewa, 2008). Other aftercare resources including abstinence support groups can provide

social support and help to prevent clients from relapsing. The social support provided by regular AA attendance, regular participation in aftercare, and participation in other support groups has been significantly related to greater abstinence (Ellis et al, 2004).

Crossen-White and Galvin (2002) identified the relevance of aftercare to the recovery process, which was needed to offer wide-ranging support to drug-dependent clients in recovery, such as help with accommodation, learning basic life skills and constructing a new lifestyle without substances. Extended treatment resulted in additional contacts, which also provided opportunities for delivering more of the "active ingredients" of behavioral treatments, such as educational information, coping skills training, and nonspecific factors such as empathy (Piasecki, 2006).

There seems to be a growing recognition for the need to develop health professionals' skills and knowledge to allow them to deliver effective care for substance-dependent clients. Attitudes, however, are also important as they have an impact on the extent to which knowledge is recognised and used (Watson, Maclaren & Kerr, 2006).

Kiepek (2012) indicated that interactions between health professionals and clients are social situations where there is an imbalance regarding whose voice is attributed authority and in the potential power to distribute or withhold social goods. Having a better understanding of the dynamics of professional interaction with substance-dependent clients plays a crucial role in raising awareness of healthcare professionals' inadequacies (Bota, 2006). Studies which have considered the role of therapeutic attitude in the willingness of professionals to interact with substance-using clients have found this to be an essential predictor of effective engagement with such individuals (Watson et al, 2006; Lock et al, 2002; Gilchrist, Moskalewics, Slezakova, Okruhlica, Torrens, Vajd & Baldackhino, 2011; Van Boekel et al, 2013).

In treatment facilities, substance-dependent clients interact directly with healthcare professionals (da Silveira, Soares, Gomide, Ferreira, Casela, Martins & Ronzani, 2015). The interactions between healthcare professional and substance-dependent clients are crucial to a treatment's success, with positive first encounters being key for the client. A positive experience, where the client feels understood and not judged, could make the client much more likely to pursue treatment, while a negative experience;, where the client feels stigmatised, could deter the client from asking for further help (Cornfield, 2018). Healthcare professionals are recommended by substance-dependent clients to offer empathy and sensitivity, which is a reflection of the need for a healing environment that promotes trust, rapport and safety (Smith, 2007).

A study conducted by Salamina, Diecidue, Vigna-Taglianti, Jarre, Schifano, Bargagli Davoli, Amato, Perrucci, Fabriazio & VEde TTE Study Group (2010) discovered that the presence of psychotherapy in substance-dependent clients' treatment programme halved their risk of dropout. This suggested that counsellors and psychotherapists are likely to provide a unique ingredient in their substance-dependence treatment that help keep clients engaged and increase their chances of obtaining positive therapeutic outcomes (Cornfield, 2018).

Although general practitioners have been recognised as suitable to treat patients with substance misuse problems, Greenwood (1992 in Au, 2006) reported that general practitioners might have difficulties in establishing rapport with substance-dependent clients. The reasons for this include fear of criticism for irresponsible prescribing and concern that substance-dependent clients will put off their other patients. Emergency rooms (ERs) are well-known to be highly-involved with substance-dependent clients, and there has been significant progress in getting emergency room physicians and nurses to perform screening and brief interventions with alcohol and drug-involved individuals (Au, 2006).

International studies that have investigated healthcare professionals' attitudes toward substance use and substance users have focused on those working in mental health services (Dean & Soar, 2005; Howard & Holmshaw, 2010). The nature and focus of care in these services is perceived to be congruent with addressing issues surrounding dependence and addiction. However, much of the studies found that healthcare professionals' attitudes were predominantly suboptimal. In contrast, a sample of emergency department doctors and nurses demonstrated near optimal attitudes for effective working with substance-using patients, except for permissiveness. This may reflect a moral conservatism toward drug users in Ireland (Kelleher & Cotter, 2009).

Fear of being stigmatised by healthcare professionals seems to be a barrier to substance-dependent clients seeking treatment, despite changes in societal attitudes towards substance use, substance-dependent clients continue being stigmatised (Cornfield, 2018). Substance-dependent clients described treatment facilities as being "prison-like" and the healthcare professionals working there as being rude (Meade, Towe, Watt, Lion, Myers, Skinner, Kimani & Pieterse, 2015). If substance-dependent clients are subjected to greater stigma by society as a whole and possibly are subjected to lower standards of health care as well, then oppression is at work and should be recognised by healthcare professionals (Lewis et al, 2014).

Research has supported the notion that clinicians, to develop positive therapeutic attitudes and sufficient empathic capacity for working with substance-dependent clients, should explore and question biases that inform their attitudes towards this population (Cornfield, 2018). Without doing so, negative attitudes and biases could result in the development of stigma, a major barrier to treatment seeking and success.

2.5. Factors affecting attitudes of healthcare professionals towards substance-dependent clients

Attitudes are complex psychological constructs, and their development is an even more complex process involving the interaction of many interrelated factors. This section discusses the factors that have been previously-explored as possibly being related to attitudes towards substance-dependent clients (Cornfield, 2018).

Au (2006) reported that factors influencing the under-diagnosis of substance-dependence might emerge from personal or societal biases, deficient medical education about addiction, and false perception of inadequate response to interventions. These factors might not only influence the diagnosis of substance-dependence but the attitudes that healthcare professionals hold when it comes to working with substance-dependent clients.

According to Van Boekel et al (2014), several factors might contribute to low regard among healthcare professionals for working with substance-dependent clients. Peckover and Childlaw (2007) indicate that the lack of knowledge by nurses led them to feeling threatened when working with substance-dependent clients. Substance-dependence specialised clinics, however, have been found to being more conducive to the development and maintenance of healthcare professionals' positive attitudes (Cornfield, 2018). Healthcare professionals specialising in substance-dependence demonstrated higher regard for working with clients with substance-dependence compared to professionals working in general psychiatry and primary care (Van Boekel et al, 2014).

Frequent contacts with substance-dependent clients, familiarity of working with substance-dependent clients and confidence in substance-abuse treatment were positively associated with working with substance-dependent clients (Van Boekel et al, 2014; Cornfield, 2018). The high regard of healthcare professionals specialising in substance-dependence might be a result of their familiarity in working with this population (Van Boekel et al, 2014).

Receiving training in aspects of working with substance-dependent clients who have experienced co-occurring mental health problems and illicit substance-dependence resulted in healthcare professionals having positive attitudes towards clients (Howard & Holmshaw, 2010). Education or training and role support were also identified as important evidence-based strategies that assisted in the development of positive attitudes (Skinner, Roche, Freeman & Mckinnon, 2009; Van Boekel et al, 2014). Increasing education among specially-trained mental healthcare professionals correlated with an increased therapeutic commitment, more positive attitude, and intent to engage the client dependent on substances (Nilsen, Stone & Burleson, 2013). Training of healthcare professionals was found to be beneficial in working with substance-dependent clients (Kalebka, Bruijns & Van Hoving, 2013), and this was identified to lead to a better understanding of substance-dependence, which also equipped practitioners to handle clients better (Rawat, nd)

It was demonstrated in a study that healthcare professionals who had received training, held fewer negative attitudes towards substance-dependent clients regardless of their length of clinical work experience or type of work settings (Howard & Holmshaw, 2010). Nilsen et al (2013) indicated that there was no significant association between years of experience in medical-surgical nursing and overall therapeutic commitment towards the substance-dependent client. On the contrary, Van Boekel et al (2014) indicated that healthcare professionals with fewer years of work experience showed more positive attitudes towards substance-dependence clients compared to more experienced healthcare professionals.

A change to more positive attitudes and development of skills to enable working with alcohol and alcoholism-related issues were associated with knowledge offered as part of the nursing education or programs. Personal use of substances by the healthcare professional generally was also found to be associated with more tolerant and permissive attitudes towards

substance-dependence. This was similar to Bota (2006) who indicated that healthcare professionals who had a personal history of substance-dependence had a positive attitude towards other substance-dependent clients. Van Boekel et al (2014) reported that personal drinking habits of healthcare professionals also appeared to be related to positive attitudes toward clients who were substance-dependent.

Feelings of anger towards substance-dependent clients, perceived violence, mistrust towards client manipulation, and poor motivation were identified as hindering factors in the healthcare professionals' healthcare delivery for substance-dependent clients (Van Boekel et al, 2014; Gotay, 2014). Perceptions of controllability of substance use also seemed to play a critical role in the formation of negative attitudes towards substance-dependent clients (Brener, Hippel, Kippax & Preacher, 2010). Attributing the responsibility for substance-dependence problems to the client was associated with decreased regard for working with clients who were dependent on substances (Van Boekel et al, 2014).

The combination of the limited time the physician spent with a client during the substance treatment and feelings of helpless when it came to the treatment intervention were noted to contribute to the negative attitudes from physicians (Bota, 2006). The learned "feeling of helplessness" may trigger a "blame" placed on the substance-dependent client because of his or her continuous misuse of the resources, such as, emergency departments owing to relapses leading to overdose and referred by law enforcement. This may lead to judgement by the physician towards the user, and he or she is looked at as an individual with a "character flaw" (Gotay, 2014).

Healthcare professional's level of competence and knowledge when working with substance-dependent clients was found to be enhanced by training (Kelleher & Cotter, 2009). As a result, undergoing training helped achieve a certain level of confidence in working with substance-dependence clients (Peltzer, 2009).

2.6. Negative attitudes of healthcare workers

Over time, several studies have confirmed stigmatising attitudes of healthcare professionals towards people with dependency issues (Lovi & Barr, 2009). A study that was conducted by Lovi and Barr (2009) confirmed that through the lived experience of registered nurses working in an AOD dependency unit, the inappropriate judgements of this population were prevalent. These inappropriate judgements manifested themselves through negative and stigmatising attitudes of general registered nurses, their lack of understanding, and knowledge of what healthcare is required for this population and their reluctance to be reassigned to this unit temporarily. In addition, social values may influence these attitudes of nurses towards alcoholics. This finding is supported by studies, which reported that nurses tended to take a contrary position with alcoholic patients. An exploratory survey revealed that 43% of emergency nurses in Alberta disliked caring for alcoholic patients (Chung, Chan, Yeung, Wan & Ho, 2003).

Googins (1984) as cited by Soto and Stuart (2014) suggested that the attitudes of clinicians, which include social workers, closely mirror that of the general public who believe that alcoholics have a moral deficiency. This belief in moral deficiency leads to the assumption that substance-dependence cannot be treated. Alcohol and substance-dependent clients were sometimes viewed as being difficult to diagnose, and because of tolerance and dependence, often problematic to manage and treat (Lindberg, Vergara, Wild-Wesley & Gruman, 2006).

Healthcare professionals demonstrated negative attitudes towards substance-dependent users when compared to clients or patients suffering from other ailments, such as physical disabilities, mental disabilities and intellectual disabilities (Cornfield, 2018). In addition, it was also found that, out of all patients groups, healthcare professionals had the least desire to work with, and the most negative attitudes towards, substance-dependent

clients (Cornfield, 2018). The negative attitudes of healthcare professionals led to the display of low treatment optimism (indicating negative experience and low morale in treating substance abusers) and treatment interventions.

Emotional reactions, anger and feelings of fear and sadness was shown to play a major role in attitudes (Corrigan, 2000). These reactions were explained by the involvement in the personal setting and emotional involvement in working with substance-dependent clients. These reactions were suggested to lead to healthcare professionals having lowered regard, less motivation and feelings of dissatisfaction when working with this patient group. This was sometimes explained by the perception of healthcare professionals that these patients were potentially violent, manipulative, or poorly motivated, which might cause feelings of frustration, resentment and powerlessness among the professionals.

Soto and Stuart (2014) stated that the beliefs that have been commonly known amongst social workers include that substance-dependent are homeless, live in poverty, are unemployed, lack morals, and have been referred by the criminal justice system. Social workers' negative attitudes include the idea that treatment will not be effective because of a likelihood of relapse.

A study on district nurses by Peckover and Chidlaw (2007) provided some insight into how these negative attitudes towards substance users are manifested. In this study, it was noted that participants used individual and personal terms when describing all patient groups except the substance-using groups. This suggested that the nurses had less humanistic attitudes toward the substance-using population as well as a diminished capacity to empathise with this patient group (Cornfield, 2018).

Several explanations for the negative attitudes of health professionals towards patients with substance-use disorders have been identified. According to a study conducted by Van Boekel et al (2013), nurses described the care for patients who use illicit drugs as

emotionally-challenging and potentially-unsafe. Barriers in the care provided to these patients were violence, manipulation and irresponsibility. This was supported by Ford (2011) who stated that nurses reported that patients' manipulative behavior, in relation to medication and treatment regimes, impeded their ability to provide nursing care to these clients. This resulted in the nurses being cautious when working with their patients, and this affected trust in the therapeutic relationship.

2.7. Positive attitudes of healthcare professionals

Healthcare professionals' confidence in the success of the treatment of substance-use disorder is also expected to influence their attitude. Previous studies have indicated that endorsement of substance-use disorder as a disease generally shows more positive attitudes (Van Boekel et al, 2014). Wild, Cameron, Newton-Taylor, Ogborne, Mann, Erickson and MacDonald (2001) discovered that positive attitudes from health professionals were due to the belief that drug problems were caused by a pathological reason and preferred drug treatment for rehabilitation instead of incarceration for punishment of the client. The belief was that the substance abusers needed help and guidance with their drug problems (in Gotay, 2014). Bota (2006) stated that health professionals who had a personal history of substance-abuse disorder had a positive attitude towards other substance users. Health professionals who believed a substance-dependent clients could recover and lead a productive life, felt more sympathetic toward the clients because they believed that the client was not able to control their substance use.

According to Au (2006), the attitudes and beliefs of physicians are amenable to change. As such, they offer potential points of intervention to improve physician adherence to practice recommendations. Physicians' attitudes and beliefs are related to the delivery of preventative services, including more positive beliefs towards prevention in general, attitudes toward working with substance-dependent individuals, and self-perception of knowledge and

management skills regarding the specific prevention. Results obtained from a study conducted by Richmond and Foster (2003) indicated that health practitioners demonstrated non-stereotyping and permissive attitudes when working with substance misusers. The results obtained from the Substance Abuse Attitude Survey (SAAS) measure showed that the practitioners had an overall accepting and tolerant attitude toward substance use and generally did not tend to make stereotypical assumptions about mental health service users who abused substances (Richmond & Foster, 2003).

In a study that was done by Gotay (2014), health professionals displayed positive attitudes owing to the low level of discrimination and a prominent level of acceptance towards the substance abusers. This was demonstrated by healthcare professionals strongly agreeing or agreeing whether it was worthwhile to serve substance users, provided, if asked, they did not have the right to refuse care to the client and, given a choice, would work with substance users.

In a study that was conducted by Van Boekal et al (2014), it was found that professionals of specialist addiction services showed higher regard for working with substance-dependence compared to professionals of psychiatry services and general practitioners. Professionals of addiction services felt significantly less anger for people with substance-dependence issues compared to healthcare professionals of the other two sectors. Van Boekel et al (2014) also found that when healthcare professionals do not distinguish between substance-dependence and other disorders, then attitudes of the healthcare professionals were more positive in nature.

2.8. Effects of healthcare professionals attitudes on treatment intervention

Several theories are used to explain how negative clinicians' attitudes lead to their associated detrimental effects. One theory suggests that negative attitudes held by practitioners, along with their accompanying beliefs and prejudices, can be unwittingly

imposed on clients by clinicians, resulting in reduced collaboration between the two parties, and a reduction in the client's feelings of empowerment and self-esteem (Cornfield, 2018).

Cornfield (2018) further added that the negative attitudes enacted by clinicians could cause a reduction in the client's feelings of efficacy, a trait that is a significant predictor of recovery from addiction. If a client is treated by a healthcare professional that is pessimistic about the chances of the client's recovery, it would not be a surprise if the client also incorporated this belief of low self-efficacy into their own self-concept. Akinola (2015) found that healthcare professionals who believed that substance-dependence recovery was possible, was found it to be possible even in clients with relapse histories. However, these healthcare professionals also suggested that they did not find working with substance-dependent clients pleasant. Another theory suggests that practitioners' negative attitudes lead to poor communication, thus hindering the development of the therapeutic alliance (Cornfield, 2018).

The stigmatising attitudes of nurses and mental health professionals have also been shown to affect treatment recruitment and retention. These attitudes can also affect their willingness to treat substance-dependent clients and influence the quality of care they provide (Gilchrist et al, 2011). Skinner, Roche, Freeman and Addy (2005) concluded that nurses and mental health professionals exhibiting negative attitudes towards people experiencing dependency are likely to be less willing to intervene in Alcohol and Other Drugs (AOD) related issues.

Most counsellors are likely to see substance-dependent clients during their careers, and their attitudes towards these clients will strongly influence the therapeutic value of these encounters, which can either be helpful or harmful (Cornfield, 2018).

Negative attitudes of healthcare professionals have been described as a barrier to accessing care with substance users often encountering "hostile judgemental attitudes" in general practice and being "often made to feel not worthy of receiving help" in hospital

settings (Gilchrist et al, 2011). Research has shown that substance-dependent clients who perceive stigma from their healthcare providers are significantly less likely to complete treatment and that negative clinician attitudes are associated with increased rates of treatment dropout and substance-dependence relapse (Cornfield, 2018).

Only a few studies investigated whether negative attitudes of health professionals have consequences on healthcare delivery to patients with substance-use disorders. One study confirmed that patients, who reported higher perceived discrimination by health professionals and dissatisfaction with the treatment, were less likely to complete their treatment (Van Boekel et al, 2013). Negative attitudes of health professionals may derail the empowerment of patients and, consequently, influence treatment outcomes and patients' self-esteem. Moreover, negative attitudes of healthcare professionals may increase the chance of dropout or relapse during treatment (Van Boekel et al, 2013).

Gaston (1990) (as cited in Cornfield, 2018) stated that counsellors' attitudes toward their substance-dependent clients could help predict how counsellors responded to their clients in a session. The attitudes can affect the development of the therapeutic relationship, a factor that is widely-considered to be important in any type of counselling or psychotherapy and has been shown to predict treatment outcomes throughout a multitude of studies.

Soto and Stuart (2014) stated that the client's success could depend on the therapeutic relationship that is formed between that client and the healthcare professional. If the relationship is positive, then the outcome for the client is likely to be more successful. If the relationship is strained, then it can be difficult for the client to reach his/her goals.

Soto and Stuart (2014) identified several factors, including distrust, anger and biases that can damage the therapeutic relationship between the client and the social worker. Therefore, it is beneficial if the social worker does not harbour any biases when working with those who use or abuse substances. The problem is that many social workers have a negative

viewpoint of those with substance abuse issues, and that attitude can stand in the way of the client receiving the most effective help. Van Boekel et al (2013) mentioned that substance-dependent clients are usually associated with violence, manipulation and having poor motivation for treatment. Healthcare professionals view these as interfering with the progress of treatment care and intervention (Gotay, 2014).

According to Bota (2006), healthcare professionals' negative attitudes towards substance-dependent clients was the belief that they abused the resources for their substance-dependence. The abuse was caused when patients would not follow the treatment plan developed by the interdisciplinary team resulting in relapse and wasting valued time from professionals (Gotay, 2014).

In a study that was done by Appiah et al (2017), some of the participants implicated treatment-related issues in their relapse process. It was found that factors including the inability to access a counsellor for support during severe craving to use substances, bad attitudes of some mental health practitioners, and a shortage of supply of medication were in many ways responsible for the participants' return to abuse substances.

It was found that higher drop-out rates were at out-patient-based facilities compared with in-patient-based facilities, as abusers had a higher chance of being influenced before they completed the treatment (Ramlagan et al, 2010). As such, prevention interventions and policies need to aim at reducing abuse levels by targeting the at-risk populations identified in this study. The WHO World Mental Health Survey (Wang et al, 2007) found that unmet needs for mental health (including substance abuse) treatment are pervasive, which were especially concerning in less-developed countries (including South Africa).

2.9. Summary of chapter

The chapter started by discussing issues related to substance-dependence in South Africa as well as other countries. The chapter went on to demonstrate the difficulty of

substance treatment service when it came to the treatment of substance-dependence. The chapter then discussed the issue of substance-dependence relapse, which seemed to be an issue when it came to substance-dependence treatment and recovery. The precipitants of relapse were discussed as these, at times, had an influence on the treatment of the substance-dependent clients. This chapter then discussed the different factors that affected the healthcare professionals' attitudes when working with substance-dependent clients. Several factors were identified, which these ranged from personal to work-related factors. The chapter also discussed the attitudes that the healthcare professionals had when working with substance-dependent clients. First discussed were the negative attitudes and then the positive attitudes. The different attitudes were demonstrated by different healthcare professionals such as nurses, physicians, counsellors, social workers as well as general practitioners. This chapter then examined how the different attitudes the healthcare professionals had impacted on the treatment plan or intervention that was implemented when working with substance-dependent clients.

CHAPTER THREE

Theoretical framework

3.1. Introduction

This chapter begins by explaining the theory of planned behavior and the different components that are of importance in the theory. This chapter also discusses the elements of theory of planned behavior theory of planned behavior as it relates to this research study and also explains how healthcare professionals worked with relapsed substance-dependent clients.

The chapter then discusses how the theory of planned behavior was implemented in the investigation of the attitudes that healthcare professionals have towards working with relapsed substance-dependent clients. The chapter then discusses the three determinants of behavior intention according to the theory and reviews how these have influenced the healthcare professional's intention to work with substance-dependent clients. In the current study, the determinants to engage in behavior are not used as predictors but as explainers on how the decision to work with substance-dependent clients was reached, as the participants in the study were already working with clients who were substance-dependent.

3.2. Theory of planned behavior background

Figure 1 illustrates the theory of planned behavior

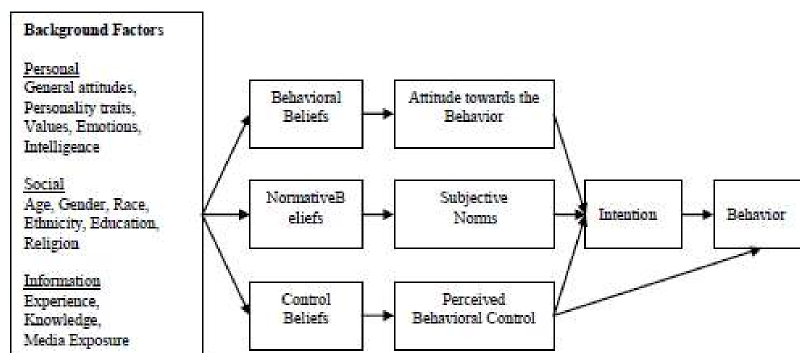

Figure 1: Theory of Planned Behavior, Source: (Ajzen, 2005)

Human behavior is guided by different subjective probabilities (Fishbein & Ajzen, 1975). This means beliefs about the consequences of the behavior, beliefs about the normative expectations of other people and beliefs about the presence of factors, which may facilitate or impede performance of the behavior. These beliefs are based on a wide range of background factors. In their aggregates, behavioral beliefs produce attitude towards behavior, normative beliefs result in subjective norms and control beliefs generate perceived behavior control (Sommer, 2011).

The theory of planned behavior, which was developed by Icek Ajzen is an extension of the theory of reasoned action made necessary by the original model's limitations in dealing with behaviors over which people have incomplete volitional control (Ajzen, 1991). The theory of reasoned action, which was developed by Fishbein and Ajzen (1975) proposed that behavioral intentions were determined by attitudes and perceived social pressure from others. This model also proposed that both attitudes and subjective norms are determined by "salient" underlying beliefs consisting of an outcome evaluation. The theory conceptualized that behavior is dependent on the formation and intent and that intentions are defined as measures of the probability that a person will engage in a specific behavior. Ajzen (1991) extended the theory of reasoned action by including perceived behavioral control as a determinant of both intention and behavior (George, 2008). Perceived behavioral control as an additional construct could solve the problem of the theory of reasoned action in terms of explaining behaviors in which the person does not have volitional control (Sommer, 2011).

The theory of planned behavior stated that the proximal determinant of behavior is the intention to act (Hardeman, Johnston, Johnston, Bonetti, Wareham & Kinmonth, 2002). Intentions are assumed to capture the motivational factors that influence a behavior as they are indications of how hard people are willing to try, of how much of an effort they are planning to exert, in order to perform the behavior. The theory assumes that what an

individual does in a given context (a behavior), the formation of an intention to perform the behavior and postulates that intentions reflect three motivational determinants, which are attitudes, subjective norms and perceived behavioral control (Renzi & Koblas, 2008). The relative importance of attitude, subjective norm and perceived behavioral control in the prediction of intention is expected to vary across behaviors and situations. Thus, in some applications it may be found that they only have a significant impact on intentions, in others that attitudes and perceived behavioral control are sufficient to account for intentions and, in still others, that all three predictors make independent contributions (Ajzen, 1991). It may be possible that not all three predictors informed the healthcare professionals' intention to work with clients who had relapsed.

According to the theory, attitude is conceptually-defined in terms of a client's perceived behavioral beliefs and outcome evaluations of engaging in a specified behavior. Subjective norms are related to normative beliefs in which the client experiences pressure or expectations from others to engage or not engage in the behavior, thus influencing motivations to participate in the identified behavior. Perceived behavioral control is related to a client's perception of confidence in ability to complete the behavior. The theory proposes that to change a behavior, changes must be made to behavioral, normative, and control beliefs to increase control over the behavior. In summary, the theory suggests that changing beliefs is necessary for behavioral change. As a general rule, the stronger the intention to engage in a behavior, the more likely should be its performance (Ajzen, 1991).

In a clinical consultation, the clinician's treatment decisions and actions are examples of intentional behavior (Francis, Eccles, Johnston, Walker, Grimshaw, Foy, Kane, Smith & Bonetti, 2004). In this study, the researcher was considering how the predictors influenced the treatment interventions or plans that the healthcare professionals utilized when it came to working with substance-dependent clients who had relapsed.

3.3. Determinants of behavior intention

Ajzen (1991:189) explains that the theory of planned behavior goal is not just to predict human behavior but rather:

> …deals with the antecedents of attitudes, subjective norms, and perceived behavioral control. These antecedents in the final analysis determine intentions and actions. At the most basic level of explanation the theory postulates that behavior is a function of salient information, or beliefs, relevant to the behavior.

The first influence, which is attitude, is seen as the overall evaluation by the client. Attitudes are defined "as a learned disposition to respond in a consistently favorable or unfavorable manner with respect to a given object" (Conner & Norman, 2005). Attitudes towards the behavior are proposed to arise from a combination of beliefs about its consequences (behavioral beliefs) and evaluations of these consequences (outcome evaluation). Since the characteristics that come to be linked to the behavior are already weighted positively or negatively, clients automatically and concurrently obtain an attitude toward the behavior. This results in individuals learning to favor behavior they believe has desirable consequences and also form unfavorable attitudes toward behavior that is linked with mostly unwanted and negative consequences (Ajzen, 1991).

In the present study, the healthcare professionals' attitudes towards working with substance-dependent clients who had relapsed might be influenced by what they thought when it came to working with relapsed clients and what might come out of this behavior. The theory of planned behavior believes that a person who holds strong beliefs that positively valued outcomes will result from performing a behavior in question, will have a positive attitude towards the behavior (Glanz, Rimer & Viswanath, 2015).When an individual holds a strong belief that negatively valued outcomes will result from behavior, they will have a negative attitude towards that behavior (Glanz et al, 2015).

The second is subjective norms, which are determined by clients' beliefs about whether important people approve or disapprove of their performing the behavior (normative beliefs) and the strength of the clients' desire to gain approval of these groups (motivation to comply) (White, Jimmieson, Obst, Graves, Barnett, Cockshaw, Gee, Haneman, Page, Campbell, Martin & Paterson, 2015). Subjective norms represent the supposed social pressure to perform or not to perform a behavior (Renzi & Klobas, 2008). Subjective norms of healthcare professionals might be based on how they think other individuals view working with clients who had relapsed (for example, other healthcare professionals), and also how important they deemed the opinions of those individuals.

The third influence is the sense of self efficacy or the ability to perform the behavior that the person is interested in, which is termed the perceived behavioral control (Ajzen, 2005). Perceptions of behavioral control are also considered to directly influence the behavior (White et al, 2015). Perceived behavioral control is based on an individual's beliefs about whether internal and external factors may prevent or assist in the performing of the behavior (control beliefs) (White et al, 2015). Perceived behavioral control deals with the presence or lack of necessary resources and opportunities. These control beliefs may be based in part of previous experience with the behavior. The more resources and opportunities individuals believe they have, and the less difficulties or inhibitions they foresee, the greater should be their perceived control over the behavior (Ajzen, 1991). Perceived behavioral control may be underpinned by healthcare professional's belief about factors that may allow and motivate or prevent them from working with substance-dependent clients who had relapsed and the impact those factors might have on working with relapsed clients.

As a general rule, the more favorable the attitude and subjective norm with respective to a behavior, and the greater the perceived behavioral control, the stronger should be an individual's intention to perform the behavior under consideration (Ajzen, 1991).

3.4. Application of the theory

The theory of planned behavior is one of the most contemporary social cognition theories that seek to inform the relationship between attitude and behavior. The theory seeks to explain and predict non-volitional as well as volitional behaviors. It thus acknowledges that behavioral performance is influenced by psychological and social factors that are perceived to influence one's ability to carry it out. This is important when considering the complex behaviors, such as working with substance-dependent individuals who have relapsed.

The theory of planned behavior (TPB) has been applied to a wide range of behaviors to better understand which individuals behave in which way. It is one of the best-supported social psychological theories with respect to predicting human behavior. The central premise is that behavioral decisions are the result of a reasoned process in which the behavior is influenced by attitudes, norms and perceived behavior control (Sommer, 2011).

The theory of reasoned action and the theory of planned behavior have provided support for the ability to predict a wide range of behaviors. The theories have been used in prediction of health-related behavior, recycling and driving behavior (Sommer, 2011). The theory of planned behavior has also been applied in research in numerous disciplines including nursing, information technology, social policy, sociology, health and psychology (George, 2008). Even though the model began within social psychology, the theory is regarded as the dominant model in the field of health psychology, additionally, the model is currently being utilized in clinical psychology research (George, 2008). To increase understanding of health behavior, social cognition models have been developed and adopted in behavioral science research.

These models are used to identify and explain how expectations, judgements, beliefs, and intentions lead to performance of various behaviors (Dumitrescu, Wagle, Dogaru & Manolescu, 2011). The theory has been applied mainly to predict and explain a wide range of behaviors, including health-relevant behaviors (Hardeman el al., 2002) such as binge drinking, oral health behavior and adoption of value added services (VAS) (Tan, Hassali, Saleem, Shafie, Aljadhay & Gan, 2016).

The theory of planned behavior was applied in a study that focused on understanding binge drinking and the importance of beliefs for developing interventions (Cooke & French, 2008). The theory was also applied in a study that was conducted by Mesidor and Sly (2014). The study looked at the relationship between social-cognitive factors (for example, attitudes, subjective norms and perceived behavioral control), psychological distress, and help-seeking intentions for a sample of international and African American college students. The results of this study indicated that the theory of planned behavior variables (for example, attitudes, subjective norms and perceived behavioral control) accounted for a substantial amount of the variance in help-seeking intentions.

A study that was conducted by Dumitrescu et al (2011) aimed at testing the efficiency of the theory of planned behavior in predicting intention to improve oral health behaviors. The theory was also used in a study to investigate the predictors of students' intention to enrol in university (Cooper, 2016). Tolliver (2016) examined the beliefs that were relevant to executives' intentions to hire psychologists, determined how the executives' perceived control over hiring psychologists varied by several demographic variables and examined how well the theory of planned behavior predicts executives' intentions to hire psychologists.

Studies that used the theory were mostly quantitative, and only a few qualitative studies used the theories. An example is a study that conducted by Renzi and Klobas (2008)

using the theory of planned behavior to explain differences in university teaching. The study explored factors which influenced university teachers to adopt teaching models based on online interaction. Another qualitative study that used the theory of planned behavior model was a study that investigated possible predictors that affected public intention to adopt VAS in Malaysia (Tan et al, 2015). The current research study also added to the limited qualitative studies that had applied the theory of planned behavior.

A strength of the theory of planned behavior is that the approach provides a framework for discerning and understanding the reasons or beliefs that motivate a behavior of interest for each particular population of interest (Glanz, Rimer & Viswanath, 2015).

3.5. Criticism and limitations of the theory of planned behavior

One of the criticisms levelled at the theory is that the focus on rational reasoning, excluding unconscious influences on behavior and the role of emotions beyond anticipated affective outcomes (Manstead, 2011; Sniehotta, Presseau & Araujo-Soares, 2014). Godin and Kok (1996) proposed that role beliefs and moral norms be added to the model in further research studies of health-related behaviors. Ajzen (2011) argued that the most frequently mentioned biasing factors neglected in the theory of planned behavior were affect and emotions. This concern is based on the mistaken perception that the theory posits a rational actor who is unaffected by emotions and that is typically used to operationalise the theory's constructs.

Sniehotta et al (2014) also stated that the theory of planned behavior failed to specify how cognitions changed, making it difficult to devise effective interventions to modify attitudes, subjective norms and perceptions of behavioral control. In addition, where empirical tests of behavior change interventions have been tried, and observations have not been in line with the theory. Ajzen (2015) argued that theory of planned behavior was not a

theory of behavior change, instead, it was meant to help explain and predict people's intentions and behavior. The theory, however, can serve as a useful framework for designing effective behavior change interventions (Ajzen, 2011).

The importance of past behavior is an issue that has been debated a lot in the context of the theory of reasoned action or theory of planned behavior. According to these models, past behaviors should exercise an influence on current behavior through the constructs included in the models (Manstead, 2011).

3.6. Summary of chapter

The current chapter provided a background of the theory of planned behavior. This chapter looked at the three influences or determinants of intentions to perform a behavior, to see how these influenced the healthcare professional's intention to work with substance-dependent clients. The chapter also focused on the application of the theory and its criticism and limitations.

The current chapter presented information related to the theoretical framework that was utilised in the study. Chapter Four focuses on the methodological procedures that were followed.

CHAPTER FOUR

Methodology

4.1. Introduction

This chapter focuses on the aim of the current study as well as its objectives as well as the methodological procedures that were followed. The chapter contains a description of the research design, sampling technique, research procedure, data collection and data analysis. The chapter concludes with an overview of the study's ethical considerations as they related to the research process.

The purpose of this study was to explore and describe the attitudes that healthcare professionals had towards substance-dependent clients who have relapsed; to also explore and describe how the attitudes that healthcare professionals hold influence the treatment plan or intervention that was utilised or implemented. In seeking to understand this phenomenon, the objectives of the study included (1) To explore and describe the attitudes that healthcare professionals have towards substance-dependent clients who had relapsed. (2) To explore and describe how the attitudes of healthcare professionals towards substance-dependent clients who have relapses influence the treatment plans or interventions that are utilised.

4.2. Research design

This study used a qualitative research design. Qualitative research design was deemed suitable for this study as it seeks to understand, explain, explore, discover and clarify situations, feelings, perceptions, attitudes, values, beliefs and experiences of a group of people (Kumar, 2011). A qualitative study mainly entails the selection of people from whom the information, through an open frame of enquiry is explored and gathered (Kumar, 2011). One of the most distinguishing features of qualitative research is the adherence to the concept of respondent consistency whereby the researcher makes every effort to seek agreement of respondents with interpretations, presentation of the situations, experiences, perceptions and

conclusions. By exploring and describing the attitudes of healthcare professionals towards substance-dependent clients who had relapsed, the researcher attempted to gain a better understanding of the manner in which attitudes influence the treatment plan or intervention utilised.

This study was exploratory-descriptive in nature. An exploratory-descriptive design includes qualitative descriptive work in which specific methodology is not mentioned as serving a foundation for the study. Problem statements and purpose statements often address the desire to increase knowledge of a process or situation (Gray, Grove & Sutherland, 2016). The exploratory-descriptive nature of the study provided the researcher with an opportunity to gain a better understanding of the attitudes that healthcare professionals have towards substance-dependent individuals who had relapsed.

4.3. Sampling

The study made use of two non-probability sampling techniques to select research participants. The sampling technique was a combination of purposive and snowballing technique. Purposive sampling is the deliberate choice of a participant owing to the qualities the participant possesses. It is a non-random technique that does not need underlying theories or a set number of participants. The researcher decided what needs to be known and sets out to find people who could and were willing to provide the information by virtue of knowledge or experience (Etikan, Musa & Alkassim, 2016).

Non-probability purposive sampling was employed to provide the researcher with participants who were considered to have first-hand knowledge and experience in working with substance-dependent clients who had relapsed. In addition to their knowledge and experience, the sample was selected because of their availability and willingness to take part

in the study (Etikan et al, 2016). For the study, the researcher decided to focus on healthcare professionals, namely, nurses, psychologist or counsellors as well as social workers.

The sample was expanded by asking the participants to identify other potential participants who met the research criteria and would be willing to be part of the study. This sampling technique is known as snowballing, which is the process of selecting a sample using networks (Kumar, 2011). Snowballing sampling is used to identify participants that were appropriate candidates for a study that are difficult to locate. This selection method was continued until a saturation point was reached, in terms of the information that the researcher was looking for (Hesse-Biber, 2016).

The number of participants that were interviewed in this study was not pre-determined, but was rather determined by the information that was received during the interviews. Interviews were conducted until the data saturation point that was acceptable was reached, which was judged by the researcher based on the research questions that were answered. The study focused on nine participants that worked at in-patient rehabilitation centres, private practice, private hospital as well as outpatient after care. The sample was made up of four social workers, an auxiliary social worker, a nurse, a drug counsellor, a registered counsellor and a clinical psychologist.

4.4. Data collection

In this study, data was collected using semi-structured and individual interviews. Interviews are a particular kind of conversation between the researcher and interviewee that requires active asking and listening (Hesse- Biber, 2016), which allowed the participants to feel comfortable. The purpose of using semi-structured interviews was to gain information about the attitudes that healthcare professionals had towards substance-dependent clients who had relapsed. All nine interviews were conducted using English by the researcher.

The interviews were dependent on the availability of the participants and were conducted within a five week period. They were recorded using a digital audio-recorder, and were transcribed and coded by the researcher. An independent coder was used to verify emergent themes.

An interview schedule (see Appendix D) was used as a tool for collecting data. Open-ended questions were prepared beforehand by the researcher to guide the interview, but additional questions were asked during the interviews. The interviews were conducted face-to face with the healthcare professionals, except for one interview that was conducted via telephone owing to the participant being unavailable for a face-to face interview. Before the interviews were conducted, an information sheet (see Appendix A) explaining the study objectives, aims was given to participants. Once the participants agreed to be part of the research study, a time and date for the interview was set.

Prior to the data collection, the research process was verbally explained to the participants. The participants were given an information sheet that explained the aims and objectives of the study. They were also given an informed consent sheet informing them that they were participating voluntary in the study and they could discontinue at any time. Issues of confidentiality and anonymity were also discussed with the participants. The interviews were audio-recorded, and consent was obtained from the participants.

4.5. Research procedure

The study was first presented by the researcher to the university psychology department. Once the research received approval from the psychology department, the researcher then submitted the research proposal to the Faculty Postgraduate Studies Committee (FPGSC) and the Research Ethics Committee- Human (REC-H) at the Nelson Mandela University. Once feedback was obtained from the committees, the necessary

changes were made. Once the final approval (see Appendix E) was granted, the researcher contacted the managers, who acted as gate keepers of the in-patient treatment centres. These in-patients treatment centres were purposefully selected as healthcare professionals provided substance-dependence treatment for clients. The gate keepers identified potential participants who would be interested in being part of the study. The researcher made contact with the potential participants, and a mutually agreed upon date and time was set for the interviews. The participants from the in-patients treatment centres recommended other participants that met the research criteria and would be interested in being part of the study. The researcher made contact with these potential participants, and an interview time and date was agreed to.

The research process was explained by the researcher prior to each interview. The participants were made aware of the voluntary nature of participating in the study after written consent was obtained. This requirement is discussed in more detail under the "ethical considerations" i.e. section 4.8. The researcher terminated the data collection phase by thanking participants for being part of the research study.

4.6. Data analysis

Thematic analysis is a method of identifying, analysing and reporting patterns (themes) within data. It minimally organises and describes the data set in detail. It also often goes further than just describing, and interprets various aspects of the research topic (Braun & Clarke, 2006). The current study made use of the framework for qualitative data analysis by Braun and Clarke (2006). The process of data analysis begins when the analyst starts to notice, and look for, patterns of meaning and issues of potential interest in the data, which could also be during data collection. The end point is the reporting of the content and meaning (themes) in the data (Braun & Clarke, 2006). Braun and Clarke's (2006) framework for data analysis consists of six phases. Accordingly, the researcher analysed the data from the interviews as follows:

- Phase one is familiarising self with the data. The audio-recording was transcribed by the researcher, which resulted in the researcher being familiar with data. The researcher read the transcripts repeatedly (and listened to the audio-recorded data at least more than once) to be more familiar with the data. This was also done to make note of any initial analytic observation. During this process, the researcher made notes of ideas that came to mind as she read and listened to the recordings. Braun and Clarke (2006) state that during this phase, it is a good idea that the researcher starts taking notes and marking ideas for coding that they can refer to in subsequent phases.
- Phase two is generating initial codes. The researchers familiarise themselves with the data and generate ideas about the data and what was interesting to them. For the study, the researcher identified features of the data that appeared to be interesting. These data items were then coded by the researcher, and this phase was ended by organising all codes and relevant data extracts. Coding to some extent depended on whether the themes were more data-driven or theory-driven. In the former, the themes depended on the data, but in the latter, the data might be approached with specific questions in mind that the analysts wished to code around (Braun & Clarke, 2006).
- Phase three is searching for themes. This phase, which re-focuses the analysis at the broader level of themes, rather than codes, involves sorting the different codes into potential themes, and collating all the relevant codes data extracts within the identified themes (Braun & Clarke, 2006). The researcher grouped codes such as "non-judgemental", for example, as part of a theme called "healthcare professional attitudes". The researcher ended this phase by collating all the coded data relevant to each theme.
- Phase four is reviewing themes. The researcher went through the themes that were identified in the previous phase. The researcher read all the ordered extracts for each

theme, and considered whether they formed a coherent pattern. The researcher then checked whether the themes accurately represented the meaning depending on the theoretical framework. This involved checking that the themes worked in relation to both the coded extracts and the full data set as well as generating a thematic "map" of the analysis.

- Phase five is defining and naming themes. The researcher conducted and wrote a detailed analysis of each theme and identified the essence of each theme and constructed a concise, punchy and informative name for each theme. The researcher revisited and redefined certain themes throughout the research project.
- Phase six is producing the report. This involved the researcher weaving together the analytic narrative and data extracts to tell the reader a coherent and persuasive story about the data, and contextualising it in relation to existing literature.

The findings of the study were interpreted using the theory of planned behavior. The theory of planned behavior allowed the researcher to make sense of the date generated during the interviews as participants confirmed some of the factors that were involved in the theory.

4.7. Strategies ensuring the trustworthiness of this study

To ensure the trustworthiness of the data, the researcher used an independent coder. A reflective journal was also kept by the researcher during the research process. In addition, the trustworthiness of the study was enhanced by including peer-reviewing of the interview schedule with other healthcare professionals.

According to Long and Johnson (2000), the worth of a study relates to the soundness of its method, the accuracy of its findings, and the integrity of conclusions that are reached. Ensuring that a qualitative study is trustworthy involves a credibility consideration, dependability and transferability (Shenton, 2003).

4.7.1. Credibility

One of the key criteria addressed by positivist researchers is that of internal validity, in which they seek to ensure that their study measures or tests what is actually intended (Shenton, 2003). The qualitative equivalent of this concept is credibility, and it deals with the question, "How congruent are the findings with reality?" (Shenton, 2003, p. 64). Lincoln and Guba (1985) argue that ensuring credibility is one of the most important factors in establishing the trustworthiness of a research study. Shenton (2003) makes the following provisions that may be used by researchers to promote confidence that they have accurately recorded the phenomena being investigated. These include:

4.7.1.1. Negative case analysis

This provision is related to what Silverman (2005) calls the problem of anecdotalism in qualitative research. The problem of anecdotalism occurs when research findings depend only on well-chosen examples that support the argument the researcher is trying to make (Silverman, 2005). This study presented deviant cases where they were available to avoid anectodalism and serve as a form of negative case analysis. For example, the researcher presented instances where the participants did not have the same view regarding their understanding of a certain concept.

4.7.2. Transferability

Transferability is concerned with the degree to which research findings of one study transferred to another context (Shenton, 2003). This calls for researchers to provide detailed description of their methodology, for example, data collection and the phenomenon that they are investigating. If there are enough similarities between the two situations, readers may be able to infer that the results of the research would be the same or similar in their own situations (Shenton, 2003). The researcher attempted to provide a detailed account of the theoretical framework, aims of the study and the research area. A detailed description of the

recruitment procedure, the sample, data collection and data analysis process were provided. This was done so that the findings of this study could potentially be transferable to similar settings (Silverman, 2005).

4.7.3. Dependability

Dependability is concerned with ensuring that if the study was replicated by other researchers under the same conditions similar results would be found. This is usually difficult to do in qualitative research. Shenton (2003, p.71) argues that:

> In order to address the dependability issue more directly, the processes within the study should be reported in detail, thereby enabling a future researcher to repeat the work, if not necessarily to gain the same results. Thus, the research design may be viewed as a "prototype model"

Such in-depth coverage also allows the reader to assess the extent to which proper research practices have been followed. So as to enable readers of the research report to develop a thorough understanding of the methods and their effectiveness, Shenton (2003) identifies that the text should include sections devoted to:

> a) research design and its implementation, describing what was planned and executed on a strategic level
>
> b) operational detail of data gathering, addressing the minutiae of what was done in the field
>
> c) reflective appraisal of the project, evaluating the effectiveness of the process of inquiry undertaken

When reporting on this project, the researcher attempted to provide a detailed account of the theoretical framework that guided the research project. The researcher provided the study aims and then gave a description of the areas from where the participants were sampled. The researcher also provided a detailed description of the recruitment procedures, the sample, the data collection and data analysis process. These clear descriptions might help future researchers conducting the same or similar research reach similar conclusions.

4.8. Ethical considerations

Ethical clearance for the study was granted by the Nelson Mandela University's FPGSC. Issues of informed consent and managing confidentiality are outlined below.

4.8.1. Ethical review

Terre Blanche, Durrheim and Painter (2006) identify that independent and competent research ethics committees should "subject all protocols to independent ethical review prior to commencement of data collection". The researcher initially presented her research proposal at a meeting of the Departmental Post-graduate Studies Committee for the Department of Psychology, before initiating the research project. After the meeting, feedback was obtained and the necessary changes to the proposal were made by the researcher.

After that, the researcher submitted the revised proposal to the Faculty Postgraduate Studies Committee of the Faculty of Health Sciences, followed by a review by the Research Ethics Committee- Human (REC-H) at the Nelson Mandela University. The proposal was discussed and evaluated by this committee. The proposal was approved and feedback was provided. The researcher revised the proposal and submitted the final draft, which was officially processed and accepted by the university.

The data gathering process was initiated only once final approval was received from the University Ethics Committee.

4.8.2. Informed consent and confidentiality

In every discipline, it is considered unethical to collect information without the knowledge of participants, and their expressed willingness and informed consent (Kumar, 2011). Informed consent is one of the primary ethical issues that researchers have to consider when conducting research (Fouka & Mantzorou, 2011). The participants were given an information sheet that explained the aims and objectives of the study. Another aspect of

informed consent includes the assurance that participation is voluntary and that participants can refuse or withdraw without incurring any consequences (Terre Blanche et al, 2006). The researcher gave the participants an informed consent sheet informing them that they were participating voluntarily in the study and they could discontinue at any time. The interviews were audio-recorder, and consent was obtained from the participants. Participants were also given an opportunity to ask questions before taking part in the study. One interview was conducted telephonically and the participant gave verbal consent to participate in the study and for the audio recording of the interview.

Issues of confidentiality and anonymity were also discussed with the participants. Anonymity is ensured by making sure that the reader cannot link the identity of participants with their individual responses (Fouka & Mantzorou, 2011). The recorded interviews were independently transcribed and saved to an encrypted hard drive. The researcher, researcher supervisor and the independent coder were the only people who had access to the resulting data. A copy of data collected was stored in the supervisor's office for a period of five years.

4.8.3. Respect for persons

The ethical principle of respect for person's demands ensures that individuals participate voluntarily, having had adequate information about what involvement in the research would include as well as possible consequences. This means dealing with people as free to choose, but also acknowledge more vulnerable people's rights to be protected (King, Horrocks & Brooks, 2018). The participant's participation in the research study was voluntary and this was explained clearly to them. The researcher also protected the client's identities by making use of participant codes.

4.8.4. Beneficence and non-maleficence

The ethical principle of non-maleficence seeks to make sure that no harm comes to the participants as a result of the research (Munro, 2011). The researcher ensured that the nature of the study and interview in no way had the potential to harm the participants that had taken part. The ethical principle of beneficence engages in the ways in which participants might benefit from being part of the research (Munro, 2011) By taking part in the research study, the participants might have had an opportunity to reflect on their work with substance-dependent clients. This might have given them an opportunity to identify and want to reflect on issues they might be struggling with when it came to working with substance-dependent clients and how these might affect the participants and their clients.

4.9. Conclusion

This chapter addressed the primary aim and objectives of this study, and provided a detailed description of the research methodology. The study was a qualitative study, which was exploratory-descriptive in nature and made use of non-probability purposive and snowballing sampling techniques to identify and recruit participants. Semi-structured individual interviews were used to gather data.

Data analysis was accomplished using Braun and Clarke's (2006) six phases for qualitative data analysis. All aspects of the ethical principles recognised within guiding codes were upheld throughout the research process as the researcher strove to conduct research in an accountable and professional manner. Chapter Five addresses the results of this research project.

CHAPTER FIVE

Research Findings

5.1. Introduction

Chapter Four described the application of the research methodology and research process adopted to achieve the research goal and objectives as stated in Chapter One and restated here. The goal of this study was to understand the attitudes that healthcare professionals had towards substance-dependent clients who had relapsed. The following objectives were formulated to guide the attainment of this study's goal:

- To explore and describe the attitudes that healthcare professionals have towards substance-dependent clients who have relapsed
- To explore and describe the manner in which the attitudes that healthcare professionals have of substance-dependent clients who had relapsed influenced the treatment plans or interventions that are utilised

This chapter describes the findings that originated from the analysis of the data generated through the semi-structured interviews conducted with healthcare professionals who had worked or were working with substance-dependent clients who had relapsed. A thematic data analysis as described in Chapter Three was conducted by following the steps of qualitative data analysis. The findings that emerged from this analysis are reported under themes and sub-themes. The data taken from each interview is presented as extracts within the text, highlighting the intersectionality across the data set. The extracts are located by interview code.

5.2. Description of participants

A total of nine participants were recruited using of non-probability, purposive and snowballing sampling as described in Chapter Four. The healthcare professionals that were

part of the study were nurses, psychologist or counsellors as well as social workers. The sample was selected on the basis that they often had contact with substance-dependent clients. The healthcare professionals were deemed proficient and well-informed when working with substance-dependent clients who had relapsed. In addition to their knowledge and experience, the sample was selected due to availability and willingness to take part in the study (Etikan et al, 2016). The work experience with substance-dependence of the healthcare professionals ranged from three to 13 years.

5.3. Themes and sub-themes

The emerging themes and sub-themes in this study are reflected in Table 1. Three main themes emerged that related to the research objectives. Theme 1, which were the healthcare professional's attitudes towards working with clients who had relapsed, focused on the different attitudes that healthcare professionals displayed when working with a client who had relapsed after undergoing the treatment process. Theme 2, which were the factors that influenced the attitudes that healthcare professionals had when working with clients who had relapsed. Theme 3, which looked at the treatment plan or intervention that the healthcare professionals implemented when they worked with relapse clients. Theme 3 also elaborated on the aftercare services that were available to clients after they had completed their treatment.

Table 1. Themes and sub-themes

Themes	Sub-themes
5.4. Healthcare professionals' attitudes	5.4.1. Positive attitudes 5.4.2. Negative attitudes
5.5.Factors affecting the healthcare professionals' behavior	5.5.1. Client's attitudes and behavior 5.5.2. Reasons for client's relapse 5.5.3. Healthcare professionals' confidence in working with substance-dependence
5.6.Nature of treatment intervention implemented	5.6.1. Treatment interventions 5.6.2. Aftercare services

5.4. THEME 1: Healthcare professionals' attitudes

The participants were asked to describe how they found working with substance-dependent clients who had relapsed, and two sub-themes emerged from the analyses... The results of this study suggest that healthcare professionals had wide-ranging attitudes towards substance-dependent clients who had relapsed.

5.4.1. Sub-theme 1A: Positive attitudes

The findings of this study established that positive or favorable attitudes were held by some healthcare professionals toward their substance-dependent clients who had relapsed. These attitudes (in this sub-theme) ranged from non-judgemental to that of understanding and motivating towards such clients.

5.4.1.1 Non-judgemental attitudes

Under the positive attitude sub-theme, some healthcare professionals were identified as displaying non-judgemental attitudes during the treatment of substance-dependent clients who had relapsed.

Participant 1 demonstrating non-judgemental attitudes towards relapsed clients:

"Lots of them come, they don't want to speak to us, but we know them, but there is no judgement, that's what I always tell them, 'We not here to judge you guys, we here to help you guys.'" **(Participant 1)**

Participant 1 indicated that when clients returned to treatment they might be unwilling to communicate with the healthcare professionals. During relapses, clients might return to treatment centres or healthcare professionals from which they had previously received treatment. As a result, they were already known to the healthcare professionals they had interacted with after the relapse had occurred. Participant 1 mentioned that as a healthcare professional, she would inform the clients on their return that they would not be judged. Furthermore, she assured these clients that they, the healthcare professionals, were there to assist them.

Participant 1 expanded on her lack of judgement by reiterating:

"Like I said there's no judgement, they come back, they come. I'm here to work, that's my work there's no view on that." **(Participant 1)**

Participant 1 also indicated that her work was her primary focus and regardless of whether her clients were returning after relapses she maintained her lack of judgement towards them.

Participant 2 expressed her attitude towards judgement:

"A second chance maybe might work. So that's what I always tell them, 'When you here for the second time, don't think that we are here to judge you…'" **(Participant 2)**

Participant 2 indicated that when a client returned for treatment after relapsing, there was a possibility that the client might recover. Participant 2 stated that she informed the clients that they were not going to be judged by healthcare professionals. This suggested that

such non-judgemental attitudes from the healthcare professionals correlated with their belief that recovery remained a possibility.

Participant 2 provided additional reasons that led to her being non-judgemental towards relapsing clients:

"So you cannot judge a person that much because he has relapsed, it's because of situations where maybe it's because peer pressure, maybe you never, there's lots of reasons, hence I say, I believe, yeah I do have confidence in them in a way that they will change, there are chances of them changing." **(Participant 2)**

It can be surmised that Participants 1 and 2 informed their clients of their non-judgemental attitudes to bring reassurance to the clients and enable them to feel comfortable during treatment after they had relapsed.

Participant 4 demonstrated her attitudes towards substance-dependent clients who had relapsed:

"No, it doesn't change my attitude towards them (silence) (sigh). Because often they relapse for a reason, ummmm I don't want to see them as 'ugh here you are again', that's not why they here, that's not. They come because they need, they seek help, they want to change, they want to something differently, they manipulating, they want you to fix them. I know I've seen that all but you need to let them see that they can be enough on their own." **(Participant 4)**

Participant 4 indicated that if a client had relapsed it did not change her attitude (as a healthcare professional) towards the client. She demonstrated an understanding that a client might relapse for multiple reasons, and that this must not influence the way the client was viewed. She expanded on this by saying that the client had come to seek help and her focus was on aiding the client to change his/her perspective and to treat them.

Participant 8 suggested non-judgemental attitudes towards substance-dependent clients who had relapsed:

***"So it will take a client 1,2,4 relapses perhaps, but I don't judge him any differently because I'm trying to use that to make them see that this is a disease and every time the consequences are worse, so my attitude is not one of anger or hostility or disciplinary…."* (Participant 8)**

Participant 8 specified that it did not matter about the number of times a client returned for treatment, he still did not judge the client for relapsing. Participant 8 stipulated that the reason for his attitude was to make the client aware that substance-dependence had worsening consequences after each relapse. Participant 8 also stated that he did not have any anger or hostility when working with relapsing clients. This suggested that Participant 8 had a very good understanding of the recovery or relapse cycle that was often experienced by those who had substance-dependence issues.

Participant 7 further supported that healthcare professionals demonstrated non-judgemental attitudes towards substance-dependent clients:

***"I try not to label them, I think that… that label that we put on certain people, we need to take out that label, the label of 'you have relapsed'".* (Participant 7)**

Participant 7 indicated that she tried not to label her clients when they returned for treatment after they had relapsed. This healthcare professional's non-labelling of her clients suggested that it was a preventative measure to ensure that all clients were treated equally, regardless of how many times they had accessed treatment. In addition to this, it could be seen to imply that the labelling of relapsed clients could lead to associative negative attitudes.

This sub-theme clearly demonstrated that some healthcare professionals showed non-judgemental attitudes when working with substance-dependent clients who had relapsed.

5.4.1.2. Understanding attitudes

Healthcare professionals in the study were also identified to display or demonstrate understanding attitudes when working with substance-dependent clients who had relapsed. The healthcare professionals displayed sympathetic and compassionate attitudes towards relapsed clients. Understanding that relapse was part of the recovery process was suggested to lead to the positive attitudes that were demonstrated by the healthcare professionals in the study. The interview extracts demonstrate participant findings which suggest that they possessed understanding attitudes when working with clients who had relapsed.

"So like I said it's part of the process, and my attitude towards them is neutral, acceptance of what you've done, not judgemental." **(Participant 8)**

Participant 8 indicated that he viewed relapse as part of the recovery process. He promoted acceptance of relapse and held neutral attitudes towards clients who had relapsed.

Participant 8 expanded on his positive attitudes towards relapsed clients:

"One of like I said, empathy. One of reinforcement, one of that it's okay, it's part of the process, it's not bad to relapse…." (**Participant 8)**

Participant 8 stated that when he was working with clients who had relapsed he had empathy towards them. He stated that his attitude was one of reinforcement, making the client aware that it was not bad to relapse and that it was often part of the recovery process. Participant 8 demonstrated understanding attitudes because he did not view clients relapsing negatively, but viewed relapsing as part of the recovery process.

Participant 1 suggested that healthcare professionals demonstrated understanding attitudes:

"So I like said I do understand when they come back, and not to give up, also that way not to demotivate myself, not to give up and not liking my profession anymore. You do see a lot of them relapsing, especially the young ones." **(Participant 1)**

Participant 1 indicated that she understood when clients returned after relapsing, and that having such understanding resulted in her not giving up on the client. She also stated that having an understanding of such relapse prevented her from becoming demotivated within her profession.

Participant 6 suggested that healthcare professionals demonstrated understanding attitudes when working with relapsed clients:

" … if you in addiction enough you realise that relapse (silence) happens, it's not that they have thrown away two years of their life after being clean for let's say two years. It's that they they've got all that experience, they've grown but they've stumbled. You know where other people stumble with depression or anxiety or high-blood pressure or cholesterol or whatever, you know… addicts they struggle as well." **(Participant 6)**

Participant 6 indicated that when a healthcare professional was regularly exposed to substance-dependence, they understood that relapse was always a possibility. Subsequently, this led healthcare professionals to view client relapses as a stumble in their recovery journey. Participant 6 made a direct comparison between relapsing and a client struggling with depression, anxiety or high blood pressure. Such a comparison would suggest that Participant 6 held the view hat there was little difference between substance-dependent clients relasing and clients with other habitual or medical disorders.

Participant 6 expanded by saying:

"Keeping the caring attitude for your clients, whether they be coming for the first time or be relapsing addicts." **(Participant 6)**

This emphasised his caring attitude when working with clients, and regardless of whether they were coming for the first time or they had relapsed, his attitude towards the clients remained the same. This could be seen to support the belief that some healthcare professionals' attitudes were not influenced by client relapse:

"I tried to make them feel comfortable, if I think of specific people I try to let them understand, yeah (pause) I don't have those negative attitudes of feeling… or my feeling of helplessness, of feeing of anger. I treat them like any of the other clients. I don't treat them differently." **(Participant 7)**

Participant 7 stated that she tried to make her clients feel comfortable. She expanded on this by saying that she did not hold any negative attitudes or feelings towards clients who had relapsed. In highlighting that she did not feel helpless or angry and that she treated all clients the same, she clearly portrayed positive attitudes towards clients who had relapsed.

Participant 4 also demonstrated a positive attitude towards relapsing clients:

"So the moment I start you like that, I was like 'Yeah I can roll with you going back, it's okay for you to come back' and I need to say that to them as well, 'It's okay when you come back because when you come back it shows that you want to change again' ummmm yeah that's how I roll with it". **(Participant 4)**

Participant 4 indicated acceptance of clients relapsing and returning to treatment. She also stated that she informed relapsing clients that she was "okay" with them coming back after they had relapsed. This again implied that healthcare professionals maintained a positive attitudes towards clients who had relapsed.

This sub-theme clearly demonstrated that some healthcare professionals were sympathetic, compassionate and showed understanding when working with relapsed clients.

5.4.1.3. Motivating attitudes and/or supportive attitude

Healthcare professionals in the study were also identified to display encouraging, supportive and motivating attitudes when working with substance-dependent individuals who had relapsed:

"I don't think I have an attitude, I mean it's … we all people, we make mistakes and yeah you need to help them, help them realise their mistake and get them back on track and so that they can go forward." **(Participant 5)**

Participant 5 demonstrated a belief that she held a sympathetic attitude when it came to working with clients who had relapsed. Participant 5 further added that she viewed clients who had relapsed as individuals who had made mistakes, and that her position as a healthcare professional was to assist the client to get better and move forward. This suggested that Participant 5 focused on motivating the client to recover to move on with their lives.

Participant 4 also demonstrated a compassionate attitude:

"I believe that they need a second chance in life, so yeah I'm really passionate about substance-dependence treatment." **(Participant 4)**

Participant 4 indicated that she believed that clients who had relapsed deserved to be given another chance, and she added that she was passionate about substance-dependence treatment. This implied that she did not have a problem when clients returned to treatment after relapsing, which displayed optimism and positivity in her role.

Participant 9 valued her client's past experiences, and she saw them as a tool that could be used to both learn from and motivate relapsing clients. In focusing on their strengths and dismissing relapse as a failure, she portrayed both positive and motivational attitudes. She identified her role to be one of support and encouragement and to ensure clients felt comfortable with her:

"Obviously not judging, ummm working on the positives, what did they learn, working on their strengths ummm knowing and obviously letting the client feel that they are comfortable with me, no matter if they've failed or relapsed that they can come back, that I'm there for them basically, as support." **(Participant 9)**

Participant 4 also reflected motivation and support when dealing with clients who had relapsed:

"And I'm like 'seven times you fall, eight times you get up' ummmm I also try not to make them feel 'ugh you back again' but really you here because you took care of yourself kind of thing. Even if it's not true in the beginning if that seed is planted then they roll with that sometimes, so it doesn't make a difference if they relapse and they come back."
(Participant 4)

Participant 4 demonstrated that she provided motivation when the clients returned to treatment after they had relapsed. She viewed the fact that the client had returned positively, and demonstrated that clients were in fact taking care of themselves by seeking treatment. She also implied that she had a good understanding of the recovery/relapse cycle in saying that clients who failed repeatedly needed to get up and try again.

Participant 4 expanded on this whilst discussing motivating attitudes she had towards relapsed clients and how these could be used to assist the client with their recovery:

"So sometimes it helps if I make them see it differently, so that they can focus on the fact that they choose to come back and not just carry on with drug abuse." **(Participant 4)**

Participant 3 also provided a further example of a motivating attitude:

"So you've got to continuously keep on motivating, you've got to continuously… we look, we describe them as teaching points, turning points and teachable moments. So relapse is

actually just that, in my opinion, it's that, it's something we haven't covered yet, it's something that… can make you stronger, as long as there is motivation." **(Participant 3)**

Participant 3 clearly stated that motivation was a key factor in making clients stronger and aiding their recovery. He highlighted the importance of viewing relapse as a tool, a learning point and something to be utilised positively rather than a failure:

"In the beginning I pick up that they, they, they…there's a sense of shame again, but as soon as I intervene and make them aware 'but no recovery road is perfect' (silence) it helps them to, to feel empowered, that it's okay. That it's okay to rather get, the fact that they come back is a better indication of 'I want help, I'm working towards my sobriety, I'm working towards my abstinence.' Because there's people that relapse and they don't come back to the centre, and I think that's where the… the shift is." **(Participant 3)**

Participant 7 stated that when the clients returned for treatment after relapsing they could feel a sense of shame. She indicated that a client could feel empowered when their healthcare professionals enabled them to understand that relapse was a normal part of recovery. Participant 7 described that the focus was on the fact that the client had returned for treatment and not that they had relapsed.

This sub-theme has, therefore, corroborated the ideology that healthcare professionals hold supportive and/or supportive motivational attitudes towards clients that had relapsed.

5.4.2. Sub-theme 1B: Negative attitudes

The previous sub-theme demonstrated the range of non-judgemental, positive, motivational and supportive attitudes that healthcare professionals were found to display when working with clients who had relapsed.

However, there were also negative, unfavorable attitudes demonstrated by some healthcare professionals towards their substance-dependent clients who had relapsed. These attitudes are demonstrated in the following interview extracts.

5.4.2.1. Experiencing relapsed clients as difficult to work with

The difficulties that some of the healthcare professionals experienced were suggested to bring about unfavorable attitudes in their work with relapsed clients. The extracts below demonstrate the findings from participants suggesting that working with relapsed clients can be challenging:

"… sometimes it's challenging, sometimes it depends on the person if he's willing to change or not." **(Participant 2)**

Participant 2 elaborated on the difficulties of working with a relapsed client:

"Sometimes it's challenging though because someone will come here, he knows everything, he has attended all the group topics, and he knows how to answer questions that they asked by the social workers and stuff. People who have that attitude they superhuman and whatsoever." **(Participant 2)**

Here Participant 2 inferred that the familiarity of a programme and the healthcare professionals could lead to an attitude which was not conducive to change. She stated this to be a challenge, and it would appear to demonstrate a negative attitude towards returning clients and their prospects of success. This difficulty was also demonstrated by Participant 5:

"… some of them can be difficult, some of them yeah…but yeah noo I don't think… they not a problem, yeah. I think I work quite well with them." **(Participant 5)**

Participant 5 initially stated that some of the clients who had relapsed were difficult to work with. She then hesitatingly added that she, however, did not think that clients who had

relapsed were a problem and that she thought that she worked quite well with them. Such a contradiction and hesitation could imply a lack of confidence in the returning clients and could be seen as having a negative attitude.

Participant 4 further supported the notion that some healthcare professionals had difficulties in working with clients who had relapsed:

"… it's hard to work with somebody that's, that's here for a second, or a third time, or a fourth, or an eight time because they … they often think, 'I've tried it nothing is working'". **(Participant 4)**

Participant 4 indicated that it was difficult to work with client that had relapsed many times because the client thought that the treatment would not work. This suggested that difficulties or barriers might arise owing to the lack of faith that the clients had in the intervention. It was suggested that the healthcare professional might at times feel like they had to prove themselves to the client for them to buy in to the treatment plan.

5.4.2.2. Disappointment because of client relapsing

The findings presented in the study demonstrated that when clients relapsed some of the healthcare professionals indicated that they experienced disappointment. The interview extracts corroborated these unfavorable attitudes:

"It was sad, especially also when you as the social worker do see the potential of the service user, but that service user, you know, don't see it your way." **(Participant 1)**

Participant 1 stated that when she saw returning clients she felt sad. This may be due to the fact that during the treatment process she saw the clients' potential and what they were capable of. Participant 1 experiencing feelings of sadness reflected her personal disappointment in a client's relapse and his/her inability to see his/her potential.

Participant 4 agreed with Participant 2, however, this time it demonstrated the healthcare professionals questioning what their programme had to offer a client who repeatedly returns, rather than the client questioning it:

"… sometimes you do question 'is my programme still valid?' 'Am I doing the right thing?' But if you know that you doing a programme that is successful or that has success, you must also take into account that a person has also choices. So that in the beginning you feel like a failure because 'ugh my person has relapsed again' or 'my person has tried committing suicide again'." **(Participant 4)**

These extracts highlights that there were times when a client relapsing can lead to a healthcare professional questioning the validity of a treatment programme. Participant 4 also stated that it had resulted in her questioning whether or not she was doing the right thing for the client. She indicated that when she started with substance-dependent clients who had relapsed she would feel like a failure when relapse occurred. She expanded on this to acknowledge that clients had choices and that they were accountable for the success of their recovery.

It could be surmised from the account given by Participant 4 that healthcare professinals could project their feelings of failure and disappointment onto their clients but with added experience in working with this group, these feelings could be mitigated.Participant 3 expanded on feelings of disappointment and highlighted that personal feelings could negatively affect attitudes:

"You know there are some people, there are times when there's an emotional… as a professional helper there's that level of personal involvement, and that is generally where disappointment sets in because it moves a little bit away from the professional component of it." **(Participant 3)**

Participant 3 indicated that there were times when, as a healthcare professional, he became emotionally involved with some of his clients, and feelings became personal. This could result in hid becoming disappointed when a client relapsed. The risk was that he could project this disappointment and feeling of failure onto his clients which might negatively affect their recovery. Such an attitude was suggested to be evident when the healthcare professional focused more on the emotional part and less on the professional component of working with the client.

Participant 3 elaborated further with regards to these disappointing attitudes:

"The recovering process is not a once of thing, it's a journey that needs to be walked and that journey is walked over approximately, I'd say about six months at best, and as that relationship unfolds, you know, and you lose your professionalism in it… you termination becomes problematic, the once termination becomes problematic and you add to that the relapse component it's almost as if you've failed." (**Participant 3)**

As is evident a failure on the part of a client was internalised by Participant 3 as a failure in his ability as a professional. Such emotions could lead to excessive pressure and perceived negativity from the client who might now feel as if they had "failed" their healthcare professional by relapsing.

"But it is difficult, it's not nice because you, you want your patient to succeed, you want your patient to have a road to recovery, you have a patient that is 600 days clean, and you, you can feel proud of them because they doing, but you can't take the success for yourself, it's that patients choices." **(Participant 4)**

Participant 4 stated that it was difficult when working with clients who had relapsed because as a healthcare professional she wanted to see her clients succeed in terms of recovery. She also indicated that there was a deviation from a purely professional relationship

to a personal one when she described her own feelings of pride and success. However, she continued to acknowledge that success was a result of the patient's choices. This would imply that a client's choices directly influenced the healthcare professional's attitudes.

Participant 3 further explained the feelings that came about when a healthcare professional was invested emotionally when working with a substance-dependent client:

"You can't be in this in line of… you can't do… you can't work in substance-abuse if you can't handle relapse, because you gonna be very disappointed and you gonna be burnt out, you'll be burnt out sooner than later." **(Participant 3)**

Participant 3 stated that as healthcare professional, it was impossible to work with substance-dependent clients if one was not able to work with relapse. He emphasised that if healthcare professionals were not able to deal with relapse they would be disappointed and "burn out" very quickly. It was suggested that the feeling of disappointment might arise from the fact that the healthcare professional did not expect the client to relapse after treatment. This again indicated that the personal emotions of the healthcare professional became involved in the patient's recovery/relapse cycle.

5.4.2.3. Labelling of relapsed clients

The negative labelling of clients who had relapsed by healthcare professionals might demonstrate the unfavorable attitudes that healthcare professionals could have when working with relapsed clients. The following extracts serve to provide evidence of such negative labelling:

"I do know that I need to be very cautious because there's a lot of manipulation from clients and this you won't pick with experience through years of trying, sort of like asking the same question but in a different way and getting a different answer, so the lying and the manipulation is part of the addicts normal behavior… ." **(Participant 8)**

Participant 8 highlighted that when working with clients who had relapsed, he needed to be cautious as the clients could be manipulative at times. He further added that lying and manipulation was normal behavior for "addicts". Both of these attitudes were negative labels and were suggestive that he had a preconception of these traits before initiating work with relapsed clients.

Participant 1 described the expectations of uncooperative clients during treatment could lead to relapse:

"And when they come back sometimes, you know, like the one I'm waiting for, told me, he said 'You told me so I was gonna relapse' because you can pick it up with their attitudes when they here, you know if they serious and motivated, you also know". **(Participant 1)**

Participant 1 indicated that when the clients returned after relapse they sometimes blamed the healthcare professional for telling them that they were going to relapse. As a result, the healthcare professional could be seen to have labelled the client for failure during his previous treatment.

Participant 2 spoke about the behavior of the client prior to relapse, and this was suggested to influence the healthcare professional's behavior:

"Looking at how he carries himself here, then when he leaves then he relapses then you tell him 'You know what I saw you the first time you were here, you into friends who you… you don't care about other people and you know'. If the environment was the problem then you say 'You refuse maybe to move away from where you staying where it is rough or whatsoever' so the views will be looking at the reasons why maybe he relapsed." **(Participant 2)**

Participant 2 indicated that she observed the way the clients acted during their treatment before relapsing. When the client returned after they had relapsed, the healthcare

professional then reminded of their behavior during the first cycle of treatment. This gave the indication that the healthcare professional was insinuating (to the client) that the client could have prevented his/her relapse.

Participant 8 spoke about clients who had relapsed negatively and utilised negative terminology and labels when talking about them:

"Clients that are over 30 tend to dry knuckle, white knuckle, and deal with life in a very harsh manner and be very hostile towards people and 'Why me, having a pity party', a lot of unpleasantness with the family and trying to justify reasons to use, and then actually using knowing full well that they can go back to rehab and they can go through the whole process again and recover because it is possible, because they intelligent enough to know. So go on binge drinks and they go on using drugs, full binge knowing they can go back to rehab and get clean because the medical aid pays per year for certain treatments ummmm so they are called sort of 'rehab-riders'. They know they can abuse the system and the consequences ummmm vary and every time they relapse they get worse and worse and worse…". **(Participant 8)**

Participant 8 stated that some clients relapsed because they knew that they could go back to treatment and recover. Participant 8 expanded on this in saying that such clients were called "rehab riders". He further described that the clients knew that they could abuse the system. This suggested that this healthcare professional viewed these clients negatively and also attached negative labels towards clients who returned after relapsing.

This sub-theme focused on the negative attitudes that were demonstrated by healthcare professionals towards working with clients who had relapsed. These negative attitudes ranged from healthcare professionals finding it difficult to work with clients, viewing them as liars, manipulators, abusers of the system and "know it all". There was also

ample evidence to highlight that healthcare professionals often projected their own feelings of disappointment, failure and sadness onto their clients upon their return to treatment.

5.5. THEME 2: Factors that influence healthcare professionals' work with substance-dependent clients who had relapsed

The previous theme identified the different attitudes that were held by healthcare professionals with regards to working with substance-dependent clients who had relapsed. Healthcare professionals were evidenced to have both positive and negative attitudes that had a direct effect on the way that they dealt with the clients who had relapsed. However, the findings also revealed that healthcare professionals working with relapsed clients were influenced by other factors, apart from their attitudes.

5.5.1. Sub-theme 2A: Client attitudes and behavior

The way clients carried themselves and the attitudes that they demonstrated during the treatment process (after they had relapsed) were seen as having an effect or an influence on the way healthcare professionals responded when working with them.

The extracts below demonstrate the variety of attitudes displayed by clients during their relapse treatment.

"…you know sometimes it depends on their attitude, their mind-set if they come in, but as where me treating them as professional, no, as the professional you have to be neutral with the client." **(Participant 1)**

Participant 1 specified that the client's recovery might also depend on their attitudes and mind-set when they returned. However, she stated that this did not influence the way she as a healthcare professional treated the client. This demonstrated that her attitude remained neutral and was not influenced by the client's attitude; as would be expected of a professional.

Participant 4 also discussed the client's attitude during relapse treatment:

"Then on the other hand someone that comes for the second time often feel destitute because 'Ugh I've done it again', they often don't see that relapse is part of their journey so with them the guilt feelings…". **(Participant 4)**

Participant 4 went as far as to say that returning clients might feel destitute, and added that they often had feelings of guilt from relapsing. She indicated that they might have feelings of frustration and disappointment because they had "done it again".

Participant 2 identified that boredom was experienced by relapsed clients:

"They get bored, they do not want to attend AA meeting, they do not want to attend this and… it depends on that particular person if he want to change or not." **(Participant 2)**

Participant 2 spoke about clients becoming bored with treatment by mentioning that they did not want to go to their AA meetings and that they were not interested in attending the different interventions. Participant 2 stated that it was up to the client to make a decision as to whether they wanted to change or not. This suggested that the healthcare professional did not have much control when it came to the decisions a client made after the treatment process. Therefore, intervention in the recovery relapse cycle lay heavily on the client's shoulders.

The findings that were presented in this sub-theme demonstrate that the healthcare professionals were aware that clients who had relapsed returned with a wide range of attitudes, which appeared to be mainly negative in nature.

5.5.2. Sub-theme 2B: Reasons for a client's relapse

The reasons that led to the relapse of the clients were deemed important by healthcare professionals. The identification of the reasons that led to clients relapsing influenced the

healthcare professional's work with these clients. The reasons were also shown to influence the treatment plan or intervention that was subsequently implemented by the healthcare professionals. On returning to the facility after relapse the healthcare professionals generally focused on what led to their client's relapse, the reasons behind it and their return to treatment.

The following extracts demonstrate the importance of identifying the reasons for the client's relapse:

***"….we first screen that person to get to the bottom of 'Why did he relapse?'…".* (Participant 2)**

Participant 2 indicated that the first thing they did when the client returned was to establish the reasons that led to the client's relapse. During the interview, Participant 2 was asked why they investigated the reason for the client's relapse. She confirmed that the reasons for the relapse were important:

"*Yeah in a way you…the reasons are important".* (Participant 2)

Participant 9 also identified that healthcare professionals found the client's reasons for relapse important:

***"At the end of the day you there for the client, you not there because of the addiction per say but what reasons got them to becoming addicted. Do you understand? It's obviously they use it for coping reasons, why, why did they have to cope? And that's where I come, you know, and try to (inaudible). So I don't work with a lot with the addiction itself, but the reasons why they are addicted."* (Participant 9)**

Participant 9 expanded on the importance of investigating what led to a client's relapse. Participant 9 went as far as to say that when treating a client she sought the reasons

behind what clients needed to cope with. Thus, indicating that the reasons for addiction had a much higher importance that the addiction itself.

"Issues like overcrowding, gangsterism, violence, unemployment, poverty, lack of resources, out… the client system goes back to that. And we can't for a second undermine the power that has on influencing behavior. Some make it, most don't." **(Participant 3)**

Participant 3 indicated that after the treatment process, the clients returned to the same circumstances that they had left before. Participant 3 indicated that these circumstances influenced the client's recovery, and that the client had a high chance of failure. As a healthcare professional, she placed importance on being aware of the power that environment could have upon the client.

When a client returned for treatment after relapse, these circumstances would still be there, and the healthcare professionals and the client would need to work together to develop strategies to minimise their impact on the clients' recovery process. These circumstances were further explained by Participant 3:

"… we know there will be some distractions along the way, and so when we identify the distraction, once we see the consequences of that distraction, which now led to relapse, we need to look at how do we get ourselves back on track." **(Participant 3)**

Participant 6 continued to explain the importance of sourcing the reasons why a client relapsed:

"What I'm usually thinking is 'Well there was an activating event, what triggered their relapse, was it something out of their control or was it something in their control but they just didn't use what they've been taught, the new coping mechanism and avoidance strategies they've learnt?' you know, or 'Did they just not service their vehicle which is

sobriety?' You know so it's very much then 'Okay, what went wrong, how do we fix it so it doesn't happen again?'" **(Participant 6)**

Participant 6 demonstrated that when he saw a client after relapse his initial thoughts were what the reasons behind the client relapsing were. He continued to say that he also explored whether clients had control of what had led to their relapse. He then tried to ascertain if the client actually implemented the strategies that they had learnt during their treatment intervention. Seemingly, the focus was mainly about what had led to the client relapsing and how does the client and the healthcare professional make sure it did not occur again. Thus, the reasons for relapse were utilised as a focal point during relapse treatment.

Participant 6 similarly highlighted the impact that a client's environment had upon his/her recovery:

"They, they do get better, you know it's… they keep moving forward but that sometimes becomes difficult for them, you see. Because they, most of them go back to that same environment, so if you looking at client coming from the Northern areas, right, they know that 'Okay, that house and that house and that house sells drugs, the dealers are there and they there and there' and it's usually next door to them, in their street, in every neighbourhood, so it's very difficult environment for them to stay clean and not relapse because every day there's something standing in front of your door with an ice-cream and you like ice-cream but you not allowed to have it." **(Participant 6)**

Participant 6 clearly stated the difficulties that a client could be faced with when returning to the same environment and the negative impact that this could have upon their sobriety.

"Reason being because I go back where it went wrong, and I can often get it down to the point where they haven't followed schedule, they haven't used their tools, and they haven't

implemented certain safety measures: people, places and things. They've often been to bars trying to drink coke and party at certain places trying to blend in without alcohol and finding themselves giving in, due to peer pressure. So they have been told that they must avoid those places of high risk, so it's very easy narrow it down to where they went wrong." **(Participant 8)**

Participant 8 continued along the same theme of emphasising the importance in finding the reasons behind the relapse. Participant 8 stated that knowing where the client "went wrong" can be used to plan how they move forward with the client. Participant 8 identified that clients' failing to adhere to their schedule implementing the safety measures that they had been taught during the previous treatment process often lead to relapses. He further added that he found it easy to narrow it down to what caused the client to relapse.

Participant 1 suggested that the healthcare professionals might be consciously aware of reasons that might lead to a client's relapse even before the client relapses:

"But when you hear than one, like I said, you know like their attitudes and mind-set was not right or you just say 'I should have implemented changes' because sometimes they have partners that use, you know, girlfriends they don't want to let go of." **(Participant 1)**

Participant 1 indicated that when she became aware of one of her client's relapses she might attribute it to the client's mind-set or attitude or both during and post treatment. This healthcare professional added that this could lead her to thinking that she should have changed the way in which she initially worked with the client. She alluded to the fact that she might have awareness of issues that could lead to client failure during the initial treatment. In this case, she specified having knowledge of the client's partners that misused substances.

5.5.3. Sub-theme 2C: Healthcare professionals confidence in working with substance-dependent clients

The level of confidence that healthcare professionals had when working with substance-dependent clients, also appeared to influence their work with these clients. This confidence, which healthcare professionals gained, could be seen to grow based on their increased exposure to working with substance-dependent clients, and clients who had relapsed:

***"It's not about me and I think it's taken a long time to get to the place where it's about me rendering service and it becoming, coming to a place where it's about them and I'm only a co-ordinator, a facilitator, a conductor…".* (Participant 3)**

Participant 3 described how it had taken him a long time to understand that the treatment process was about the client and not about the healthcare professional. He stated that it was about him providing a service to the client and also just facilitating the process. This suggested that his attitudes changed to be client-focused instead of being focused on his success, or not, as a professional. As, with the passage of time, he would have been exposed to more clients, it could be surmised that increased client exposure was also a factor in him changing his attitude.

Participant 3 continued to explain the effects that exposure and time had on his ability to "handle relapse" and the increased knowledge he acquired when working with substance-dependent clients who had relapsed:

***"… As time elapses and the more you work with, the more knowledgeable of your subject matter, the better it becomes for you to handle, to handle relapse."* (Participant 3)**

Participant 4 also explained the impact that time had upon her work as a healthcare professional working with clients who had relapsed:

"When I started, you know I pretty much believed that it's my fault when they relapse… I'm reluctant to say it's confidence, I just think you, its growth…". **(Participant 4)**

As a result, with the passage of time and increased exposure to clients who had relapsed, Participant 4 had experienced professional growth. Her belief that a client's relapse was her fault had then been recognised as part of the recovery-relapse cycle and not a reflection of her personal capabilities.

A further example of how time and exposure had an impact upon a healthcare professional's attitude is expressed by Participant 7:

"Previously in my life there was a feeling of anger coming up in me if I'm, can be very honest. But as my professional life had been grow… had grown and I've developed myself and educated myself more and empower myself enough to understand where it's coming from, and it becomes easier, it's not such a huge issue anymore, especially because I have realised working here at the treatment centre and getting more educated on the field of addiction and you know with my own professional development that recovery is a process and no recovery is perfect." **(Participant 7)**

Participant 7 described how her previous feelings of anger had evolved into understanding the recovery process. She highlighted the connection between her own exposure, education and her professional growth to her improved knowledge of addiction and the recovery process. She identified that such growth had led to her feeling empowered.

"I personally I wasn't comfortable before I actually went in and spoke to the client. I wasn't sure because you ignorant basically, once you get involved with the clients who are addicts, you understand them." **(Participant 9)**

Participant 9 explained how interaction with and exposure to clients had changed her from being ignorant of them to understanding them and their issues. Her initial discomfort had also been eradicated with communication, the passage of time and exposure.

From these interview extracts, it is evident that time and exposure were inter-linked with knowledge, understanding and growth. Both of which inevitably had a positive impact on the attitudes of the healthcare professionals when working with their clients. Therefore, it could be assumed that they must be beneficial to the treatment that clients received.

5.6. THEME 3: Nature of treatment intervention/ plan implemented

During the treatment process after relapse, it was found that the different healthcare professionals implemented different interventions or plans when it came to working with clients who had relapsed. The decision to use a certain treatment intervention or plan seemed to be influenced by the healthcare professional's attitudes, the client's reasons for relapsing, the healthcare professional's confidence and capability to work with substance-dependent clients, as well as the client's attitude when they returned for treatment.

This theme answered research question 2, namely, in what manner do the attitudes that healthcare professionals have affect the treatment intervention and plan used? Two sub-themes were identified under these questions, namely, a) treatment intervention or plan implemented and b) aftercare services that were available for the clients after the treatment process.

5.6.1. Sub-theme 3A: The treatment plans or interventions

The treatment plans or interventions that the healthcare professionals implemented (when it came to working with clients who had relapsed) varied in nature and were dependent on certain factors.

Participant 1 provides an example of a healthcare professional who tried to engage the client's family in the treatment progress. This was, assumedly, to ensure that there was a mutual understanding of the journey that the client was on and the type of support he/she would need once he/she had completed therapy.

***"The intervention then we focus on, the relapse prevention, we focus more on this one's plans and goals as previous, you know. Also, then I try family sessions, see. That is well implemented more in the second time when they come back as well."* (Participant 1)**

Participant 1 also stated that their treatment was looking forward and focused on the client's goals and aspirations. Participant 1 continued to explain the relapse intervention:

***"The relapse intervention is where the client also just talk more, you know, get back to the roots".* (Participant 1)**

This implied that relapse intervention focused on the initial reasons that led to the client's substance use and the subsequent factors behind his/her current relapse.

***"… when he comes back for the second time then we try and re-correct what happened."* (Participant 2)**

Participant 2 stated that during treatment process (after the client had relapsed), the focus was more on identifying what went wrong and how the client and the healthcare professional fixed what went wrong. This was attempting to prevent issues leading to a relapse in the future.

Participant 6 was asked whether the attitudes that he held when it came to clients who had relapsed influenced the intervention he decided to use. His response to the question was as follows:

"I would say it influences the intervention that we will use in the sense of they've been to rehab before, you know, whether it be here or wherever, you know. It's now their second around so they more accustomed to it so you can go a bit deeper with them a lot of the time and do more." **(Participant 6)**

Participant 6 stated that the intervention he used was influenced by a client being to "rehab" before because the client was more accustomed to how procedures were done at "rehab". He described how his intervention with the client would then be a "bit deeper" (more personal), presumably as he believed the client would be able to handle more.

In contrast, Participant 7 as a healthcare professional does not differentiate between a new or returning client:

"The matrix treatment program that we use here at the treatment does… it's a cognitive behavioral therapy program and we don't differentiate between somebody that come, came back for relapse… because of relapse, somebody that come here for the first time…". **(Participant 7)**

Participant 7 utilised CBT regardless of the circumstances that the client was in therapy for, and a matrix programme was followed for new and returning clients.

Participant 4 explained that the treatment interventions she implemented were dependent on the client's needs and is one that continuously evolves to reflect such:

"But no treatment plan is stagnant, so you have to review it constantly, you have to change it constantly. Sometimes you have people if they here for the second time you adapt your programme so that you focus on other areas. Because you get to know your patients, so you get to know what's important to them and then you focus on that, yeah. But you need to review your programme constantly, you cannot go through life with like a horse (inaudible)". **(Participant 4)**

Participant 4 discussed the importance of constantly reviewing a client's treatment plan and changing it when it was necessary to meet the client's current needs. She adapted her treatment plan depending on the areas that clients deemed important to their lives. This suggested that the treatment intervention that the healthcare professional utilised was somewhat influenced by the client. She emphasised the importance of preventing the treatment plan from becoming stagnant.

Participant 9 also personalised a client's treatment plan:

"You know I don't work with a specific treatment plan ummm I have my guidelines but obviously it depends on the client and where the client is at that time, so I work according to their sort of process, their pace ummm I just change it all the time so I'm not fixed as to so, you know, I have to do this today, if something has come up or they bring something in to therapy then I work according to that. You know what I'm saying? So I work according to the client, where the client is at basically." **(Participant 9)**

Participant 9 used guidelines to underpin the treatment but the pace and the direction that the treatment took was directly influenced by the client, what was important to them, where they were in their recovery and what topics they brought into a session.

Participant 8 described how she found it easier to work with client's who had relapsed as their journey into treatment was quicker because they had already been equipped with the tools to aid recovery:

"The new client, however, you need to go through the whole tool process, which is the matrix model and… so that takes a little bit more time to equip the client with all those tools, so working with a relapse client is sort of easier for me because he's got the program, he's got the tools and we investigate where it went wrong. **(Participant 8)**

With client's who were returning to therapy after relapse, Participant 8's focus was to investigate what went "wrong" after the initial treatment, and to discover what led to his/her relapse.

This sub-theme focused on findings that demonstrated the different treatment interventions that were implemented by healthcare professionals when working with clients who had relapsed. In the majority of cases, it was evidenced that the treatment interventions were client-focused and subsequently adapted to the client's changing needs as and when appropriate. Only a small sample of healthcare professionals used a rigid treatment programme regardless of their client's relapse history.

5.6.2. Sub-theme 3B: Aftercare services

This sub-theme focuses on the aftercare services that were part of the treatment interventions implemented by healthcare professionals. After the client underwent a substance treatment intervention or programme, some of the healthcare professionals then referred their clients for aftercare services. This was predominant in-patient treatment facilities.

Participant 1 confirmed the utilisation of after-care services:***"…we do follow-ups nhe. Once a month when they done after completion of programme."*** **(Participant 1)**

Participant 1 explained that after they had assisted their clients, they had monthly check-ups on completion of the treatment programme.

Group sessions were also indicated as a tool for follow-up treatment by Participant 2:

"There is what we call aftercare services, where we want to know after his programme, what is he going to do? Where is he going? Who is he going to stay with? Is he going back home? So that helps a lot to say maybe 'If he goes home back home then he will do this,

then this person that is responsible for her will make sure that at certain times he goes and attend groups, like our group sessions'." **(Participant 2)**

Participant 2 described how prior to existing treatment, they established as much detail as possible about support networks that were available to the client when they left, for example, where they stayed and who would be "responsible" for them. Participant 2 was seen to advocate group sessions as follow-up to therapy.

Networks of aftercare support that could be utilised were identified by Participant 6:

"… also connect them with as much resources as you can if they busy with the right things they don't get bored and they don't have as much time to get busy with the wrong, so you link them up to the NGOs, NPOs that offer counselling, group therapy, you link them up with psychologists and psychiatrists, and you know your clinical social workers so that they have all the resources that they need, they just need to use them." **(Participant 6)**

Participant 6 recommended that clients accessed as many after-care treatment as possible to ensure their success. He referred them to multiple resources as he held the belief that keeping the client engaged in these services would reduce the likelihood of boredom, which he felt would lead to relapse.

This theme presented findings that demonstrated the interventions that were utilised by the healthcare professionals during treatment process with a client that had relapsed. The interventions varied depending on the healthcare professional's attitudes, confidence and capability as well as the reasons that led to the client relapsing.

5.7. Summary of chapter

Three themes emerged from the results of the study. Under the first theme, the results showed that healthcare professionals had a range of attitudes when it came to working with

substance-dependent clients who had relapsed. These were both positive and negative attitudes. The second theme presented results that focused on the factors that influenced the healthcare professional when it came to working with relapsed clients. The client's attitudes, reasons that led to client relapsing and the confidence of the healthcare were the factors that were identified as influencing the healthcare professionals, other than healthcare professionals' attitudes. The third and last theme presented results on the different treatment interventions that were used by healthcare professionals when they worked with substance-dependent clients, aftercare services were also seen as being important in the client's recovery process.

Chapter Five presented the findings of the current study, and Chapter Four discusses the findings of the study using the theory of planned behavior as a framework.

CHAPTER SIX

Discussion

6.1. Introduction

Chapter Five discussed the main findings of this study. The aim of Chapter Six is to relate the findings of the study to the existing literature in Chapters One, Two and Three, demonstrating how the research findings addressed the research questions. This is done by reintroducing the overview of the study and focusing on the research aim and rationale.

6.2. Answering the research question

The study presented two research questions, namely, 1. What are the attitudes of healthcare professionals towards substance-dependent clients who had relapsed? 2. In what manner do these attitudes affect the treatment plan or intervention implemented? This section discusses the three main themes that were identified in the findings and how these were then utilised to assist in answering the questions being asked by this research study. To maintain consistency, the themes are addressed in the same order that they were presented in the previous chapter.

6.3. Healthcare professionals' attitudes

Attitudes are defined as "a learned disposition to respond in a consistently favorable or unfavorable manner with respect to given context" (Conner & Norman, 2005). Cornfield (2018) describes attitudes as complex psychological constructs, and their development is an even more complex process involving the interaction of many interrelated factors. Attitudes are also considered an overall evaluation by an individual.

Ajzen's (2005) theory of planned behavior proposes that attitudes towards a particular behavior arise from a combination of beliefs about its consequences (behavioral beliefs) and the evaluation of consequences (outcome evaluation). This means that attitudes are developed

from the beliefs that people hold about a given behavior (Ajzen, 2005). Gaston (1990) (as cited Cornfield, 2018) states that counsellors' attitudes toward their substance-dependent clients can help predict how counsellors respond to their clients in a session. Such a statement would allude to counsellors possibly having a pre-existing bias towards any clients with whom they will interact. It can be assumed that this bias may be positive or negative in nature.

The findings of the study ascertained that healthcare professionals possessed both positive and negative attitudes with regard to working with substance-dependent clients who had relapsed. This could be a major factor in the quality of care that a client receives and could have a positive or detrimental effect towards their recovery. Gilchrist et al (2011) concur with this belief and state that healthcare professionals' attitudes can influence or affect the quality of care they provide to substance-dependent clients. Similarly, Cornfield (2018) states that most counsellors are likely to see substance-dependence during their careers, and their attitudes towards these clients will strongly influence the therapeutic value of these encounters, which can either be helpful or harmful. It is worth noting that Cornfield (2008) is referring to "most counsellors" and not specifically the healthcare professionals who work exclusively with substance-dependence.

Au (2006) also reported that factors influencing the under-diagnosis of substance-dependence might emerge from personal or societal biases, deficient medical education about addiction and false perceptions of inadequate responses to interventions. These factors might not only influence the diagnosis of substance-dependence, but the attitudes that healthcare professionals have when working with substance-dependent clients.

6.3.1. Negative attitudes

According to the theory of planned behavior when an individual holds a strong belief that negatively-valued outcomes will result from behavior, they will have a negative attitude towards that behavior (Glanz et al, 2015). The findings of the study showed some of the healthcare professionals interviewed experienced difficulties when working with substance-dependent clients; particularly those who had relapsed. Such difficulties were suggested to bring about negative and unfavorable attitudes when working with this client group. Further suggestions that this client group can be difficult or problematic to work with were identified by Lindberg et al (2006) who stated that alcohol and substance-dependent clients were sometimes viewed as being difficult to diagnose, and because of tolerance and dependence, often problematic to manage and treat.

The study revealed that the attitudes of some of the healthcare professionals changed over time in accordance with increased exposure to and knowledge about the issues that could present when working with clients who were substance-dependent. These attitudes were overwhelmingly seen to begin as negative owing to lack of knowledge, and identified as frustrating or failing, but evolved to be more positive in nature. Gilchrist et al (2011) concurred that negative attitudes and dissatisfaction resulted from a perceived or actual knowledge or skills that healthcare professional's exhibit.

One of the difficulties or barriers that the study revealed was the familiarity of a programme and the healthcare professional to the relapsed client, potentially leading to an attitude which was not conducive to change. This was seen as a challenge by the healthcare professional, which then resulted in negative attitudes towards returning clients and their prospect of successfully recovering.

Several of the healthcare professionals noted that when some of their clients returned to treatment after relapsing, they had a lack of faith in the intervention. The healthcare professionals suggested that the lack of faith caused difficulties in their work, as they personalised the client's relapse as their own "failure", which led them to question their professional abilities. This finding was supported by a study conducted by Richmond and Foster (2003) where healthcare professionals displayed low scores for treatment optimism (indicating negative experience and low morale in treating substance abusers) and treatment intervention.

The stigmatising attitudes of nurses and mental health professionals have also been shown to affect treatment recruitment and retention. These attitudes can also affect their willingness to treat substance-dependent clients and influence the quality of care they provided (Gilchrist et al, 2011). The current study found that although the healthcare professionals experienced difficulties when working with clients who had relapsed, they were still willing to assist them. This was suggested to result from the fact that the healthcare professionals interviewed had self-selected to work with substance-dependent clients and held the belief that recovery was possible. This provides evidence supporting the behavioral belief that the healthcare professionals had influenced their attitudes towards working with substance-dependent clients, however, their intention to continue assisting clients who had relapse was not shown to be negatively influenced.

According to a study conducted by Van Boekel et al (2013), nurses described the care for patients who use illegal substances as emotionally-challenging. This was reflected in the study, with some healthcare professionals indicating that they felt sad when they saw their clients return after completing treatment. This sadness was attributed to the inability of the clients to see their potential and capabilities, coupled with the healthcare professionals desire to see their clients succeed in recovery. Emotional reactions, anger as well as feelings of fear

and sadness were shown to play a major role in attitudes (Corrigan, 2000). The sadness was suggested to reflect the personal disappointment of healthcare professionals in response to a client's relapse. Several healthcare professionals noted that the disappointment they experienced after the relapsing of clients was due to them being emotionally-involved with the progress of some of their clients. This suggested that some of the healthcare professionals focused on the emotional and professional aspect of their client relationship rather than the professional component exclusively.

Involvement in the personal setting and emotional-involvement, also referred to as personal continuity was seen as being prevalent and highly-valued in working with substance-dependent clients (Van Boekel et al, 2014). When this occurred, the risk that was identified was that the healthcare professionals could project their negative feelings onto their clients, subsequently negatively impacting their client's recovery.

Soto and Stuart (2014) indicated that social workers' negative attitudes included the idea that treatment would not be effective because of a likelihood of relapse, which contradicted the findings in this study. The study revealed that even though some of the healthcare professionals exhibited negative attitudes towards the relapsed client, they still believed that recovery was possible. This concurred with Akinola (2015) who found that healthcare professionals believed that substance-dependence recovery was possible even in clients with relapsed histories. However, it also suggested that they did not find working with substance-dependent clients pleasant.

Ford (2011) stated that nurses reported that patient's manipulative behavior, in relation to medication and treatment regimes, impeded their ability to provide nursing care. Issues of manipulative behavior were similarly highlighted by some of healthcare professionals interviewed, who reported the need to be cautious when working with this

client group. The effect of such caution is implied by Ford (2011) as being a destruction of trust within the therapeutic relationship. In line with previous findings and this study's findings, Van Boekel et al (2013) found that the negative feelings (such as frustration, resentment and powerlessness) healthcare professionals had towards substance-dependent clients were explained by the perceptions that these clients were potentially-violent, manipulative, or poorly-motivated.

Certain healthcare professionals believed that some clients relapsed because they knew that they could return to treatment and recover. One healthcare professional, in particular, viewed such clients as abusing the system. This was supported by Bota (2006) who indicated that healthcare professional's negative attitudes towards substance-dependent clients were of the belief that they abused the resources for their substance-dependence (Bota, 2006). The abuse was caused when patients would not follow the treatment plan developed by the interdisciplinary team resulting in relapse and wasting valued time from professionals (Gotay, 2014). These negative views by the healthcare professionals were also attached to negative labels towards the clients.

The healthcare professionals in the study explained that to work successfully with substance-dependent clients, they needed to be able to work with relapse. They stated that if a healthcare professional was unable to accept and deal with relapse they would be disappointed and burnt out. This was another instance in which the personal emotions of healthcare professionals were shown to become involved in the client's relapse or recovery process, as such, it was important for healthcare professionals to be aware of this.

The study found that within the group of healthcare professionals involved there were no negative associations or distinctions between clients who were substance-dependent and those who had other medical ailments. However, Cornfield (2018) argued that healthcare

professionals demonstrated negative attitudes towards substance-dependent users when compared to clients or patients suffering from other ailments, such as physical disabilities, mental disabilities and intellectual disabilities. In addition, it was also found that, out of all patients groups, healthcare professionals had the least desire to work with, and the most negative attitudes towards, substance-dependent clients. Again Cornfield's (2018) findings were not representative of the findings from this study. The plausible explanation for this would be that the professionals included in this study were ones who had specifically decided to work with those who had substance-dependency issues.

6.3.2. Positive attitudes

According to the theory of planned behavior, individuals learn to favor behaviors that they believe have largely desirable consequences (Ajzen, 2005). As attitudes towards the behavior are a person's overall evaluation of the behavior, if the outcome or result of a particular behavior is seen as being positive, valuable, beneficial, desirable, advantageous or a good thing, then a person's attitude will be favorable with a greater likelihood of the person engaging in the behavior (Ajzen, 2001).

The findings of this study ascertained that many of the healthcare professionals showed positive and understanding attitudes when working with clients who had relapsed. This was partly attributed to their belief that relapse was part of the recovery process, and was not viewed negatively. These healthcare professionals indicated that when clients returned for treatment after relapsing, they did not have negative attitudes towards them because they retained the belief that treatment could still be effective and the client might recover. These positive attitudes demonstrated by the healthcare professionals were evidenced to increase as the knowledge and experience of the healthcare professionals grew. Bota (2006) extended the belief that experience played a positive role towards healthcare professional's attitudes and beliefs. Bota (2006) found that healthcare professional who had a

personal history of substance-dependence had believed that substance-dependent clients could recover and lead a productive life after the treatment process (Bota, 2006).

A client's relapse did not appear to discourage healthcare professionals from focusing on the client's recovery. The possibility of clients recovering after treatment was seen to be an attainable and desirable consequence. This placed the focus of the healthcare professionals squarely on the journey and not the judgement of the client's perceived failure. This confidence in the success of treatment of substance-dependence was expected to influence the attitudes of healthcare professionals positively (Van Boekel et al, 2014).

Relapse to substance-dependence is seen as a global issue and is conceptualised as an integral component of the recovery process (Appiah et al, 2017). The findings of this study showed that the healthcare professionals understood the possibility of relapsing when working with substance-dependence. This resulted in them overwhelmingly portraying positive instead of negative attitudes when one of their clients relapsed. The understanding of relapse as part of the recovery process led to healthcare professionals adopting more empathic attitudes when working with these clients. This allowed the healthcare professionals to dismiss seeing relapse as a representation of failure, and focus more on the client's strengths.

The theory of planned behavior believes that a person who holds strong beliefs that positively-valued outcomes will result from performing the behavior in question, will have a positive attitude towards the behavior (Glanz et al, 2015). Some healthcare professionals in this study deemed client relapse as a mistake and believed clients deserved to be given another chance. In this case, the role of healthcare professionals was seen as motivating and one of assisting clients to recover. Amongst these professionals there was an emphasis placed on making such clients comfortable as well as dispelling any negative expectations and

feelings (such as being ashamed) they had when returning for treatment. The need for being non-judgemental towards this client group was also emphasised. The belief that substance-dependent clients needed help and guidance with their problem was discovered to bring about positive attitudes from healthcare professionals (Gotay, 2014).

Healthcare professionals indicated that working with and interacting regularly with substance-dependent clients led to them having a better understanding of substance-dependence with relapsing being part of the recovery process.

Understanding that there were a variety of reasons behind why clients relapsed was also shown to consolidate non-judgemental attitudes of healthcare professionals. Acknowledgment of the impact of such reasons led to changes in treatment plans and focused on making positive changes to the client's lifestyle to ensure future success. Wild et al (2001) identified that positive attitudes from health professionals were due to the belief that drug problems were caused by a pathological reason and preferred drug treatment for rehabilitation instead of incarceration for punishment of the individual. The focus of the healthcare professionals was to make sure that clients understood the consequences of their relapse, and that they worked towards their recovery.

A previous study found that general psychiatrists gave preferential treatment to non-substance-dependent clients with similar mental/medical disorders, resulting in substance-dependent clients waiting longer for treatment (Gilchrist et al, 2011). However, this study served to contradict such findings. It is important to note that Gilchrist et al's (2011) study was of general psychiatry and not of those working solely with substance users, which would explain the discrepancy between the two studies.

Additionally, in contrast to Gilchrist et al's (2011) findings, the current study found that not only did the majority of professionals interviewed fail to display any negative bias

towards their client's for being substance-dependent, they actually regarded relapse (of substance-dependent clients) as being no different to relapse of those with medical disorders. This perspective was shared by Van Boekel et al (2014) who believe that when healthcare professionals do not distinguish between substance-dependency and other disorders, then attitudes of those involved are more positive in nature. Previous studies indicated that endorsement of substance use disorder as a disease generally shows more positive attitudes (Van Boekel et al, 2014).

Gotay's (2014) study revealed that healthcare professionals displayed positive attitudes owing to the low level of discrimination and a prominent level of acceptance towards the substance abusers. This was demonstrated with the question in their survey of strongly agreeing or agreeing that it was worthwhile to serve substance users, provided, if asked, they did not have the right to refuse care to the client and, given a choice, would work with substance users (Gotay, 2014). All of the healthcare professionals involved in this study believed that those who were substance-dependent had the right to access treatment, as the delivery of such treatment was an integral part of their chosen career path. Thus, it could be surmised that they overwhelmingly held positive attitudes towards relapse and recovery and believed that there was a chance that their clients could achieve and retain sobriety.

6.4. Factors influencing the healthcare professional's intention to work with relapsed clients

There are various factors which influence the health care professional's intention to work with clients who had relapsed.

6.4.1. Client's attitudes and behavior

Overwhelmingly the clients' attitudes towards their recovery, treatment plan and subsequent sobriety were cited as reasons for either their success or their return to relapsed

states. The professionals interviewed agreed that the clients' attitude was a key factor in their recovery and was something that they, as professionals, had very little control over, particularly once the client had left treatment. There were many behaviors identified that could impede treatment coupled with several that were identified as hindering the healthcare professional's role. Some of these behaviors identified were the feelings of failure that clients held, which created a barrier to their treatment, opposing nonchalance that failure was not an issue as they could keep returning to treatment. Boredom with treatment options, particularly where clients were returning to the same centre, professional or programme. These were cited as behavior that several clients exhibited. This placed the emphasis on the healthcare professional's role to be strongly one of motivation. Boredom and dissatisfaction with treatment was noted amongst those accessing aftercare services such as meetings and groups.

The healthcare professionals emphasised that recovery was dependent on the will, and, therefore, the attitude of the client to change. This was supported by Tang et al (2005) who argued that substance-dependent clients should be responsible for their own behaviors and should learn a lesson from their own faults. The healthcare professionals noted that they did not have a lot of control when it came to the decision clients made after the treatment process. Coloma-Carmona et al (2016) found the main barriers to identification and treatment of problem drinkers to be the belief that patients will lie about their actual consumption and will not identify its negative consequences, and the belief that they will reject participating in an intervention for their alcohol consumption.

6.4.2. Reasons for relapse

The findings of the study demonstrated that, upon returning for treatment, healthcare professionals firstly enquired about the reasons that led to their client's returning to treatment. Some of the healthcare professionals indicated that the reasons that led to clients relapsing were believed to be more important than the relapse itself.

It was noted that clients returning to the same circumstances that they were in prior to treatment posed a risk to them re-using substances. The healthcare professionals placed importance on the influence that the environment, whether it had a positive or negative impact upon their clients. Knowledge of the environment, including social groups and personal relationships that a client had influenced many professionals' strategies and treatment plans. In hindsight, some professionals exhibited the wish that such knowledge had altered their initial treatment with the client, as they suspected that these factors could lead to a relapse. The importance that knowledge and management, had in preventing relapse was highlighted by Au (2006), who found that physician's attitudes and beliefs that were related to the delivery of preventative services included more positive beliefs towards prevention in general, attitudes toward working with substance-dependent clients as well as self-perception of knowledge and management skills regarding the specific prevention.

Investigating whether the reasons that led to the relapse were within the client's control were often utilised to determine if the client actually implemented the strategies he/she had learnt during their initial treatment intervention. Among the beliefs that ultimately determine intention and action, there is according to the theory of planned behavior, a set that deals with the presence or absence of requisite resources and opportunities (Ajzen, 1991).

Both extremely positive and negative experiences are identified as being high risk in the maintenance of abstinence among former substance-dependent clients (Appiah et al, 2017; Chetty, 2011). Unhealthy interpersonal relationships, and exposure to traumatic experiences were also among possible reasons that led to clients relapsing (Appiah et al, 2017). Alcohol cravings, duration of client's dependence on substances and co-morbid diagnosis (such anxiety or depression) were noted to be possible causes of alcohol relapse (Korlakunta et al, 2012). The identification of reasons (that led to a client's relapse) resulted in healthcare professionals working with the clients to develop strategies that would minimise

their impact on the client's recovery process. The reasons behind substance-dependence relapse were often a focal point of relapse treatment programming and planning.

6.4.3. Healthcare professional's confidence in working with substance-dependent clients

One of the factors that the theory of planned behavior has identified to influence an individual's behavior is perceived behavioral control (Ajzen, 1991). Perceived behavioral control is the extent to which a person feels able to enact the behavior. In the current study, the behavior was working with substance-dependent clients who had relapsed. Perceived behavioral control has two aspects, firstly, how much a person has control over the behavior? The findings of the study indicated that the healthcare professionals felt that they were in control of working with substance-dependent clients, however, the success of the treatment was partly dependent on the client. Secondly, how confident a person feels about working to perform the behavior? The healthcare professionals in the current study indicated that they were confident when working with substance-dependent clients who had relapsed. Perceived behavioral control is determined by control beliefs about the power of both situational and internal factors to inhibit or facilitate the performing of the behavior (the exposure to, experience, knowledge of healthcare professionals allowed/ enabled healthcare professionals to be able to work with relapsed clients).

The healthcare professionals questioned in this study indicated that they were confident when working with this client group, namely, substance-dependent clients who had relapsed. Previous exposure of healthcare professionals to substance-dependence, their experiences and knowledge when it came to substance-dependence better facilitated the healthcare professionals working with their clients. This exposure, experience and knowledge were evidenced to increase and improve over time, reflecting the healthcare professionals' growth and their abilities in their job role. This contradicted Peckover and Childlaw's (2007)

study, which indicated that nurses felt threatened when it came to working with substance-dependence because of their lack of knowledge.

Both Kalebka et al (2013) and Rawat (nd) concurred with the idea that professional development led to an increased understanding of substance-dependent clients and this resulted in an improved working relationship with these clients. Training of healthcare professionals was also found to be beneficial when working with substance-dependent clients (Kalebka et al, 2013), which was identified to lead to a better understanding of substance-dependence, and also equipped healthcare professionals to better handling of clients (Rawat, n.a). A culmination of these factors ultimately led to the healthcare professional feeling empowered and capable of working with relapse clients. In contradiction to the findings of this study, Nilsen et al (2013) indicated that there was no significant association between years of experience in medical-surgery nursing and overall therapeutic commitment towards substance-dependent clients.

The healthcare professionals in the study referenced how initially their personal feelings and emotions were affected by client responses to treatment and that this made it hard to accept that relapse was not their “failure”. Many demonstrated that over time they were able to recognise that the treatment process was about the client and not about them. Subsequently, identifying relapse as part of the recovery process in substance-dependence was not a reflection of personal capabilities. This type of change was evidence by De Vargas (2012) who stated that a change to more positive attitudes and the development of skills to enable nurses to work with alcohol and alcoholism-related issues were associated with knowledge offered in the area as part of the nursing education or programme.

The theory of planned behavior postulates that perceived behavioral control reflects people’s confidence and capability to perform the target behavior. The findings of the study

attested to the fact that knowledge and exposure to substance-dependence resulted in healthcare professionals feeling comfortable as well as capable of successfully working with clients who had relapsed. This was supported by Kelleher and Cotter (2009) who found that training enhanced the healthcare professional's level of competence and knowledge when working with substance-dependent clients. Undergoing training helped achieve a level of confidence in working with substance dependence (Peltzer, 2009).

6.5. Treatment interventions or plans implemented

According to the theory of planned behavior, the identification of beliefs can inform interventions designed to encourage behavioral performance by altering existing beliefs or exposure to new beliefs (White et al, 2015). The healthcare professionals' attitudes, the client's attitude during treatment, the reasons that led to the client relapsing and the healthcare professionals' confidence in working relapse clients were suggested to have influenced some of the treatment interventions that were implemented.

6.5.1. Treatment intervention

Treatments can be distinguished from one another along three broad dimensions, namely. Structure, behavioral content and pharmacotherapy. Treatment structure refers to the manner in which treatments are delivered, including variables such as the number of sessions, their timing, the provider selected to deliver the treatment, the total amount of treatment time and the counselling format (Piasecki, 2006). Service quality and effectiveness varies considerably from service provider to service provide (Myers et al, 2009).

The results of the current study showed that the majority of the healthcare professionals (after a client relapsed) saw the involvement of family, or significant relationships in the treatment intervention as important. Healthcare professionals believed that family involvement and group therapy were integral to the treatment of drug addiction

(Akinola, 2015). This concurred with Appiah et al (2017) who demonstrated that clinicians should make an effort to educate families and other close relations on the need to offer unconditional support for family members undergoing substance-dependence rehabilitation. Several professionals made reference to these significant others as being responsible for trying to ensure that aftercare services were utilised by their clients.

Ellis et al (2004) suggest that helping clients improve and build their social networks while in treatment improves substance-abuse treatment outcomes. The improvement in the quality of these resources was what was associated with a lower risk of relapse. Global positive social support was found to account for a significant proportion of a person's confidence that they would not return to substance use when facing a difficult situation, above and beyond that person's assessment of the stress of his or her recovery (Schmitt, 2003). In addition to this, Dennis at al (2007) determined that the duration of abstinence was associated with reduced environmental risks and increased number of clean and sober friends as well as the level of social support.

In this study, the findings demonstrated that during the relapse treatment, healthcare professionals focused on the personal issues that their clients presented, which led to their initial substance-dependence. The healthcare professionals suggested that during the initial treatment, their clients were often uncomfortable or unwilling to open up about their personal issues. They found that they were able to "go deeper" and probe more into these issues during relapse interventions or treatment because the clients were more accustomed to substance-dependence treatment.

Traditional relapse prevention is based on the theory that certain interactions between the individual and environment, for example, social pressure, greater access to substances, along with the inability of the individual to cope with craving caused by these interactions, as

well as negative emotional states of the client were identified to increase the risk of relapse (Grant et al, 2017; Appiah et al, 2017). This is in agreement with the previous finding that environmental factors can have a pivotal role in recovery and relapse. Relapse prevention was identified as one of the treatment interventions that the healthcare professionals in this study implemented when working with clients who had relapsed. Practitioners delivering relapse prevention therapy, therefore, aim to help the client in identifying situations that triggered relapse, and also learning cognitive and behavioral skills to cope with these situations (Grant et al, 2017).

There was a belief amongst the healthcare professionals interviewed that clients returning to treatment already had the tools they needed to recover, but circumstances might have led to them to relapse. Behavior modification skills such as assertiveness and problem-solving skills, in this case, could help recovering clients to become independent and not submit to peer pressure (Appiah et al, 2017).

The Matrix treatment programme, which is a cognitive behavioral treatment, was referenced by a number of healthcare professionals. These healthcare professionals indicated that the programme did not differentiate between working with a first-time and relapsed client. The programme consisted of relapse prevention groups, education groups, social support groups, individual counselling as well as urine and breath-testing delivered in a structured manner over a 16-week period. The treatment focuses on current issues that the client deals with and behavioral change (Obert et al, 2000).

Kiepek (2012) indicated that interactions between health professionals and clients are social situations where there is an imbalance regarding whose voice is attributed authority and in the potential power to distribute or withhold social goods. To make sure there was balance, the findings of the current study indicated that the treatment plan used by healthcare

professionals was dependent on, and focused on the client's needs, and what was important to the client. The healthcare professionals stated that they constantly reviewed and changed the treatment plans to suit the needs of the client. They focused on where the client was at in his/her recovery-relapse cycle and worked according to the pace of their client.

6.5.2. Aftercare services

The results of the study found that after the client completed the substance-dependence treatment, some of the healthcare professionals had follow-up sessions to check the clients' progress. The healthcare professionals also indicated the importance of being aware of the client's plans after the completion of treatment. As it was important for the healthcare professionals to know who was going to be responsible for the client after treatment, the healthcare professionals suggested that the client needed someone who was going to hold them accountable in terms of attending group and individual sessions.

The healthcare professionals also needed to be aware of the environment that the client would be returning to, and made recommendations if the client was going to return to the environment that led them to substance-dependence relapse. This supports the findings from a study that was conducted by Crossen-White and Galvin (2002), which identified the relevance of aftercare to the recovery process, which was needed to offer wide-ranging support to drug-dependent clients in recovery, such as help with accommodation, learning basic life skills and constructing a new lifestyle without substances. Some of the healthcare professionals in this study recommended that the clients after treatment completion attended AA (Alcoholic Anonymous) meetings. In the Therapeutic Community Model aftercare takes the form of attending AA/NA meetings, which is seen as crucial to sustaining recovery (Kasiram & Jeewa, 2008).

Many of the clients referred to in this study were linked with different resources that would aid their recovery. The healthcare professionals referred the clients to NGOs and NPOs that they considered to be a beneficial form of support to the clients. They also referred the clients to individual and group therapies outside of the rehabilitation facility (if the client was in an in-patient treatment facility) to ensure continuation of their recovery process. Extended treatment resulted in additional contacts, which also provided opportunities for delivering more of the "active ingredients" of behavioral treatments, such as educational information, coping skills training, and nonspecific factors such as empathy (Piasecki, 2006). Results from a study conducted by Crossen-White and Galvin (2002) expanded upon the importance of aftercare and indicated that substance-dependent clients reported that knowing they could return for weekly counselling helped them to deal with their new and unfamiliar lifestyle after completing treatment.

A combination of the treatment plans and interventions can be found within the Disease Model. This is a holistic approach to aftercare whereby aftercare focuses on improving communication between the client and the family, empowerment using life skills, reviewing and resolving existing problems and inviting clients to "refresh" when necessary (Kasiram & Jeewa, 2008).

The healthcare professionals that participated in this study indicated that some of their clients did not attend the aftercare services that they had recommended and to which they had referred their clients. This was identified as one of the reasons that led to the client's relapsing after the completion of a treatment programme. Thus, every effort should be made to ensure compliance to such services

6.6. Summary of chapter

The majority of healthcare professionals in this study understood that relapse was part of the recovery process, and were optimistic about the recovery of substance-dependent clients who had relapsed. This understanding was suggested to lead to healthcare professionals demonstrating positive attitudes when working with these clients. They were non-judgemental, and also motivated the clients to recover. Some of the healthcare professionals also displayed negative attitudes and feelings when working with relapse clients. The difficulties that these healthcare professionals experienced when working with substance-dependent clients who had relapsed were indicated to lead to these negative attitudes. These negative attitudes, however, did not seem to influence the healthcare professional's willing to assist these clients.

There were other factors that were identified as influencing the healthcare professional's attitudes when working with relapsed clients. The client's attitudes and behavior during treatment was indicated to be one of the factors that influenced the work of healthcare professionals with relapsed clients. A majority of the healthcare professionals found the reasons that led to a client's relapse important. This not only influenced the healthcare professional's behavior towards the relapse, it also influenced the treatment plans or interventions that were utilised. The confidence that healthcare professionals had when it came to working with substance-dependent clients who had relapsed was another factor that was deemed important. This confidence was indicated to result from the healthcare professional's exposure to and experience of working with substance-dependence, education and knowledge of substance-dependence and relapse.

The treatment interventions that the healthcare professionals implemented were influenced by the client's goals, and reasons that led to the relapse. The involvement of family was deemed important by the majority of the healthcare professionals. Aftercare

services were also identified as being important in maintaining abstinence and preventing relapses.

Chapter Seven discusses how this study attempted to address the research questions, draw conclusions, discuss limitations of the study as well as make recommendations for future studies.

CHAPTER SEVEN

Conclusion and Recommendations

7.1. Overview of the study

Relapse refers to the return of drug use, after detoxification and the attendance of in-patient treatment for at least six to twelve weeks, together with the marked return of behavior associated with substance use (Swanepoel, 2014). Relapse rates have been found to be high both nationally and internationally. In 2013, 22% of admissions into treatment centres in South Africa were re-admissions, according to SA statistics. Drop-out rates of patients may depend on whether the facility is in-patient or out-patient, where the facility is located (for example, big city or small town), and the substance that is being used (Swanepoel, 2014).

Substance-dependence treatment usually consists of healthcare professionals such as physicians, psychiatrist, nurses, substance abuse counsellors and social workers (Kelleher & Cotter, 2009). These healthcare professionals often work as an interdisciplinary team to obtain a common goal in providing drug treatment care for substance-dependent clients. The healthcare professionals in these substance treatment programmes are the first line of staff that clients encounter and continue to interact with throughout their treatment care.

Healthcare professionals are viewed as being important in the identification and accessibility to treatment for people with substance use disorder (Van Boekel et al, 2013). Therefore, the negative attitudes that healthcare professionals have towards substance-dependent clients may negatively affect healthcare delivery and could result in treatment avoidance or interruption during treatment (Van Boekel et al, 2013). The positive attitudes that healthcare professionals demonstrated were due to low levels of discrimination and a prominent level of acceptance towards substance abusers (Gotay, 2014). Investigating

healthcare professional's attitudes towards substance-dependent is important, because these attitudes can negatively or positively affect the client's treatment process and recovery.

The researcher adopted a qualitative research methodology for this study. Nine participants were sampled through the combined use of convenience and purposive sampling techniques. Data was collected using face-to-face and telephonic interviews. The telephonic interview was conducted because of the unavailability of the participant for a face-to face interview. The interviews were semi-structured and varied in length. The data collected was analysed using thematic analysis, and the findings were interpreted using the theory of planned behavior (TPB) as theoretical lens or framework.

The theory of planned behavior (TPB) is based on the assumption that human beings usually behave in a sensible manner; that they take account of available information and implicitly or explicitly consider the implications of their actions (Ajzen, 2005). According to the theory, people act according to their intentions and perceptions of control over the behavior, while intentions, in turn, are influenced by attitudes toward the behavior, subjective norms and perceptions of behavioral control (Ajzen, 2001). The TPB provided the researcher with a better understanding of attitudes as well as the other factors that influenced the healthcare professional's behavior and treatment plans when working with substance-dependent clients who had relapsed.

The results of this study indicated that the majority of the healthcare professionals displayed positive attitudes towards working with substance-dependent clients. While a few displayed negative attitudes, these attitudes were suggested to result from the difficulties these healthcare professionals reported to encountering when working with relapsed clients. All of the healthcare professionals, including the ones that displayed negative attitudes were willing and open to working with substance-dependent clients who had relapsed. This was

suggested to be a result of the healthcare professionals understanding that relapse as part of the recovery process, and believing that clients were capable of recovering when they attended and were committed to treatment. The positive attitudes of healthcare professionals were suggested to be a consequence of their job speciality.

The results also suggested that the client's attitudes and behavior (their level of motivation) during the treatment process was identified as also influencing the healthcare professionals work with the relapsed clients. The reasons for clients relapse were also believed to be an important factor by the healthcare professionals during the relapse process. When a client returned to treatment after relapsing, the healthcare professionals enquired about these reasons. The reasons that led to the healthcare professionals relapse seemed to influence the healthcare professionals work with these clients. The treatment plans or interventions were seen to be sometimes influenced by these reasons.

The experience and exposure of healthcare professionals to substance-dependent clients allowed them to gain knowledge about working with relapsed clients. The knowledge the healthcare professionals resulted in them having confidence and feeling capable of working with these clients. This was also identified as an important factor that influenced the healthcare professionals work with substance-dependent clients who had relapsed.

The healthcare professionals implemented different treatment interventions depending on what the healthcare professionals were most comfortable with utilising. Some of the interventions that the healthcare professionals implemented focused on the reasons for the clients relapse, and to select strategies to help clients recover. During the relapse process, some of the healthcare professionals found it effective to pay more attention to the client's personal issues. Other interventions focused on involving the substance-dependent client's

family as part of the treatment process. Some of the interventions that the healthcare professionals implemented were also Cognitive Behavioral Therapy and the Matrix model.

The healthcare professionals also identified the importance of aftercare service once the clients had completed treatment. The healthcare professionals were aware that one of the reasons that led to clients relapsing was the inability to cope with their environment after their relapse. The healthcare professionals in the study found it necessary to refer or inform their clients of aftercare services that would assist in their recovery.

7.2. Personal reflection of the research process

During the research process, there were some highs and lows that I experienced. Receiving the ethical clearance from the faculty actually meant that I could start contacting prospective participants and setting the times and dates for data collection. This was not as easy as I thought. In my research proposal, I specified that I was going to conduct focus groups in in-patient treatment centres, however, most of the in-patient treatment centres I contacted, could not take part in the research study owing to being unavailable. This resulted in me changing my data collection process, which led to me conducting individual, face-to-face interviews instead of focus groups. For the study, the participants changed from being only healthcare professionals who worked in in-patient centres, to any healthcare professionals that were working or had worked with substance-dependent clients. Finding these healthcare professionals also proved to be a challenge.

Another challenge that I experienced was the data analysis process, because it was the first time I had analysed data. The use of an independent coder made this process easier for me. During the research process, I learnt a lot about conducting qualitative research, I also gained a lot of information about substance-dependence and relapse from the participants.

7.3. Strengths and limitations of the study

The current study investigated the attitudes of different healthcare professionals towards substance-dependent clients who had relapsed. The study provided results about the attitudes of healthcare professionals that specialised in working with substance-dependence, which produced knowledge that provided a better understanding of the relapse process as well as the different treatment interventions utilised when working with relapse. Although the healthcare professionals in the study specialised in substance-dependence, they worked in different settings which resulted in different views and opinions when it came to the treatment of substance-dependence relapse. There has been a quite a number of research that focus on attitudes of healthcare professionals towards substance use, substance abuse and substance-using clients. However, research that focuses on the attitudes of healthcare professionals and substance-dependent relapse seems to be limited, as well as other factors that influence healthcare professionals working with substance-dependence.

The current study was limited by the uneven representation of different healthcare professional types as the majority of the healthcare professionals were social workers and healthcare professionals such as psychologists. Nurses, however, were represented in small numbers. The participants in the study were only healthcare professionals that specialised in substance-dependence and this could also be identified as a limitation. Healthcare professionals who had worked with relapse but did not specialise in substance-dependence would have provided different perspectives. Another limitation of the current study was the exclusion of the "subject norm" determinant as a factor that affected an individual's intention to perform behavior of the theory of planned behavior.

7.4. Recommendations for future research

Based on the conclusions made, it is important for healthcare professionals to have the relevant education, knowledge and experience that is needed to work with substance-

dependence and relapse. The importance of healthcare professionals' awareness of their attitudes and how these affect their behavior when working with substance-dependence was noted.

Future studies need to investigate the importance of the "subjective norm" in theory of planned behavior (TPB) in influencing healthcare professional's intention to work with substance-dependent clients who had relapsed. Forthcoming studies also need to be broadly based to better assist the generalisation of results. The investigation of healthcare professional's attitudes that do not specialise with substance-dependence towards relapse would also be beneficial.

It is recommend that similar studies are conducted in provinces or cities that have been identified to have high levels of substance-dependence relapse. Identifying healthcare professionals' attitudes from these regions could result in more knowledge.

7.5. Summary of chapter

Chapter Seven provided an overview of the current study, and the researcher provided personal reflections of the research process. The chapter also identified the strengths and limitations of this study as well as recommendations for future research.

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LIST OF APPENDICES

Appendix A: Participant information letter

Department of Psychology

School of Behavioral Sciences

South Campus

Psychology Clinic

Tel +27 (0)41 504 2330 Fax. +27 (0)41 504 1734

Dear Participant,

My name is Zintle Yokwe and I am studying towards my Masters degree in Counselling psychology at the Nelson Mandela University. I am required to conduct a research study as part of the requirement for this degree. I have decided to conduct a research study focusing on the attitudes that healthcare professionals have towards substance-dependent clients who have relapsed. This study is being conducted under the guidance and supervision of Dr. Konesh Navsaria (Counselling psychologist and lecturer at the Nelson Mandela University).

I hereby request for you to be a participant in this research study. You will be one of other participants that will be taking part in the research study. The study has been approved by the Health Sciences Faculty Postgraduate Studies Committee and Research Ethics Committee (Human) at the Nelson Mandela University.

Aims of the research study

This research study aims to explore and describe the attitudes that healthcare professionals have towards substance-dependent clients who have relapsed, and how these attitudes influence the treatment plans or interventions utilised. This information will be gathered by conducting an individual face-to-face interview in order to gain a better understanding of healthcare professional's attitudes when it comes to working with substance-dependent clients who have relapsed.

The interview will remain confidential and your participation will remain anonymous. The results of the study will be presented in the form of a written treatise. Results will be made

available to you upon request. Questions should be answered as honestly as possible in order to maintain research accuracy. If you decide to participate in this study, you will be asked to provide written consent.

Thank you for your assistance in conducting this study. Please contact me on 061 769 0368 if you require any further information.

Thank you in advance

____________________________ ____________________________

Zintle Yokwe

Researcher

Dr. K. Navsaria

Research Supervisor

Appendix B: Information letter to gatekeepers

Department of Psychology

School of Behavioral Sciences

South Campus

Psychology Clinic

Tel +27 (0)41 504 2330 Fax. +27 (0)41 504 1734

Zintle.Yokwe@mandela.ac.za

To whom it may concern

My name is Zintle Yokwe and I am studying towards my Masters degree in Counselling Psychology at Nelson Mandela University. I am required to conduct a research as part of the requirement for this degree. I have decided to conduct a study focusing on the attitudes that healthcare professionals have towards substance-dependent individuals who have relapsed. This study is being conducted under the guidance and supervision of Dr. Konesh Navsaria (Counselling Psychologist and lecturer at the Nelson Mandela University). I hereby request your consent to allow me to conduct this research at your institutions. The study has been approved by the Health Sciences Faculty Postgraduate Studies Committee and Research Ethics Committee (Human) at the Nelson Mandela University.

Aims of the Research

This research project aims to explore and describe the attitudes that healthcare professionals have towards substance-dependent individuals who have relapsed. This information will be gathered by conducting individual interviews of the multi-disciplinary team at this facility in order to understand their attitudes when it comes to working with substance-dependent individuals who have relapsed, and how these attitudes affect the treatment plans or interventions used. The information will be recorded and participant confidentiality will be ensured.

Benefits of the Research to the Treatment Facility

- The results will be disseminated to the facility.
- Results may be used to improve treatment program implementation and efficacy at this as well as similar facilities.

- Results may be used by various professionals to assess how their perceptions and attitudes affect their treatment intervention or plan
- Results could lead to a reduction in relapse rates for substance-dependent individuals

Treatment Facility Involvements

Once consent has been received from the facility gatekeepers, I will:

- Arrange a suitable time to discuss the research process and provide participants with the necessary information needed to provide informed consent.
- Arrange a suitable date, time and place for interviews to take place.
- The research will not disrupt or interfere with primary treatment activities at the facility and will not make use of any facility resources.

If you are willing to agree to the abovementioned research study for individual interviews with qualifying staff members at your facility, please complete and return the attached form to the researcher.

Thank you for reading this information.

Kind Regards,

___________ ____________________

Zintle Yokwe **Dr. K. Navsaria**

Researcher **Research Supervisor**

Appendix C: Participant consent form

NELSON MANDELA UNIVERSITY

INFORMATION AND INFORMED CONSENT FORM

RESEARCHER'S DETAILS	
Title of the research project	Attitudes of healthcare professionals towards substance-dependent individuals who have relapsed
Reference number	
Principal investigator	Zintle Yokwe
Address	Nelson Mandela University Department of Psychology Port Elizabeth
Postal Code	6000
Contact telephone number (private numbers not advisable)	061 769 0368

A. DECLARATION BY OR ON BEHALF OF PARTICIPANT		Initial
I, the participant and the undersigned	(full names)	
ID number		
OR		
I, in my capacity as	(parent or guardian)	
of the participant	(full names)	
ID number		
Address (of participant)		

A.1 HEREBY CONFIRM AS FOLLOWS:		Initial
I, the participant, was invited to participate in the above-mentioned research project		
that is being undertaken by	Miss Zintle Yokwe	
from	The Department of Psychology	
of the Nelson Mandela University.		

	THE FOLLOWING ASPECTS HAVE BEEN EXPLAINED TO ME, THE PARTICIPANT:				Initial
2.1	**Aim:**	The aim of the study is to explore and describe attitudes that healthcare professionals have towards substance-dependent individuals who have relapsed.			
2.2	**Procedures:**	I agree to and understand that I will need to complete a consent form, biographical questionnaire and participate in a focus group interview. I will also allow audio/video-recordings of these to be made. All documentation will be returned to the researcher.			
2.3	**Risks:**	I understand that there are no risks attached to this study and that I am free to withdraw at any stage without any negative consequences to myself.			
2.4	**Possible benefits:**	Results may be used by various professionals to assess how their perceptions and attitudes affect their treatment intervention or plan. Results may also be used to improve service delivery and may decrease relapse rates			
2.5	**Confidentiality:**	My identity will not be revealed in any discussion, description or scientific publications by the investigators.			
2.6	**Access to findings:**	Any new information or benefit that develops during the course of the study will be shared as follows: The results will be made available to interested participants and will be presented in the form of a written dissertation.			
2.6	**Voluntary participation / refusal / discontinuation:**	My participation is voluntary	YES	NO	
		My decision whether or not to participate will in no way affect my present or future care / employment / lifestyle	TRUE	FALSE	

3. THE INFORMATION ABOVE WAS EXPLAINED TO ME/THE PARTICIPANT BY:									Initial
Miss Zintle Yokwe									
in	**Afrikaans**		**English**		**Xhosa**		**Other**		
and I am in command of this language, **or** it was satisfactorily translated to me by									
Translator not required									
I was given the opportunity to ask questions and all these questions were answered satisfactorily.									

4.	No pressure was exerted on me to consent to participation and I understand that I may withdraw at any stage without penalisation.	

5.	Participation in this study will not result in any additional cost to myself.	

A.2 I HEREBY VOLUNTARILY CONSENT TO PARTICIPATE IN THE ABOVE-MENTIONED PROJECT:		
Signed/confirmed at	on	20
Signature or right thumb print of participant	Signature of witness:	
	Full name of witness:	

<table>
<tr><th colspan="10">B. STATEMENT BY OR ON BEHALF OF INVESTIGATOR(S)</th></tr>
<tr><td>I,</td><td colspan="4">Zintle Yokwe</td><td colspan="5">declare that:</td></tr>
<tr><td rowspan="2">1.</td><td colspan="4">I have explained the information given in this document to</td><td colspan="5">(name of patient/participant)</td></tr>
<tr><td colspan="4">and / or his / her representative</td><td colspan="5">(name of representative)</td></tr>
<tr><td>2.</td><td colspan="9">He / she was encouraged and given ample time to ask me any questions;</td></tr>
<tr><td rowspan="2">3</td><td>This conversation was conducted in</td><td>Afrikaans</td><td></td><td>English</td><td></td><td>Xhosa</td><td></td><td>Other</td><td></td></tr>
<tr><td colspan="9"></td></tr>
<tr><td>4.</td><td colspan="5">I have detached Section D and handed it to the participant</td><td colspan="2">YES</td><td colspan="2">NO</td></tr>
<tr><td colspan="10">Signed/confirmed at on 20</td></tr>
<tr><td colspan="3" rowspan="2">Signature of interviewer</td><td colspan="7">Signature of witness:</td></tr>
<tr><td colspan="7">Full name of witness:</td></tr>
</table>

Appendix D: Interview schedule

Introduction of the research process

Signing of consent documents

Obtain permission for audio-recording

1. How long have you been working with substance-dependent clients?
2. Have you worked with substance-dependent clients who have relapsed?
3. How do you find working with substance-dependent clients who have relapsed?
4. What are differences between working with a first time clients versus a client that has relapsed?
5. What are some of the attitudes or views you have towards substance-dependent clients who have relapsed?
6. How does the way you view substance-dependent clients who have relapsed influence the treatment plan or interventions you choose to use?
7. How confident are you when it comes to working with substance-dependent clients who have relapsed?
8. How do you think other healthcare professionals perceive substance-dependent clients who have relapsed?

Examples of "probing" questions:

"Is that all?"

"Tell me more about this"

"What do you mean by that?'

"Does that affect your attitudes?"

Appendix E: Ethical clearance letter

Copies to:
Supervisor: DR K NAVSARIA

Summerstrand South
Faculty of Health Sciences
Tel. +27 (0)41 5042956 Fax. +27 (0)41 5049324
Marilyn.Afrikaner@mandela.ac.za

Student number: 213392925

Contact person: Ms M Afrikaner

03-DEC-2018

MISS YOKWE
PO BOX 4966
MLUNGISI
QUEENSTOWN
5319

OUTCOME OF RESEARCH/PROJECT PROPOSAL:
Qualification: 60200 MACounsPsych
ATTITUDES OF HEALTHCARE PROFESSIONALS TOWARDS SUBSTANCE-DEPENDENT CLIENTS WHO HAVE RELAPSED

Please be advised that your final research proposal was approved by the Faculty Postgraduate Studies Committee (FPGSC).

FPGSC granted ethics approval. The ethics clearance reference number is H18-HEA-PSY-019 and is valid for three years.

We wish you well with the study/project.

Kind regards,

Ms M Afrikaner
Faculty Postgraduate Studies Committee (FPGSC) Secretariat
Faculty of Health Sciences