Advanced International Journal for Research (AIJFR)
E-ISSN: 3048-7641 ● Website: www.aijfr.com ● Email: editor@aijfr.com

Between Vigilance and Hope: Family Experiences of Supporting Young Adults Recovering from Substance Use in Harare, Zimbabwe

Tendai Babbage [1], Ms. Charity Shangu[2], Mr. Austin Gara[3]

[1]Chitungwiza Central Hospital,
[2]Zimbabwe Digital Psychologists,
[3]Identity Consultancy
[1,2,3]Psychology Department, Chitungwiza Central Hospital, Zimbabwe

ABSTRACT

Families are central to recovery from substance use disorders, yet their own psychological needs are often overlooked, particularly in low-resource settings. This qualitative phenomenological study explored the lived experiences of relatives supporting young adults recovering from drug and alcohol problems in Arcadia, Harare, Zimbabwe. Six families comprising 16 participating relatives (10 women and 6 men; ages 28–65 years) were purposively recruited through local support networks and a clinic. Family-based semi-structured interviews lasting 45–60 minutes were conducted; three were audio-recorded and three were documented through detailed field notes because participants declined recording. Data were analysed using reflexive thematic analysis. Five interrelated themes were developed: living with emotional turmoil and relapse vigilance; sustaining hope through signs of recovery; stigma, secrecy, and social isolation; coping through family solidarity and faith; and unmet needs for professional guidance. Caregiving involved persistent anxiety, disrupted rest, role overload, and uncertainty, but families also mobilised relational and spiritual resources. Stigma restricted disclosure and help-seeking, while limited access to family-oriented services left relatives feeling unprepared for the demands of recovery. The findings support a shift from individually focused treatment toward culturally responsive, family-inclusive recovery care. A provisional CARE framework—community connection, access to psychological support, resilience through faith and family systems, and caregiver education—is proposed for feasibility testing rather than assumed to be effective. The study highlights family members as both recovery resources and people with legitimate mental-health needs.

Keywords: caregiver burden; family recovery; phenomenology; stigma; substance use; Zimbabwe

1. INTRODUCTION

Substance use among young people has become an increasingly visible public-health and social concern in Zimbabwe. Economic insecurity, unemployment, changing drug markets, and gaps in specialist services create a setting in which families frequently carry much of the day-to-day responsibility for responding to harmful substance use and supporting recovery (Mukwenha et al., 2022). Zimbabwean research has also

linked young people's substance use to family and social circumstances, reinforcing the importance of understanding recovery within relational and community systems rather than solely as an individual clinical process (Maziya et al., 2023).

The effects of substance use extend across the family system. Relatives may experience fear, guilt, anger, exhaustion, financial pressure, interpersonal conflict, and uncertainty about relapse. International qualitative research describes family life as reorganised around monitoring, crisis management, and attempts to help the person who uses substances, sometimes at considerable cost to relatives' own wellbeing (Jackson et al., 2007; McCann & Lubman, 2019). The stress–strain–coping–support tradition similarly conceptualises relatives' distress as a response to sustained exposure to a difficult problem, shaped by available coping resources and social support (Orford et al., 2010).

These burdens may be intensified in communities where substance use is strongly moralised. Stigma can attach not only to the person in recovery but also to relatives, who may anticipate blame for inadequate parenting or family failure. Such associative stigma can foster concealment and reduce access to informal and professional support (Earnshaw, 2020). At the same time, families are not merely passive recipients of harm. Family solidarity, religious faith, shared meaning, and mutual coping can help relatives endure uncertainty and sustain engagement with recovery. Communal coping theory is useful here because it frames a stressor as "our problem" and emphasises collaborative appraisal and action within close relationships (Lyons et al., 1998).

Evidence from sub-Saharan Africa remains comparatively limited and context matters. In many Zimbabwean communities, formal mental-health resources coexist with extended-family networks, churches, and culturally embedded understandings of distress. A service model imported without attention to these systems may overlook both locally available strengths and locally specific barriers. Existing studies have contributed important accounts of family effects and resilience, including work in South African communities (Groenewald & Bhana, 2016), but little is known about how families in particular urban Zimbabwean communities experience the recovery phase.

This study therefore explored the lived psychological and social experiences of families caring for young adults recovering from drug and substance use in Arcadia, Harare. It asked: (a) how do family members describe the emotional consequences of supporting recovery; (b) what social and economic pressures shape their experiences; (c) how do they cope; and (d) what forms of support do they perceive as necessary? By centering relatives' accounts, the study sought to inform family-inclusive and community-responsive psychological services.

2. RESEARCH METHODOLOGY

Research Design

A qualitative phenomenological design was used to examine how relatives made sense of supporting a young adult during recovery. Phenomenology was selected because the study concerned subjective experience, meaning, and the psychological texture of caregiving rather than prevalence or causal estimation (Creswell & Poth, 2018; Moustakas, 1994). The reporting emphasis is descriptive and thematic. The analysis does not claim statistical generalisability.

Setting and participants

The study was conducted in Arcadia, an urban suburb of Harare, Zimbabwe. Purposive recruitment was undertaken through local recovery-support networks and a clinic. Eligible families lived in Arcadia,

included a parent, sibling, or guardian who was directly supporting a young adult aged 18–30 years in recovery, and were willing and able to provide informed consent and participate in the interview language. Families were excluded when the young adult was described as actively using substances at the time of recruitment, when the prospective participant was a professional rather than a relative, or when cognitive impairment precluded informed consent.

Six families participated, comprising 16 relatives: 10 women and six men, aged 28–65 years. Eight participants were biological parents and eight were siblings. The family, rather than an individual relative, was the recruitment unit. This distinction is important because the interviews elicited shared as well as differing accounts within family systems.

Data collection

A semi-structured interview guide was developed from the study objectives and piloted with one family that was not included in the final sample. The pilot assessed clarity, relevance, sequence, setting, and likely interview duration; the guide was refined before main data collection. Interviews lasted approximately 45–60 minutes and were conducted in private settings. Four families preferred to be interviewed in their homes, while two interviews took place at neutral venues.

With consent, three interviews were audio-recorded and transcribed. Three families declined recording; for these interviews, the researcher produced detailed concurrent field notes and expanded narrative records. Field notes were also used across interviews to document contextual and non-verbal observations. Participants reviewed interview summaries or transcripts and were invited to correct inaccuracies. The use of different recording modes is acknowledged as a methodological limitation because note-based records cannot preserve speech with the same completeness as verbatim transcription.

Data analysis and trustworthiness

Data were analysed thematically following the recursive phases described by Braun and Clarke (2006): familiarisation, initial coding, construction of candidate themes, review of themes against the dataset, definition and naming of themes, and production of the account. Codes attended to emotional responses, family roles, social reactions, coping practices, and perceived service needs. Themes were treated as analytic patterns developed through engagement with the data rather than as objective entities waiting to be discovered.

Credibility was supported through participant review of summaries, use of audio records and field notes, and attention to divergent family accounts. Dependability and confirmability were strengthened through an audit trail, peer debriefing, and reflexive journaling. Thick description of the setting and participants was used to support readers' judgments about transferability (Lincoln & Guba, 1985; Nowell et al., 2017).

Ethical Considerations

Ethical clearance was obtained from Great Zimbabwe University, with local permission involving the Arcadia clinic. Participants received information about the study, provided written and verbal consent, and were advised of their right to withdraw without penalty. Privacy was protected through de-identification and confidential storage. Given that the discussion could evoke distress, interviews were conducted empathically and could be paused or stopped. Participants were given information about counselling services in case they experienced emotional distress during and after the interviews. Research records will be destroyed after three years.

3. FINDINGS OF THE STUDY

Five closely connected themes captured the families' experiences. Although presented separately, the themes formed a recurring cycle: uncertainty generated vigilance; vigilance contributed to exhaustion; stigma constrained disclosure; constrained support increased reliance on the family; and small signs of recovery renewed hope.

Theme	Central meaning
Emotional turmoil and vigilance	Persistent anxiety, monitoring, disrupted rest, and fear of relapse.
Hope through recovery signs	Small behavioural and relational improvements sustained cautious hope.
Stigma and isolation	Anticipated blame encouraged secrecy and restricted social support.
Family solidarity and faith	Collective coping, prayer, and relational commitment provided meaning and endurance.
Need for professional guidance	Families wanted counselling and practical education about recovery, boundaries, and self-care.

Living with emotional turmoil and relapse vigilance

Family members described recovery as psychologically unstable rather than as a clear transition from illness to wellness. Anxiety, fear, and uncertainty remained present even when the young adult was no longer actively using substances. Relatives monitored mood, behaviour, routines, and social contacts for signs of relapse. One mother explained, "Every day is a battle; I worry if he will relapse or if he is truly committed to changing." The quotation conveys both care and sustained threat appraisal.

This vigilance affected rest and emotional energy. Participants described sleeplessness, persistent worry, and difficulty disengaging from the caregiving role. The uncertainty of recovery also complicated family boundaries: relatives felt responsible for offering support while remaining alert to behaviour they feared might precede renewed use. For some, this produced role overload as they moved between being parent, counsellor, disciplinarian, monitor, and emotional anchor.

Sustaining hope through signs of recovery

Alongside fear, families reported moments of hope. Progress was often recognised through ordinary signs—laughter, calmer interaction, renewed responsibility, or participation in family life. A father stated, "There are days when I see my son laughing again, and I hold onto that. It gives me hope." Such moments did not eliminate concern, but they helped relatives sustain involvement.

Hope was therefore not simple optimism. It was a practical and emotional resource built from incremental evidence of change. Families appeared to move repeatedly between despair and cautious confidence. This coexistence of hope and apprehension is important: psychological support that assumes either complete crisis or uncomplicated recovery may fail to match relatives' lived reality.

Stigma, secrecy, and social isolation

Participants perceived community judgment surrounding substance use and recovery. Relatives feared being misunderstood or blamed and therefore restricted what they disclosed. A sister explained, "I can't talk to my friends about this; they wouldn't understand." Concealment protected the family from anticipated judgment but also reduced opportunities for emotional support.

Stigma extended beyond the young adult to the wider household. Participants' accounts suggested that relatives could experience the problem as a threat to family identity and social standing. Isolation then amplified helplessness: family members were left to manage uncertainty internally, often without trusted spaces in which to discuss anger, grief, fear, or fatigue.

Coping through family solidarity and faith

Families mobilised collective coping in response to strain. Participants described the importance of staying united, sharing tasks, encouraging one another, and treating recovery as a family responsibility. A grandmother stated, "We have to be strong together; it's the only way we can get through this." This orientation resembles communal coping, in which a problem is appraised and managed relationally rather than by one person alone (Lyons et al., 1998).

Religious faith and church involvement also provided meaning, comfort, and hope. Prayer and belief in divine assistance helped some relatives tolerate circumstances they could not control. Faith resources were described as complementary to family solidarity. Nevertheless, the findings do not establish that spiritual coping was uniformly helpful, and culturally responsive care should explore how faith functions for each family rather than prescribe it.

Unmet needs for professional guidance

Participants repeatedly expressed feeling insufficiently prepared to support recovery. They wanted information about addiction, relapse, communication, boundaries, and their own emotional wellbeing. One mother stated, "We need someone who understands addiction to help us navigate this journey." The request was not only for treatment of the young adult; it was also for counselling and guidance directed toward relatives.

Families' reliance on informal support partly reflected the limited visibility and accessibility of family-oriented services. Participants' accounts indicated a need for affordable, local support that combines psychoeducation, counselling, peer connection, and referral pathways. Professional care was viewed as a potential source of both practical skills and validation of relatives' psychological needs.

Discussion

This study shows that supporting a young adult through substance-use recovery can be an enduring psychological experience for the whole family. Relatives in Arcadia lived between vigilance and hope. They monitored possible relapse, absorbed additional roles, managed uncertainty, and often concealed the problem from others. Yet they also drew strength from incremental progress, family solidarity, and faith.

The emotional turmoil described by participants is consistent with international evidence that relatives of people with substance-use problems experience substantial stress and disruption (Jackson et al., 2007; McCann & Lubman, 2019). Recovery did not immediately remove the stressor. Instead, uncertainty about relapse sustained high alertness. This finding supports the stress–strain–coping–support perspective: relatives' distress cannot be reduced to personal weakness; it emerges from prolonged exposure to a demanding and socially stigmatised problem, while coping and support shape outcomes (Orford et al., 1998).

The coexistence of fear and hope adds nuance to concepts of caregiver burden. Participants were not only depleted; they were active interpreters of change who used small improvements to maintain commitment. Family-inclusive interventions should therefore avoid portraying relatives solely as overwhelmed or

dysfunctional. A strengths-based approach can acknowledge burden while identifying relational capacities already operating within the household.

Stigma was a major constraint on coping. Anticipated judgment encouraged secrecy and narrowed families' support networks. This accords with clinical accounts of substance-use stigma as a barrier to help-seeking and social inclusion (Earnshaw, 2020). In close communities, anti-stigma work must be designed carefully: public messaging should challenge moral blame without exposing particular families. Confidential support groups, community education, and collaboration with trusted institutions may offer safer routes to connection.

Faith was a salient contextual resource. Churches and religious leaders may be well positioned to reduce isolation, communicate compassionate understandings of addiction, and refer families for professional care. However, partnership requires mental-health literacy and safeguards against explanations that intensify blame, delay evidence-informed treatment, or compromise confidentiality. The implication is integration, not substitution of spiritual care for psychological or medical services.

The findings also indicate a service gap. Relatives wanted help understanding recovery and managing their own responses. Family-oriented psychoeducation could address relapse warning signs, communication, boundaries, crisis planning, self-care, and realistic expectations. Counselling should provide space for relatives' grief, anger, fear, and exhaustion independently of the young adult's treatment. Such support may benefit family wellbeing while also creating a more stable recovery environment, although this study did not test effects on recovery outcomes.

Practice implication: a provisional CARE framework

Drawing on the themes, the study proposed a CARE family-support framework. Its four components are: Community connection and stigma reduction; Access to emotional and psychological care; Resilience through family and faith systems; and Education and empowerment for caregivers. The framework translates the findings into a locally plausible service concept. It could combine confidential peer groups, family counselling, psychoeducation, trained community or faith-based referral partners, and anti-stigma activities.

CARE should be described as provisional. It was derived from a small qualitative study and has not been tested for feasibility, acceptability, safety, or effectiveness. A next step would be co-design with families, people in recovery, psychologists, addiction practitioners, clinics, community organisations, and faith leaders. A pilot should assess uptake, retention, perceived stigma, caregiver distress, family functioning, referral completion, and unintended harms before any wider implementation.

Strengths and limitations

A strength of the study is its focus on an underrepresented group in a specific Zimbabwean community and its inclusion of multiple relatives across six families. The use of participant review, field notes, reflexive journaling, peer debriefing, and an audit trail enhanced trustworthiness.

Several limitations qualify interpretation. The small purposive sample from one suburb cannot represent all Zimbabwean families. Recruitment through a clinic and support networks may have favoured families already connected to help. Family interviews may have constrained disclosure of conflict or dissent, and the study does not provide a detailed account of within-family differences. Only three interviews were audio-recorded; note-based documentation of the remaining interviews may have reduced detail and quotation accuracy. Finally, the CARE framework was not evaluated. Future research should include

diverse urban and rural settings, individual as well as family interviews, and prospective evaluation of family-support interventions.

4. CONCLUSION

For families in Arcadia, a young adult's recovery from substance use was neither an individual process nor the end of psychological strain. Relatives lived with relapse vigilance, role overload, stigma, and unmet support needs while drawing on hope, solidarity, and faith. Psychological and addiction services should recognise family members both as contributors to recovery and as people entitled to care in their own right. Locally accessible counselling, psychoeducation, confidential peer support, and carefully designed community partnerships warrant development and evaluation.

Declarations

Consent to participate: Written and verbal informed consent were obtained from all participants.

Funding: The authors received no specific funding for this work.

Competing interests: There were no competing interests in this research.

Author contributions:

TB: Conceptualization (lead); Methodology (lead); Investigation (lead); Formal analysis (lead); Writing – original draft (lead).

CS: Writing review and editing (supporting).

AG: Supervision (lead); Writing-review and editing (supporting),

All authors reviewed and approved the final manuscript and agree to be accountable for all aspects of the work.

References

1. Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77–101. https://doi.org/10.1191/1478088706qp063oa
2. Creswell, J. W., & Poth, C. N. (2018). Qualitative inquiry and research design: Choosing among five approaches (4th ed.). SAGE Publications.
3. Earnshaw, V. A. (2020). Stigma and substance use disorders: A clinical, research, and advocacy agenda. American Psychologist, 75(9), 1300–1311. https://doi.org/10.1037/amp0000744
4. Groenewald, C., & Bhana, A. (2017). Mothers' experiences of coping with adolescent substance abuse in South Africa. Contemporary Nurse, 53(4), 421–435. https://doi.org/10.1080/10376178.2017.1361854
5. Jackson, D., Usher, K., & O'Brien, L. (2006). Fractured families: Parental perspectives of the effects of adolescent drug use on family life. Contemporary Nurse, 23(2), 321–330. https://doi.org/10.5172/conu.2006.23.2.321
6. Lincoln, Y. S., & Guba, E. G. (1985). Naturalistic inquiry. SAGE.
7. Lyons, R. F., Mickelson, K. D., Sullivan, M. J. L., & Coyne, J. C. (1998). Coping as a communal process. Journal of Social and Personal Relationships, 15(5), 579–605. https://doi.org/10.1177/0265407598155001
8. Maziya, N., Zirima, H., Bozho, F., Chaka, C., Masara, T., Munyira, E., & Muchesa, S. (2023). Relationship between being raised by a single parent and drug abuse among young people: Insights

from Bloomingdale suburb, Harare, in Zimbabwe. International Journal of Research and Innovation in Social Science, 7(9), 1964–1972. https://doi.org/10.47772/IJRISS.2023.71059

9. McCann, T. V., Polacsek, M., & Lubman, D. I. (2019). Experiences of family members supporting a relative with substance use problems: A qualitative study. Scandinavian Journal of Caring Sciences, 33(4), 902–911. https://doi.org/10.1111/scs.12688
10. Moustakas, C. (1994). Phenomenological research methods. SAGE.
11. Mukwenha, S., Murewanhema, G., Madziva, R., Dzinamarira, T., Herrera, H., & Musuka, G. (2022). Increased illicit substance use among Zimbabwean adolescents and youths during the COVID-19 era: An impending public health disaster. Addiction, 117(4), 1177–1178. https://doi.org/10.1111/add.15729
12. Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. International Journal of Qualitative Methods, 16(1), 1–13. https://doi.org/10.1177/1609406917733847
13. Orford, J., Copello, A., Velleman, R., & Templeton, L. (2010). Family members affected by a close relative's addiction: The stress-strain-coping-support model. Drugs: Education, Prevention and Policy, 17(S1), 36–43. https://doi.org/10.3109/09687637.2010.514801