ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

Exploring The Lived Experiences of Secondary Support Systems in Drug Dependence Recovery

Jessa Mae B. Oliverio[1] and Jerson John L. Trocio[1,2]*
[1]Researcher, Professional Schools University of Mindanao, Philippines,
[*]jess.mae.bolivar@gmail.com,[2]jersonjohn_trocio@umindanao.edu.ph

Date Submitted:
June 24, 2026

Date Accepted:
July 05, 2026

Date Published:
July 15, 2026

DOI:
10.5281/zenodo.21375221

ABSTRACT

This phenomenological study aimed to determine the experiences, challenges, and significant insights of secondary support systems supporting a patient undergoing a drug dependence rehabilitation program. Using a qualitative phenomenological research design and purposive sampling, the study included five participants who served as extended sources of support for loved ones in recovery. The research was conducted during scheduled visitation hours at a government-operated drug abuse treatment and rehabilitation facility in the Province of Sarangani, Philippines. Data were gathered through in-depth interviews and analyzed using Braun and Clarke's (2006) thematic analysis. The findings revealed that secondary support systems experienced emotional shock and distress, increased caregiving responsibilities, financial and lifestyle adjustments, social stigma, and changes in family roles. Participants also faced financial hardship, time constraints that disrupted work and daily responsibilities, and emotional and psychological burden. Furthermore, they recognized the positive changes brought about by rehabilitation, the importance of family support in recovery, a more compassionate understanding of addiction, strengthened faith, and greater personal resilience. These findings highlight the importance of supporting secondary support systems throughout the recovery process.

Keywords: *secondary support system, drug rehabilitation, experiences, challenges, insights, phenomenology, Philippines*

INTRODUCTION

Substance use disorder is still a significant global public health challenge that has an enormous impact on the lives of millions of individuals and presents substantial difficulties for healthcare providers, families, and communities around the world (World Health Organization and United Nations Office on Drugs and Crime, 2020). Recent practices in therapy recognize that there is not just one way to help someone on their journey of recovery; rather, it takes multiple people becoming part of the person's support network and providing a network that helps facilitate recovery (Ariss & Fairbairn, 2020; Hogue et al., 2021). Studies have shown that when a family participates in their loved one's recovery by providing emotional and practical support, as well as providing psychoeducation, they can expect consistent improvement in their loved one's ability to maintain adherence to the treatment program, develop their own resiliency to stressors, increase their optimism about future recovery, and decrease the likelihood of relapse (Cai & Wang, 2022).

Numerous worldwide studies have shown that family members of individuals who have substance abuse disorders may experience negative emotional, financial, and relational distance from the user and stigma due to having someone in their family who is struggling with addiction, which makes it difficult for them to provide long-term support (Mountain-Ray et al., 2019; Missouridou et al., 2023; McCann et al., 2019). As a response to this issue,

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

there is an increase in attention given to family-based interventions to improve communication, enhance coping skills, and build resilience among families impacted by substance use. Family-based interventions include counseling, psychoeducation, and peer support groups. Consequently, various worldwide rehabilitation frameworks are now promoting culturally sensitive, family-centered rehabilitation models to aid not only the recovering individual but also their supporting family units.

Family members supporting individuals with substance use disorders experience changes in their own social support systems. Caregivers frequently experience emotional exhaustion, reduced social interactions, and feelings of isolation. Many family members prioritize the patient's recovery while neglecting their own physical and emotional well-being (Kane et al., 2023).

A systematic review and meta-analysis evaluated psychosocial interventions for family members affected by another person's substance use. The review found that interventions such as family therapy, psychoeducation, behavioral therapy, and counseling significantly improved caregivers' psychological well-being, coping skills, family functioning, and relationship satisfaction. These interventions also strengthened caregivers' ability to support individuals in recovery (Rushton et al., 2023).

Evidence was reviewed regarding psychosocial interventions designed for family members affected by a relative's substance use. The findings showed that family involvement enhances communication, strengthens relationships, reduces family conflict, and promotes healthier family functioning. This evidence emphasized that rehabilitation should address not only the patient but also the well-being of affected family members (McGovern et al., 2021). However, the existing literature indicates that many interventions still focus primarily on the family unit and seldom examine the distinct needs of specific family members, whose experiences may differ depending on their relationship to the person in treatment (Kourgiantakis et al., 2021).

Unhealthy relationship habits also tend to pop up in homes dealing with addiction. For instance, some relatives accidentally start enabling the patient. They may be willfully blind or minimize the extent of damage caused by the use of the drug, accusing themselves of being the cause of the person's behavior, or providing protection for the individual from getting into trouble (Slocum et al., 2024; Substance Abuse and Mental Health Services Administration, 2020; Manurung, 2024). When family members support each other in recovery, they can help one another overcome the challenges of addiction and rebuild their lives (Slocum et al., 2024; Manurung, 2024). Family members who become codependent often stop taking care of their own needs or interests because they are entirely focused on providing care to the addicted family member, as well as attempting to control their actions. Codependency can be seen as an example of how addiction affects an entire family system, rather than just the individual suffering from addiction.

Like many other countries, the Philippines is still experiencing high rates of addiction, and the government has enacted both strict laws and regulations and local rehabilitation programs to combat addiction. Local programs often emphasize the importance of family in recovery; however, unlike other cultures, Filipino families encounter some unique issues, such as extreme social stigma related to being an addict, the high cost of healthcare related to substance use disorder, and a general lack of financial resources. Due to the collectivist nature of Filipino culture, drug use is not often seen as just a single person's problem. However, it is viewed as a problem impacting the entire family's reputation. While this approach to family may help when the family supports the recovery process, it may also backfire by causing the family to hide the problem due to shame, which delays appropriate treatment. A local study examined the relationship between family support, coping strategies, and drug dependence of Filipinos participating in community rehabilitation programs and found that having a supportive family improves the development of coping strategies as well as decreases the level of substance dependence. The findings of this study indicate that positive relationships with family members support recovery (Sy & Hechanova, 2020).

Regardless of the research findings supporting interventions designed to support the recovery of the addicted family member through family unity and relationships, many Filipino families still encounter numerous barriers to providing ongoing, long-term support, such as financial difficulties, lack of access to information, and continual stigma associated with drug use (URC, 2024).

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

Without family support, recovering Filipino substance abusers do not have access to the benefits of a family connection; research conducted on this area and the support systems needed for rehabilitation indicated that there is an increased level of isolation and additional challenges throughout the rehabilitation process. When considering the extent to which family involvement contributes to recovery in the Philippines, researchers opined that the definition of family involvement should be expansive, including extended families, aunts, uncles, and cousins (Co & Canoy, 2020). Successful completion of community-based drug rehabilitation in the Philippines substantially relies on two forces working together: an individual's intrinsic motivation and an individual's external network of support (Walag et al., 2024). As such, commitment from family, the community, and rehabilitation personnel produces the foundation on which individuals can achieve continued recovery. These three factors support the need for a comprehensive support system throughout the entire rehabilitation process.

Caregiving in the Philippines is often described as a transitional journey; Feliciano et al. (2022) noted that a significant burden is placed on family members during this process, yet many are happy to accept it. As care in the Philippines is culturally viewed as a shared responsibility of family, many family members support the care of an ill or recovering family member; therefore, many secondary support system give support to the primary caregiver during the rehabilitation of a family member through providing financial resources, babysitting, transportation, emotional support, mediating family disputes, and acting as a liaison between the ill or recovering family member and the immediate family. However, many secondary support systems experience greater difficulty than immediate family members. In most cases, they are burdened with such demands, receive no formal recognition for the role they play, have little or no input into the outcomes, and have to cope with the stress of the situation from a less developed perspective.

With this in mind, Bowen's Family Systems Theory (1978) conceptualizes a family as a system with many interconnecting emotional relationships, meaning that actions in one part of the system affect the whole (Corey, 2020). With a view to addiction, this is seen as both a personal problem of the individual and a symptom of the ongoing anxiety and unresolved tension that exists within the family as a whole. In relation to the placement of the extended family regarding their experience of and relationship to the crisis of the central individual, triangulation can be used to explain how these two individuals may create an unstable connection due to the high level of anxiety in their relationship. For example, the anxious bond between the patient and their primary caregiver will create instability in their relationship. In order to mitigate the level of anxiety created between these two individuals, they naturally seek out support from a third party who creates a triangle between the three of them and takes on some of the anxiety created by the first two individuals.

In the Filipino collective cultural perspective, this will likely be second-degree relatives. When family members present with both emotional exhaustion and financial difficulties, extended and secondary family members may take on roles as mediators to resolve conflicts, serve as resources for rehabilitation needs of the primary family member, or provide emotional support to the immediate family. As a result, extended family members often suffer a substantial amount of emotional distress by being placed in the middle of a crisis without the support of authority figures involved in the treatment process of the primary family member.

Furthermore, the theory of self-differentiation offers extended family members the opportunity to cope with the systemic emotional pressures created by their immediate family. To differentiate oneself, an individual must maintain a degree of separation between their thoughts and feelings, establish clear, distinct personal boundaries, and actively engage in a close relationship with their immediate family (Corey, 2020). As a result, lower levels of self-differentiation within a family system contribute to the development of unhealthy behaviors, while higher levels of self-differentiation exhibited by extended family members create opportunities to demonstrate authentic concern and compassion for the individual without losing oneself in the family system's turmoil.

Local researchers have evaluated the importance of healthy family support systems relative to the success of patients recovering from substance abuse and related issues. The results of such studies indicate that family support systems significantly reduce the risk of substance use and dependence and improve recovery rates (Sy & Hechanova, 2020). Individuals providing secondary support and who have difficulty distinguishing themselves

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

from the care being received by the primary patient are often exposed to the dysfunctional behavior of their immediate family; this exposure can lead to trouble in separating themselves, either physically or emotionally, from the care of the primary patient, resulting in poor mental health. For example, Filipino support systems and family structures undergo tremendous struggles between the cultural expectations to provide unified support to a family member in need versus the emotional stress caused by family triangulation in the family system. Based on one's family's cultural norms and values, it is expected that both an individual's behavior and the system that supports them will develop over time. Consequently, how an individual behaves within their immediate family unit may differ significantly from how they behave within an extended family unit (Campoamor-Olegario et al., 2025).

The concept of kapwa, which refers to shared essence, encompasses the notion that interconnectedness between family members can be created through a collective sense of thankfulness when there is a member of the family who is experiencing difficulty, either from health or environmental issues; it further demonstrates that mutual support is provided to each other among family members through extended family assistance (Casiño et al, 2025). Thus, relatives of a second cousin, an aunt, or an uncle serve not just as nonexistent, lost buffers; rather, they provide meaningful, organized anchoring for kinship networks during crises created by addiction and related family dysfunctions.

According to recent Philippine literature, defining the family to include extended family members is crucial for developing a non-Western rehabilitation support system that aligns with their culture (Co & Canoy, 2020). Despite the increased mention of family involvement in recovery from addiction, most studies still recognize parents/spouses/children as the predominant source of family involvement. There is a considerable knowledge gap regarding the roles of extended support networks in an individual's rehabilitation, even though some of the most influential and frequently utilized support networks are extended family members. Furthermore, in genetics and medical literature, "second-degree relatives" refers to family members who share 25% of a person's genes, which includes grandparents, grandchildren, half-siblings, aunts, uncles, nieces, and nephews (Genomics Education Program, 2019; ThinkGenetic Foundation, 2022). However, these same second-degree relatives typically provide some level of support to the individual while recovering from addiction by offering emotional, financial, and/or practical assistance.

For this study, the secondary support system is operationally defined as these exact second-degree relatives who actively help a family member in drug rehabilitation through emotional backing, caregiving, money, or by participating in the recovery process. The perspectives of these individuals are significant because they have many unique burdens, such as trying to support their household while providing support to another, limited authority to make treatment decisions, unclear expectations about their role, and emotional distress and lack of access to services typically provided to primary caregivers.

Thus, this research seeks to address this gap by exploring the lived experiences of the secondary support system that supports individuals undergoing treatment for substance use disorders, to uncover their experiences, challenges, and significant insights. This study is intended to provide insight to enable more inclusive and family-focused treatment options in rehabilitation settings.

Moreover, the study's findings provide valuable insights into the underrepresented lived experiences of secondary support systems, revealing issues of emotional distress and their strength and determination to recover. Understanding these views will help create a positive recovery environment for people in rehabilitation, strengthen relationships with family members, and guide rehabilitation centers in developing targeted interventions, such as workshops, counseling, and support groups, that improve retention in treatment and reduce relapses. In addition, these insights will help mental health and social services professionals by providing the information necessary to develop compassionate, family-focused interventions for individuals directly impacted by addiction.

Lastly, this study is limited by its use of purposive sampling, which may limit the representativeness of the participants and introduce selection bias, thereby limiting the transferability of the findings. The reliance on self-reported narratives introduces additional limitations, including recall bias, emotional sensitivity, and social

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

desirability effects that may influence the depth and accuracy of participants' accounts. Moreover, data collection in a single rehabilitation facility during visitation hours may constrain the diversity of perspectives captured.

The study is strictly limited to legal guardians and secondary support members, specifically aunts, uncles, grandparents, grandchildren, nieces, nephews, and half-siblings, who are at least 18 years old and have actively backed a patient in a drug rehab program for at least four months. To ensure they are actually involved in the recovery process, participants must have a consistent record of attending the facility's family programs, such as letter writing, family dialogues, and scheduled visits, over those four months. All first-degree relatives, distant relatives, minors, and anyone not verified as involved in the treatment process were excluded, thereby maintaining the research's focus on this specific type of support system.

Study Participants

This study included five (5) participants, comprising three (3) females and two (2) males, who were members of a secondary support system of a patient enrolled in a drug rehabilitation program. This sample size of five (5) was established in accordance with Creswell's (2013) guidelines, which suggest a sample size of 5-25 participants for phenomenological research. It was based on data saturation achieved during data collection. Only these five (5) participants were eligible to volunteer for interviews and met the inclusion criteria of providing actual, relevant experiences; therefore, they were the only individuals who volunteered for the interviews during the data collection process. Also, the participants reached out to the researcher to volunteer for the study.

The five (5) participants in the interviews shared rich, in-depth personal experiences and challenges. Recruitment and interviews were stopped for participants 4 and 5 because no new information was provided, indicating that the data were already saturated. As stated by Glesne and Peshkin (1992), once participants began sharing similar narratives and added no new information, recruitment ended.

For the inclusion criteria, the researcher utilized purposive sampling techniques to select the five (5) participants. These chosen individuals were secondary support system members who were at least 18 years old and had actively supported a patient in the drug rehabilitation program for a minimum of four (4) months. The participants also had to prove that they consistently and meaningfully engaged with the facility's required family program, which included participating in family dialogues, writing letters to patients in the facility, and scheduling visits for 4 months without any absences. Also, first-degree relatives, third-degree relatives, and anyone under 18 were excluded from this study. Furthermore, if a participant did not actively provide support to the person receiving treatment at any point before or during the study, they were disqualified as an eligible study participant. Participants could withdraw from this study at any time, without consequences or penalties. Each participant received a full explanation of their right to withdraw before data collection began. Furthermore, the table below outlines the essential details of the participants, including their profiles and the coding used to safeguard their identities.

Table 1. *Study Participants' Profile*

Code	Age	Gender	Civil Status	Relationship with the patient	Duration of Support
SP1	55	Female	Married	Aunt	5 Months
SP2	40	Male	Married	Cousin	4 Months
SP3	38	Female	Married	Aunt	5 Months
SP4	51	Male	Single	Cousin	5 Months
SP5	38	Female	Married	Cousin	4 Months

Materials and Instruments

The researcher utilized a recorded in-depth interview (ID) in this study. The researcher used an interview guide to elicit the experiences, challenges, and significant insights of secondary support system members who assist patients in the drug rehabilitation program. Also, the interview guide was validated by five (5) subject matter experts. After collecting data from participants, the researcher transcribed the audio tape and analyzed it using thematic analysis.

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

The interview guide was validated by five (5) subject matter experts and received an average rating of 9.6, with a description of 'good'. Hence, the interview guide that was used is valid.

Design and Procedure

This study used a qualitative-phenomenological research method to examine the secondary support system's experiences, challenges, and key insights in assisting patients in the drug rehabilitation program. Qualitative research is considered ideal for summarizing and interpreting real-world issues in a narrative report (Gravetter & Forzano, 2018; Moser & Korstjens, 2017). A phenomenological approach was used since the researcher wanted to unveil the lived experiences of the secondary support system of patients undergoing a drug dependence rehabilitation program. Also, this research design fits the study well because it allows the researcher to delve into participants' unique, personal experiences regarding this specific phenomenon (Duquesne University, 2023).

Moreover, the researcher formulated an interview guide that was reviewed and validated by five (5) experts, as mentioned above, and deemed a good interview guide. The researcher then seeks approval from the University of Mindanao Ethics Review Committee (UMERC) to conduct the study. After approval, the researcher gathered the information needed for this study in the 2nd week of March 2026 and completed it in the 2nd week of April 2026. The researcher then sent a formal letter of permission to the rehabilitation facility's management, authorizing the researcher to conduct on-site interviews. The letter specifies the provision of a private, closed room, a limited role for the gatekeeper, adherence to visitation schedules, non-interference with services, and maintenance of participant confidentiality.

To protect participants' autonomy and prevent people from feeling pressured to join, recruitment followed a strict privacy-preserving protocol as recommended by UMERC. An authorized representative from the agency announced the study and handed out invitation forms to potential participants. This representative from the rehab facility did not personally identify, choose, or refer any individual directly to the researcher. Instead, interested individuals who wanted to participate in the study reached out directly to the researcher to schedule an interview, ensuring that their participation remained entirely voluntary from the start. All participants who reached out to the researcher were clearly informed that they could say no or withdraw from the study without any consequences to their treatment, services, or standing with the facility.

Furthermore, as established above, the eligibility or inclusion criteria required participants to be legal guardians or secondary support system members, including aunts, uncles, grandparents, grandchildren, nieces, nephews, or half-siblings. The participants should be at least 18 years old and actively supporting a patient in the drug rehabilitation program for at least 4 months, without missing any scheduled appointments. During a pre-validation phase, the researcher asked preliminary screening questions based on the validated interview guide to determine whether they regularly attended the required family activities during that time frame. Participants' eligibility was determined primarily through self-reports and voluntary confirmation. No official documents from the rehab facility or attendance sheets were utilized unless a participant gave explicit written consent.

Participants were informed and oriented that they could withdraw from or leave the study at any time without consequences or punishment. To maintain privacy and confidentiality, the facility staff from the rehab stayed out of the loop and never disclosed to the researcher who accepted, declined, or turned down the invitation. Once the individual showed interest and reached out to the researcher, informed consent was obtained in a private room, with the researcher providing an overview of the study, including its purpose, risks, and benefits. Also, for clarity, the interviews were scheduled only after confirming that the participant fully understood the study and had signed the formal written consent form. This careful process ensured that the study participants were informed, voluntarily joined, and free from any coercion, pressure, or outside influence.

After participants signed informed consent and agreed to participate in the study, the researcher conducted one-on-one, face-to-face, in-depth interviews to capture their actual experiences, challenges, and insights as a secondary support system. The researcher requested participants' permission to use audio

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

recording equipment before the interview began. Participants also received instructions that they would have no negative consequences for declining to participate in any audio recordings. After agreeing, the interviews took place in a quiet, closed room inside the rehab facility, where no staff, other patients, or visitors could enter unless a participant explicitly requested a support person in the room. The researcher also reminded them that they could skip any question, take a break, or end the interview at any time. This approach respected the participant's autonomy, ensured confidentiality, and reduced the risk of accidental disclosure or coercion.

After the data were gathered from the participants, the recorded audio tapes were then transcribed and analyzed using thematic analysis by Braun and Clarke (2006). Also, the researcher translated the verbatim statements from their original languages, which are Filipino and Bisaya, into English, and the translations were enhanced using the Grammarly tool to fix the structure of the significant statements, including basic grammar, spelling, punctuation, and sentence clarity, while keeping the participants' original thoughts and meaning intact. To ensure the thematic analysis was valid and reliable, the researcher collaborated with a university data analyst specializing in qualitative data analysis, as required by the University. As mentioned, thematic analysis is simply the process of identifying and organizing patterns or themes within qualitative data; that is why it was used to analyze the transcribed data. This study followed six specific phases by Braun and Clarke: (1) getting familiar with the raw data, (2) creating initial codes, (3) searching for overarching themes, (4) reviewing the themes, (5) defining and naming those themes, and (6) writing up the final report (Dawadi, 2020).

After submitting the raw and translated data, the analyst familiarized themselves with the data and read the transcripts multiple times to understand the material fully. Initial codes were then generated by marking significant and meaningful verbatim statements, which were then sorted into emergent themes. These themes were checked and adjusted to fit the dataset accurately, then defined and named by the analyst. Finally, after the analyst handed the analysis to the researcher, the researcher wrote the final report, weaving participants' significant statements into a clear, cohesive story of the findings based on their experiences and challenges.

Qualitative research relies on the classic framework developed by Lincoln and Guba (1985). These researchers created four areas of focus for assessing the trustworthiness of qualitative research: credibility, dependability, confirmability, and transferability. The first area, credibility, is often considered the most important because it can ensure that research results are accurate and reflect participants' true experiences. To maintain consistency, the researcher focused on dependability, using peer reviews and professional feedback to stay on track (Stahl & King, 2020). Then, results are more likely to be replicable by other researchers when data are double- and triple-checked during data collection and processing, ensuring the confirmability of qualitative data. Finally, although qualitative data is not intended to be generalizable to all populations, transferability was established by providing a detailed description of the participants and the research setting. This approach enables other researchers to apply the findings to comparable contexts (Northcentral University, 2023).

Also, the researcher strictly adheres to the ethical standards set by the UMERC, as the research involves participants from a vulnerable population and could expose them to minimal psychological risks. Due to the sensitivity and nature of the chosen research topic, the researcher took full responsibility for protecting participants' physical and psychological safety (Polit & Beck, 2010; Munhall, 2012). Ensuring the safety of the participant meant that the researcher strictly complied with the core ethical principles emphasized by the University, which include respecting the dignity and lives of the participants, their choices, preventing them from unnecessary harm, minimizing risks, ensuring confidentiality and privacy, securing informed consent, and making sure they participated voluntarily without coercion or any personal conflicts involved (Scott, 2017).

In this study, every participant was treated with dignity, and all study details, including potential risks and benefits, were clearly laid out from the start. Participants maintained their anonymity and their right to self-determination, meaning they could freely choose whether to participate. Deciding not to join or withdrawing later had zero impact on the services their patients received or their relationship with the facility.

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

As mentioned above, before the interview, the researcher asked for permission to record audio, and everyone had the right to say no without any issues.

To respect and maintain participants' privacy, they were given codes to prevent easy identification. No real names were used in the transcripts or in the results of this study. The recorded audio tapes were stored in a device accessible only to the researcher. The transcripts were also stored in an encrypted folder. Furthermore, after using the participants' data, the researcher will destroy it to ensure the participants' privacy and confidentiality. The researcher also strictly followed the Philippine Data Privacy Act of 2012 to safeguard all participant information throughout the study.

Additionally, as mentioned earlier, the researcher ensured that participants did not experience any harm during or after the study. During the study, interviews were conducted in a well-ventilated, private, physically and psychologically safe room set up during regular visiting hours. Also, no staff from the facility, patients, or other visitors were allowed inside unless requested by the participant. The researcher made sure participants faced no harm during or after the study. Since the interview involved a sensitive topic like drug use, family arguments, social stigma, and mental distress, the researcher ensured careful handling to minimize potential minimal to moderate psychological risk. Nevertheless, before the interview commenced, the participants were informed and oriented about the potential risks, reminded that they were not forced to answer any uncomfortable questions, and could stop the interview at any time. Moreover, the researcher ensured that if any participant felt psychologically unsafe, emotionally upset, or disturbed during the interview, the researcher would pause the interview, offer immediate comfort, and, if necessary, provide a referral to a licensed psychologist or counselor at the rehab facility.

To show gratitude for the participants' contributions, effort, and time, a small token of appreciation was given. The researcher gave the participants a simple food pack worth two hundred pesos (P200). The token was given to the participant purely to thank them and to help the researcher achieve the study's purpose. To emphasize, the token was given as a gesture of gratitude and was never meant to influence their decision to participate or to bribe them. Also, although participants have no direct benefits from participating in this study, indirect benefits were still considered. The indirect benefits of participating in this study include contributing to the betterment of family-based and support programs in rehabilitation centers, as well as gaining understanding and awareness of their experiences as a secondary support system for patients in the rehab facility.

Moreover, the researcher declares that no personal, financial, or professional conflict of interest has influenced the interview, analysis, or the results of this study. While the researcher was employed as a Health Program Officer in the same drug treatment and rehabilitation center where the study was conducted, and some participants were connected to her workplace, the researcher held no clinical, administrative, supervisory, or evaluative authority over the participants. Also, to maintain confirmability and mitigate personal biases, the researcher exercised intentional self-reflection throughout the process. Using a structured interview guide, the researcher ensured that the data collected in the study remained focused on participants' experiences and challenges rather than on the researcher's professional observations or assumptions. This approach ensured that the researcher did not impose any values on participants and that the findings were primarily derived from participants' experiences and challenges.

To ensure that the researcher avoids any potential conflict of interest, coercion, or bribery in the participation of the participants, a representative from the rehab facility was tapped to facilitate the recruitment process, which means that the researcher was not involved in any form in the recruitment of the participants, and also ensured that the representative followed the ethical guidelines imposed in this study. The participants were clearly informed and oriented that their participation was voluntary, and that refusal or withdrawal would not affect the treatment or services provided in the facility. Informed consent was obtained privately, without the presence of facility staff, and participants were given adequate time to make a free decision. Confidentiality was strictly maintained; participants were informed of the researcher's professional role and were assured that it did not influence their participation or access to services. These measures ensured the

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

protection of participants' autonomy, welfare, and rights, while maintaining the ethical integrity and objectivity of the study.

Lastly, the researcher ensured honesty and transparency, with no form of deceit in recruitment, data collection, or reporting. To avoid plagiarism, the researcher properly paraphrased all cited ideas and concepts and appropriately acknowledged the sources and literature used in the study through accurate citations. The researcher also used the University's anti-plagiarism software, Turnitin, to check for any plagiarized content in the study. All measures in this research strictly followed the process supervised by the UMERC to ensure compliance with the protocols, as evidenced by the Certificate of Approval with UMERC Protocol No. UMERC-2026-077.

RESULTS AND DISCUSSION

This section includes the participants' experiences, challenges, and significant insights as a secondary support system. It also presents the various themes and core ideas extracted from in-depth interviews, followed by an outline of the responses from the other study participants.

Table 2. *Themes on the experiences that the secondary support system had while supporting a patient undergoing a drug dependence rehabilitation program.*

Themes	Core Ideas
Emotional Shock, Distress, and Burden	Worried and concerned Shock and disbelief Emotional confusion Feeling stressed and disturbed Exhausted and stressed
Assumption of Extended Caregiving Roles	Managing rehabilitation logistics Parenting and assisting the children Providing support in all forms
Financial and Lifestyle Sacrifices	Sacrifice personal spending Prioritizing rehabilitation needs Work disruptions Economic vulnerability
Social Stigma and Public Judgment	Stigma by association Subject to public scrutiny Emotional discomfort in social space
Family role restructuring and conflict	Provide emotional, Financial and logistical support Redistributing responsibilities at home Shifts in family roles and dynamics

Table 2 above presents the themes and core ideas identified from participants' responses to questions about experiences supporting a loved one in rehabilitation. Most participants reminisce about immense emotional and psychosocial challenges as they navigated the rehabilitation process. Their responses yielded five (5) themes: Emotional Shock, Distress and Burden; Assumption of Extended Caregiving Roles; Financial and Lifestyle Sacrifices; Social Stigma and Public Judgment; and Family Role Restructuring and Conflict.

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

Emotional Shock, Distress, and Burden

As the first theme, participants consistently described intense emotional reactions upon discovering the patient's situation and throughout the rehabilitation process. Initial reactions included worry and concern, shock and disbelief, and emotional confusion and exhaustion. These reactions prove that secondary support systems carry both sudden, acute shock and long-term, chronic stress. The amount of emotional suffering demonstrated by these individuals indicates that their level of investment in the life of the patient is very real, despite them not being primary caregivers.

One study participant shared that her initial reaction to the arrest was immediate worry and a need to seek clarity about the situation.

When he was arrested, his father said that he was in jail. Of course, as his aunt, I went there and asked what really happened. I was very worried, ma'am, because I know that he truly wanted to change, and just when he wanted to change, that was when he got arrested (SP1).

Another study participant also expressed emotional overwhelm, noting that the suddenness of the event led to a state of shock and confusion regarding their own feelings.

Everything happened so suddenly, ma'am. I was shocked when I found out what had happened to him. It was very difficult, ma'am. That was when I learned that he had not slept for several days, and that was also when I saw him in jail. I felt completely overwhelmed, ma'am, because I did not know what I was supposed to feel (SP2).

A subsequent study participant described prolonged distress, specifically mentioning the physical and mental exhaustion caused by traveling and the inability to sleep due to the patient's behavior.

I was really stressed when he was still outside, ma'am. I kept going back and forth from General Santos to North Cotabato. I was taking care of his papers, and I could not sleep because I would find out that he was drinking again (SP5).

Lastly, one of the study participants reflected emotional heaviness, highlighting how the situation caused collective pain for the entire family.

I felt deeply disheartened because just when he was about to change, he got arrested. Of course, our whole family was affected, ma'am; it was painful for all of us (SP4).

Assumption of Extended Caregiving Roles

Support systems often take on responsibilities beyond their usual scope, such as managing the logistics of the rehabilitation process, parenting the patient's children, and providing comprehensive support.

A study participant shared how she struggled to balance her personal family obligations with the extensive logistical support required for the patient's legal and rehabilitation needs.

As his aunt who guided him, ma'am, I really struggled. I also have my own family; my children depend on me. I was the one taking care of his papers, ma'am, even when he was still in jail. Even here in the rehabilitation center, I'm still the one handling everything (SP1).

Similarly, another study participant expressed the weight of taking on the role of a parent for the patient's children while managing his own household.

His children were left in my care, ma'am. The responsibility really fell on me. I am his uncle, and I am the only one he turns to when he has problems. His children are with me now; I am the one obligated to take care of them. It is really difficult because I also have my own family, but I cannot just abandon them since they are still young (SP2).

A subsequent study participant described the shift in her daily routine and the continuous provision of both emotional and material support during the rehabilitation period.

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

When he was admitted, ma'am, we continued to provide him with the support he needed. Our routine changed because we come here every month for the activities, and sometimes I also bring his toiletries (SP5).

Financial and Lifestyle Sacrifices

Supporting a family member through their recovery can place an incredible financial burden on a family. Families regularly prioritize the cost of their relative's rehabilitation over their own needs and often have to handle work interruptions while they financially support the recovering family member.

One participant demonstrated this double impact by explaining that he had to abandon his everyday work responsibilities to travel for his scheduled visits, which further strained his already tight budget.

Whenever I have work, ma'am, I really have to leave it behind. I just set aside my tasks because I feel sorry when he finds out I did not come by to visit him. That's why it's really difficult, especially since it also requires money to come here, ma'am, and we live very far away. It's really hard, but I'm just enduring it (SP2).

Another study participant emphasized the lifestyle adjustments required for visitation, such as waking up early to ensure all of the patient's requests and needs are met by a strict morning deadline.

When we go to the rehab, ma'am, I wake up early in the morning. We need to be there by 8 AM. We bring his needs and requests. So far, the trip has not been too difficult, and we are thankful to be safe because we are guided (SP3).

Another study participant also shared that managing a business was frequently interrupted, forcing constant schedule rearrangements to meet the requirements of the rehabilitation center.

My routine is really affected, Ma'am. I am busy with my business, and that is where my focus should be, but there are times when I need to go here, so there are really changes. However, I always find a way to come here, especially when a schedule is given (SP5).

Lastly, the study participant reflected on the extreme prioritization of the patient's needs, often choosing to spend her limited budget on visitation even if it leaves her with nothing for the following day.

Today, Ma'am, I have an important errand, but I really prioritized coming here. Even if I do not have a budget for tomorrow, I will deal with it, as long as I can prioritize this first (SP1).

Social Stigma and Public Judgment

Family members feel the weight of stigma by association, experiencing emotional discomfort in social spaces and feeling subject to public scrutiny because of their loved one's situation.

One study participant shared the discomfort of facing public inquiry at her place of business, where customers frequently ask about the patient's absence. However, she chooses to remain mentally resilient against the scrutiny.

As for me, Ma'am, I also feel shy when facing people. In my store, I am always the one being watched, and customers ask where a certain person is and why they no longer see him there. However, I still manage, Ma'am. I just did not let it enter my mind, and I chose not to be affected by it (SP1).

Another study participant also reflected on the initial shame she felt when processing the patient's legal documents, noting that she eventually learned to prioritize the patient's needs over the unhelpful feedback of others.

There are some pieces of feedback from other people, Ma'am. You cannot avoid thinking about it. When I was starting to process his papers, Ma'am, I sometimes felt shy, but I did not give in to what they were saying. As long as I know that I am doing something for my patient, I am okay with that. Because if I am affected, Ma'am, they are not helping anyway (SP5).

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

The study participant described the shame she felt and how seeking support from friends helped her realize that the patient's actions do not define the character of the entire family.

The first time, Ma'am, I also felt ashamed about what happened to him. I opened up about it to my companions, my friends, and my supporters. Their response to me was, of course, he is your family, but your way of thinking is not the same. Maybe it is just sadness because of hardship (SP3).

Family role restructuring and conflict

Family dynamics shift significantly as roles are redistributed during the recovery process. This transition involves providing emotional and logistical support, which can lead to changes and potential conflicts as these new responsibilities are taken on.

One study participant shared that she consistently restructures her daily life and personal errands to prioritize the patient's needs, rescheduling her own important tasks to provide financial and material support.

I just set aside my errands, Ma'am, for him because I really prioritize visiting him. Sometimes I give him money and bring him things. I also have personal errands, but if I think about it, this is more important, so I reschedule them if possible so I can really travel here, Ma'am (SP1).

Another participant in the study shared about how he has taken on a father-figure role for the patient's children since the incarceration began.

I have also become like a father to his children, Ma'am. They have all been under my care since he was jailed (SP2).

Lastly, the study participant further illustrated this restructuring by detailing his new responsibilities in ensuring the children's logistical needs and physical safety are met.

When his children have somewhere to go, Ma'am, I am the one who drives them and makes sure they are safe (SP4).

Table 3. *Themes on the challenges that the secondary support system faced while supporting a patient undergoing a drug dependence rehabilitation program.*

Themes	Core Ideas
Financial Strain and Economic Burden	Lack of financial resources Inability to provide funds Logistical costs, petrol, food
Time Constraints and Disrupted Daily Activities	Additional costs for visits and other needs Needed to give up other errands Absences at work Delaying other tasks to do Consuming more time with patient's documents and case condition
Emotional Hardship and Psychological Distress	Day to day anxiety Feeling down due to feeling of emptiness Fear for patient's wellbeing Emotional exhaustion

Table 3 presents the specific challenges faced by the secondary support system while supporting a patient undergoing a drug dependence rehabilitation program. According to interviews with participants, they frequently had substantial difficulty due to economic and logistical constraints. The financial aspect was a major concern for them; they had to pay for the patient's rehabilitation, as well as petrol, food, and travel expenses to the patient's location. Participants reported that they had to alter their day-to-day routines and often had to miss work due to

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

their involvement with the patient's case, or delay their personal appointments to manage the patient's case and maintain documentation.

Financial Strain and Economic Burden

The secondary support system lacked the resources to provide the necessary funds for treatment. This includes logistical costs such as petrol, food, and fare, as well as additional expenses for visits and other needs.

One participant highlighted the emotional toll of financial instability, noting that high travel costs sometimes left them without fare on the morning of a visit.

Financially, Ma'am, our budget is really affected every time we go here. I really feel like crying when looking for money because the expenses are not easy, even just for gasoline or fare, Ma'am. This morning, I didn't even have money for the fare, Ma'am. I was only able to leave later because we really had nothing at all (SP1).

Another study participant also expressed that the distance he had to travel to reach the facility created additional financial burdens, such as having to rely on his neighbors for transportation and balancing the costs of his children's education.

Financially, Ma'am, it is really hard because we live far from here. Right now, I am thankful because a neighbor brought me here, Ma'am, and I am very grateful. The expenses are really not easy, Ma'am, especially since the children are still studying. I really try my best to ask for help, Ma'am, so that I can come here (SD2).

One study participant emphasized that the primary financial burden stems from the long-distance travel required, specifically the recurring costs for vehicle fuel or public transportation fares.

The travel itself is really difficult, Ma'am, because as you know, our place going here is very far, especially with the fare or the fuel for the vehicle (SP3).

Lastly, the study participant described the financial weight as heavy, explaining that she serves as the sole provider for everything from initial admission requirements to ongoing personal supplies and transportation costs.

Financially, Ma'am, it is heavy. I handle all the expenses, Ma'am, from the requirements when he first entered up to now. The things sent to him here, as well as the fare or fuel, Ma'am, are all on me (SP5).

Time Constraints and Disrupted Daily Activities

Participants said they had to skip errands and miss work. Taking care of the patient's paperwork and health needs takes a lot of time, which causes delays in other important tasks.

One participant explained that she prioritizes rehabilitation activities, even if it means closing her store and canceling other plans to be at the facility.

If there are activities here, Ma'am, I really prioritize coming here. I leave my other appointments. I close my store when I go here, Ma'am (SP1).

Another participant said he had to miss work and saw this disruption to his job as unavoidable if he wanted to support the patient.

I really have to be absent from my work, Ma'am, that is all. I really need to come here (SP2).

Another participant shared that going to the facility meant asking for permission to miss both work and community responsibilities, like local barangay meetings.

When I go here, Ma'am, I really end up being absent from my work. If there is a barangay meeting, I ask permission to be absent because I need to come here (SP3).

Lastly, one study participant described how the facility's schedule dictates her life, forcing her to leave her business unattended and to cancel or delay personal family matters frequently to accommodate the patient's needs.

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

Overall, Ma'am, it really depends on the schedule. There are times when I really need to come here, so I leave my business. Alternatively, sometimes, Ma'am, I have errands or family matters that I may have to extend, cancel, or skip altogether because I am here (SP5).

Emotional Hardship and Psychological Distress

A sense of anxiety about daily living and emptiness: families have concerns about the patient's well-being and the emotional exhaustion that can follow prolonged stress.

One participant in this study expressed that the stress has taken both a spiritual toll on her and a physical one; she reports being unable to sleep because she questions the weight of the burden placed upon her.

There are times, Ma'am, when I cannot sleep, and I find myself saying, 'Lord, why did You give me this kind of burden?' I do not have problems with my family or my children. His siblings, Ma'am, are also poor, but at least my children can support us (SP3).

Also, another study participant reflected on a sense of loneliness and the loss of a close companionship, noting that the absence of his cousin has made their previously shared struggles feel more difficult.

I also feel lonely sometimes, Ma'am, because my cousin and I were really close. Even though things were difficult before, since the two of us were both earning money, it was somehow okay (SP4).

Additionally, a subsequent study participant expressed deep worry and pity, rooted in past trauma where the patient was physically harmed; this history continues to fuel a persistent fear for the patient's current safety.

Sometimes I end up crying from worry and pity for him. When he was still in jail before, Ma'am, whenever he asked for something, I would send it because there was a time he was reportedly beaten when he was unable to pay. That is why now, Ma'am, I still feel fear and pity for him (SP2).

Lastly, one study participant described her determination to endure sadness and difficulty, motivated by the responsibility of being the one who initiated the rehabilitation process and the fear of what would happen to the patient if left unsupported.

Even though it is difficult and sad, Ma'am, I will still endure it just to be able to help. I was the one who brought him here, Ma'am, so I try not to think about it too much, right, Ma'am? Rather than just leaving him alone, I think about what might happen to him outside. I really want him to be able to get out while he is already okay (SP5).

Table 4. *Themes on the significant insights that the secondary support system has learned while supporting a patient undergoing a drug dependence rehabilitation program.*

Themes	Core Ideas
Recognition of Transformation Through Rehabilitation	Promotes behavioral, emotional, and spiritual change Encourages self-awareness and accountability Repairs damaged relationships
Importance of Family Support and Presence	Consistent presence of the support system/family Emotional reassurance Active involvement and monitoring Expressing care, love, and support
Shift in Perception Toward Addiction and Recovery	Becoming more empathetic Growth in empathy and awareness Shifting from hopeless to hopeful thoughts Positive thoughts towards rehabilitation

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

Strengthened Faith and Reliance on Spirituality	Developing stronger faith Fervent prayers really help Trusting everything to Him
Development of Personal Resilience and Coping Strategies	Patience and emotional control Problem-solving strategies Reliance on support networks

Table 4 above shows the different themes and core ideas on the significant insights that the secondary support system has learned while supporting a patient undergoing a drug dependence rehabilitation program. The Participants gained significant insight into the capacity for change and recovery among individuals undergoing rehabilitation. They realized that the process promotes behavioral, emotional, and spiritual change and gained insight into individuals' capacity for change and recovery during rehabilitation.

Recognition of Transformation Through Rehabilitation

Families observed that the process promotes behavioral, emotional, and spiritual change. It encourages the patient's self-awareness and accountability, which helps repair damaged relationships.

One study participant observed a profound spiritual and emotional shift, noting that the patient had developed a connection to faith and a newfound ability to express his feelings.

I really noticed the changes in him. One thing I am truly thankful for, Ma'am, is that he now knows how to pray to God. He no longer prays, and he is no longer confident in himself or able to express his feelings (SP1).

Additionally, another study participant noted behavioral change and credited the structured programs and staff for facilitating greater mutual understanding through open dialogue.

I really appreciate the staff's help, Ma'am, and the rehab program. Through the dialogues, I was able to understand all sides of him, which is why I understand him better now. It is also good for him, Ma'am, that he was able to tell me everything about what he really feels and experiences (SP3).

In addition, a subsequent study participant reported significant improvements in communication from their first day of admission to their last, noting that the patient had become much more open and much more willing to engage in meaningful conversation with them.

I can now talk to him properly and for longer, Ma'am. I also understand his words better now… he has become more open about his feelings compared to when he was still outside (SP5).

Lastly, one study participant highlighted relational healing, specifically a noticeable decrease in the patient's anger, and a tangible drive to make positive changes for the benefit of their family.

It helped lessen his anger toward his child… You can see in his eyes that he is now determined to change for his family (SP4).

Importance of Family Support and Presence

Participants realized that it was essential for them to be consistently involved in their loved one's recovery through an ongoing pattern of support and an active commitment as caregivers.

One study participant emphasized that family support must be constant, both during the rehabilitation facility period and into the patient's life after treatment, requiring greater understanding and patience.

It is really necessary, Ma'am, that we, as his family, should always be by his side and show him support. Not only here in rehab but also outside. We really need to understand him and have a lot of patience, Ma'am (SP1).

Along with this, other participants highlighted that an addiction crisis or a recovery support crisis requires everyone in the family to work, where members must actively help one another navigate the situation.

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

It is really necessary, Ma'am, for the family to help each other in this kind of situation (SP2).

In addition, one study participant noted the unique and irreplaceable role of the family, suggesting that it is the primary, and often the only, support system capable of providing the endurance and support needed.

You really need to help and be patient with your patient here, Ma'am. Because there is no one else who can help him, Ma'am, except us, his family (SP5).

Lastly, study participants highlighted that the visible progress and changes in the patient serve as a motivation for the family to continue their support and cooperation.

He really needs support, Ma'am, because we can see that he is changing. That is why we really need to help each other (SP4).

Shift in Perception Toward Addiction and Recovery

People move from feeling hopeless to feeling hopeful. Families start to show more empathy and understanding, which challenges the idea that addiction always leads to decline.

One participant in the study shared how her views changed. She used to think addiction could never be overcome, but learning about rehabilitation programs showed her that change is possible.

Before, Ma'am, when someone was called a person with an addiction, it felt like there was no chance for change. However, now, because of rehab, there is still a chance to change (SP3).

Another participant in the study pointed out that helping someone change takes active support, not neglect. Still, the patient is ultimately responsible for their own transformation.

If you want him to change, it is not enough to leave him to do whatever he wants; you really need to guide him, Ma'am. The change still depends on him, Ma'am (SP5).

Additionally, a subsequent study participant observed that consistent family support and the absence of neglect were essential factors enabling the patient to repair his relationship with his child.

He really needs support, Ma'am, because we can see that he is changing. Now, he also has a better relationship with his child because the child can see that he is already changing, and he can also see from us that we are not neglecting him (SP4).

Lastly, one study participant shared a more empathetic view of the origins of addiction, recognizing that it can stem from personal pain rather than choice, and affirmed that rehabilitation has shown him that recovery is achievable.

Not all patients choose to become addicted, Ma'am. In his case, he started because his wife hurt him, and he could not control himself from using. However, now that he is here in rehab, he has changed, Ma'am. It turns out that change is still possible (SP2).

Strengthened Faith and Reliance on Spirituality

Spirituality serves as a core coping mechanism for support systems, providing them with the emotional fortitude to endure the challenges of the rehabilitation process. The concepts of divine intervention and prayer provide families with emotional strength to help them through many of the obstacles encountered in the most difficult situations.

One study participant emphasized the importance of prayer in her own ability to cope with the stress of providing care, expressing her trust that a higher power is watching over her.

Moreover, I keep praying for everything, Ma'am, trusting that God is watching over me (SP3).

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

In addition, a subsequent study participant shared his perspective on the efficacy of faith, suggesting that maintaining trust in God and persistent prayer are the keys to overcoming problems.

Just trust in God, Ma'am. All problems can be solved as long as we keep praying (SP4).

Lastly, one study participant reflected on how he entrusts his hardships to God to gain the strength to endure, while also noting the importance of having his spouse as a secondary pillar of support.

I pray through all the hardships, I endure them, and I entrust everything to Him. I also have my spouse who supports me (SP2).

Development of Personal Resilience and Coping Strategies

Members of the support system develop their own ways to remain resilient amidst trials. This includes accepting help from others, valuing one's own peace of mind, and maintaining deep love and belief in the patient's capacity to change.

One study participant shared that her involvement in the rehabilitation process is not only for the patient's welfare but also for her own peace of mind.

I keep in mind that I am not only doing this for my patient, Ma'am, but also for my own peace of mind (SP5).

In addition, a study participant also emphasized the importance of staying strong and being open to help from others to prevent burnout and emotional exhaustion.

In this situation, Ma'am, you really need to stay strong and not keep the problem to yourself, so you will not get too tired. If people are willing to help, you should not refuse them, Ma'am. It is better that you truly accept the help you need (SP3).

Furthermore, a study participant explained that love and trust in the patient give her the strength to find ways to support the patient. She also highlighted the importance of family cooperation and faith in God as primary sources of strength.

If you truly love him, Ma'am, you can endure everything. When you believe in him, you will really find ways to support him. His cousins, Ma'am, we all believe that he will change; that is why I am doing my best to guide him in his recovery. There are also people around me who are willing to help me. Families really need to help each other, Ma'am, and we should not forget to always pray to God, because it is from Him that we draw our strength (SP1).

DISCUSSION

Experiences of the Secondary Support System

The study results show that secondary support systems faced numerous emotional and role-related challenges while assisting a patient in a drug dependence rehabilitation program. This included dealing with emotional shock and stress, new responsibilities related to the caregiving role, financial and lifestyle sacrifices, social stigma, and changes to their family's structure. Five themes emerged regarding the experiences of the secondary support system.

The findings indicated that *Emotional Shock, Distress, and Burden* were significant experiences for the second support system. Participants shared that they had a wide range of strong feelings about the patient's use of drugs, from shock and disbelief to being affected by a heavy burden of feelings and intense fears, which began to develop into chronic stress as they continued to provide support during the patient's rehabilitation.

Caregiving is a complex and multidimensional construct that encompasses both the subjective aspects of stressors and the objective aspects of burdens. The study provides evidence that being a primary caregiver creates stress not only for the person providing care, but also for all those helping to provide care or support. The stress

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

of providing care as a primary caregiver can affect everyone in the support network, both psychologically and physically, and may compromise the overall health of the entire network.

This concept of "collective pain" mentioned in the findings supports the view that families function as a biopsychosocial unit and that the "moral residue" or pain resulting from the crisis is shared among all family members, especially during systemic events such as when the patient is arrested, which negatively dulls the patient's moral agency and motivation to change (Makanjuola & Ngcobo, 2025). For those who have endured an acute trauma, moving in the direction of a state referred to as "compassion fatigue" can occur. Compassion fatigue is a long-term psychological drain caused by the continuing demands placed upon the person supporting another. This may make it difficult to sustain efforts to advocate for one's patients (Borges et al., 2025).

Another theme that emerged is *the Assumption of Extended Caregiving Roles*. The second support system shared that they took on responsibilities beyond their usual scope, such as handling legal documentation and managing the patient's logistics. In some cases, they even took on the role of parenting the patient's children while the patient was in the facility.

When parents have issues with substance use, the home is in disarray, and children may rely on their grandparents or relatives to provide them with consistent care, emotional support, and supervision daily (Jørgensen et al., 2025). Extended families are critical in meeting the physical, emotional, and financial needs of individuals when their immediate caregivers are unable to fulfill their roles; therefore, extended family interdependence is a necessary component of recovery and family resiliency (Hogue et al., 2021).

The study also revealed *Financial and Lifestyle Sacrifices* among participants. The second support system prioritized the rehabilitation needs and fees over their own personal spending and work commitments. They expressed that their daily routines and businesses were often disrupted to ensure the patient received the necessary care.

Economic hardship is one of the key predictors of how much of a financial burden caregiving will be for a family with a substance use disorder. A large portion of the family's limited income is often needed for day-to-day living expenses. Still, it is now being used to pay for treatment, creating not only financial instability but also emotional stress and strain upon the family (Abdelrehim et al., 2022). One research study identified caregivers experiencing financial distress and the highest perceived burdens due to their loved one's substance use conditions (Nguyen et al., 2025). Due to the impact of addiction on both the financial and personal well-being of caregivers, they were overwhelmed with the responsibilities of providing financial assistance and caregiving daily.

Another theme identified in the study is *Social Stigma and Public Judgment*. The second support system felt stigma by association, where they experienced shame and discomfort in public spaces due to the community's perception of drug addiction. They shared that they often felt scrutinized or judged by others because of their loved one's situation.

Due to the cultural lens that society uses to view substance use, it is often viewed as a moral failing instead of as a medical condition. Therefore, the entire family unit benefits from the stigma associated with substance abuse, often resulting in feelings of embarrassment and shame while experiencing social judgment (Hayeck et al., 2024). Therefore, the public condemnation creates a hostile social environment perpetuated by negative stereotypes of the community and discriminatory attitudes. The pressure created by this public judgment is often so severe that it drives family members to withdraw from the community and into severe emotional distress and/or low self-esteem (Dir et al., 2025).

Lastly, the findings revealed that *Family Role Restructuring and Conflict* occurred within the household. Because of the patient's absence or condition, a second support system was required to redistribute responsibilities and roles to ensure the household could remain functional. This redistribution led to increased tension for some families, as they were continually required to change and adapt.

Due to the substance use of the individual in the household, family members were forced to alter their roles and daily functioning significantly, therefore requiring them to readjust and reorganize themselves based on the substance-using behaviors of the individual (Hlahla et al., 2023b). Such changes create conflict and tension for the family member(s) who are responsible for unfamiliar duties and require them to restore stability to the

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

home. Substance abuse is often linked to internal family conflict, lack of trust, and familial strain due to the interaction between the substance abuser and the rest of the family, resulting in discord and negative behavioral changes for all family members (Manurung, 2024).

Challenges Faced by the Secondary Support System

Based on the study results, secondary support systems faced significant challenges during their support of a patient undergoing a drug dependence rehabilitation program. These challenges were primarily due to the high costs of travel and food during visits, additional daily living expenses, and the time lost during treatment. On the challenges faced by the secondary support system, three (3) themes emerged.

The first was the *Financial Strain and Economic Burden* created by the presence of these systems. The financial burden on secondary support systems extended well beyond rehabilitation fees; daily transport costs for providing support, food for visits, and other daily necessities added to the already high monthly expenses. The cumulative effect of all these expenses on the family supporting someone in treatment was very onerous.

The financial burden on families supporting someone in treatment can be overwhelming, leaving them without enough money to meet every day needs; this is especially true when their resources are limited. Costs incurred in supporting someone through treatment are frequently underestimated. The additional costs of supporting someone through direct expenses (e.g., transportation, food) are major barriers, to the extent that they can lead to family breakdowns (Schmidt et al., 2023b).

Additionally, the economic costs of drug abuse remain substantial, particularly when the patient cannot work, and the family must cover rehabilitation expenses alone. In addition to the direct financial burden experienced by the family unit through out-of-pocket expenses, the long-term costs associated with drug abuse will remain high if someone is unable to work and a family is paying for the rehabilitation of someone else. The financial strain on the family often causes stress and disrupts family unity (Manurung, 2024). Financial challenges and unemployment are thought to be major stressors to recovery and negatively affect the psychological well-being of family members who are attempting to obtain resources for ongoing care (Khan et al., 2026).

Another challenge identified in the study is *Time Constraints and Disrupted Daily Activities.* The support systems, who reported needing to miss work or cancel other appointments to attend to the patient's needs and to the rehabilitation facility, stated that they had difficulty balancing their work responsibilities with the time-consuming nature of caring for a relative in rehabilitation.

Family members providing care for a relative in rehabilitation often feel an imbalance between work and family duties due to the extensive demands of both roles, as well as their own personal needs (Fana & Sotana, 2021). In addition, the loss or disruption of one's work life will typically result in missed work days, abrupt changes in work schedules, and reduced productivity while attempting to support the patient in rehabilitation (Naguib et al., 2025). The caregiver's quality of life may also be negatively affected by decreased financial well-being and quality of social functioning due to the role of the caregiver, which will create a significant disruption to the regularity of daily routines for both the patient and the caregiver, as well as the support network used by the caregiver in supporting their loved one (Fana & Sotana, 2021).

The findings also revealed *Emotional Hardship and Psychological Distress* as major challenges. Beyond the physical and financial consequences of caregiving, they also have to deal with daily anxiety and fear concerning the patient's recovery and future. The support systems have expressed feelings of being alone and empty while they are going through the long and uncertain process of helping their loved one to heal.

Families coping with substance use disorder can face emotional decline, mental disturbances, and physical deterioration due to the experience of managing addiction while living in an addicted home. Internal chaos often occurs as a result of the ongoing stress of providing support to someone with addiction. This ongoing stress contributes to the reduction of the primary caregiver's mental health and long-term social stability (Mardani et al., 2023). In addition, caregivers are often highly vigilant, anxious, and concerned about supporting their loved one while at the same time attempting to minimize the impact of supporting the individual on their own mental health. The ongoing stress may lead to feelings of emotional exhaustion, fear, and psychological distress experienced by support systems (Kitt-Lewis & Adam, 2024).

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

Significant Insights of the Secondary Support System

The study found that secondary support systems gained important insights while helping a patient through drug dependence rehabilitation. They noticed changes during recovery, saw how crucial family support is, changed how they view addiction, grew stronger in their faith, and built personal resilience. Based on the significant insights gained from the secondary support system, five (5) themes emerged.

The findings revealed that *Recognition of Transformation Through Rehabilitation* was a significant insight. The second support system realized that the rehabilitation program facilitates profound behavioral and spiritual changes in the patient. They expressed that witnessing these positive changes helped in repairing previously broken family relationships.

Recent literature supports the view that rehabilitation serves as a transformative process not only for the patient but also for the family system and support network. Substance abuse destroys trust, disrupts families, and causes emotional instability. Still, with the right kind of restoration, you can return to living in society and develop healthier relationships by reducing harmful behaviors and developing new coping strategies (Manurung, 2024).

Research has also shown that individuals who demonstrate increased emotional intelligence during rehabilitation experience lower levels of depression and develop stronger social support; hence, rehabilitation can help build your ability to manage your emotions and rebuild long-term, meaningful relationships with others (Zhao et al., 2024). Finally, therapists use rehabilitation programs to provide therapy, structured interventions, and peer support to promote resiliency despite difficulties experienced during this time. Based on these findings, it is clear that rehabilitation produces positive changes in behaviors, emotional stability, and social connection that family members and support systems may notice (Cruz et al., 2024).

Another insight identified is *The Importance of Family Support and Presence*. The second support system realized that their consistent emotional reassurance and active involvement were key factors in the patient's success. They shared that the family serves as the primary support group, motivating the patient to continue their journey toward sobriety.

The family is an important source of support for people in treatment because they have a strong ability to influence how well an individual progresses and can provide support at many levels. Family-based interventions are often more effective than individual interventions because they can facilitate communication, develop better coping strategies, and change relationship dynamics. Families who actively participate in treatment have also been shown to reduce the rate of substance use following treatment (Hogue et al, 2021). Family-centered approaches to rehabilitation can create psychological resilience in addition to providing support and reducing feelings of hopelessness and helplessness, which may be triggering for relapses (Cruz et al, 2024). Ongoing family involvement and support from extended family members (e.g., grandparents and relatives) help establish a more stable recovery environment. This evidence demonstrates that it is important to establish and develop family support programs to aid the rehabilitation of individuals who have been rehabilitated from drug or alcohol use in order to help prevent them from returning to using or drinking again and to assist them emotionally as they recover (Jørgensen et al., 2025).

The findings also revealed a *Shift in Perception Toward Addiction and Recover*y. The second support system moved from a place of judgment or hopelessness to a more compassionate understanding of addiction. They expressed that they now view the patient with more empathy and have a more hopeful outlook on the recovery process.

The need to address stigma is crucial to provide genuine hope for individuals with substance use disorders. Moving toward less labeling and stereotyping of those who suffer from traditional views of addiction is necessary for a person's recovery. A stigma-free language and focusing on the personal resilience of a person can help to shift the way that society views addiction from one of shame to hope and inspiration, which are both fundamental to long-term recovery (Earnshaw, 2020). In addition, viewing addiction as a manageable medical condition rather than a trait of the person will increase compassion and build a stronger family and friend support system for the afflicted individual. Adopting this perspective will prompt individuals to respond to those in recovery with hope, respect, and understanding rather than judgment (Hayek et al., 2024).

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 7 (July 2026)

Another important insight is *the Strengthened Faith and Reliance on Spirituality*. The second support system shared that they learned to rely on prayer and their faith in God as their main source of strength during the most difficult times. They shared that their spiritual grounding gave them the peace and fortitude to continue supporting the patient.

Spiritual approaches are valuable for strengthening families and support systems involved in the rehabilitation process. Programs designed to support families with substance abuse use home visiting and spiritual elements as means of strengthening parents' and the extended family's faith and emotional resilience to decrease the extreme anxiety, fears, and daily panic that accompany being a family member with a loved one who is dependent on substances (Ulfiandi & Wahyuni, 2024). In addition, having similar spiritual practices, such as prayer, meditation, and other forms of spiritual support, can be protective factors that help alleviate ongoing stress for caregivers. Therefore, having recovery-based elements in faith-based recovery extends beyond the recovering individual; it also stabilizes the entire family unit. Families of individuals who are facing addiction often use faith as a source of hope, peace, and understanding, which allows them to view recovery as an opportunity for growth and redemption instead of overall hopelessness (Bradley, 2025).

Lastly, the findings revealed *The Development of Personal Resilience and Coping Strategies*. The support systems discovered their own capacity for patience and emotional control through the hardships they faced. They learned the value of accepting help from others and developed personal strategies to maintain their own well-being while caring for the patient.

Family involvement in substance use disorder treatment is considered a powerful resource for both the patient and the family unit. As relatives actively participate in the recovery process, they often develop stronger problem-solving skills, emotional regulation, and greater resilience while managing the challenges of rehabilitation (Hogue et al., 2021b). Likewise, psychosocial interventions for caregivers have been found to improve overall well-being and reduce personal burden by helping them move from distress toward active coping and positive reframing. These processes may contribute to personal growth, increased patience, and stronger emotional capacity among caregivers supporting a loved one in recovery (Sampogna et al., 2023).

Lastly, this study supports Murray Bowen's Family Systems Theory. The findings show that when a loved one underwent rehabilitation, the secondary support systems experienced emotional shock, financial strain, and social stigma. Family stability and patient recovery require a major restructuring of the family unit's roles and responsibilities. Members of the secondary support system assume caregiving roles, coordinate their work with other support systems, provide additional parenting support to the patient's children, and assist with economic vulnerability. These adaptations demonstrate Bowen's view that changes affecting one member influence the entire family system. These adjustments demonstrate Bowen's view that changes affecting one member influence the entire family system.

Bowen believed that when a family experiences a crisis in the immediate family, an extended family member will be drawn in as a natural stabilizer to the family unit. When someone in the immediate family has an addiction, the immediate family becomes unstable and at risk of breaking apart. Extended family members typically step up to provide parenting, manage the logistics of addiction, and financially absorb the costs of addiction in order to keep the family unit from collapsing. Although this practice allows for the immediate family unit to remain intact, it also places a huge burden on the secondary support system. These individuals are often chronically anxious, experience financial hardship, and develop compassion fatigue due to the family's dependence on them. Secondary caregivers will usually sacrifice their own physical health, emotional well-being, and careers to keep the peace.

For this reason, the focus of treatment cannot be solely on the individual experiencing addiction. Mental health practitioners must acknowledge that changes to the roles of extended family members are significant. In order for the secondary system to provide support during recovery, they should practice establishing healthy boundaries and self-differentiating, maintaining an emotional connection to the family while remaining separate from the family's chaos. Doing so will allow them to support recovery while also avoiding burnout.

Therefore, the rehabilitation process placed the extended family in a stressful, demanding situation, confirming Bowen's proposition that the behavior and well-being of each individual are inseparably linked to the functioning of the whole family. The findings highlight that recovery is not only an individual journey but also a systemic family process in which all members adapt, respond, and influence one another.

CONCLUSION

Based on the results and findings of this study, the secondary support systems experienced various emotional and role-related demands while supporting a loved one in drug rehabilitation. These support systems faced intense emotional shock, disbelief, and chronic stress upon discovering the patient's drug involvement. They also experienced fears regarding the stigma associated with addiction and experienced public shaming and social judgment in their communities because of that addiction. In addition, they assumed extended caregiver roles, managing the logistics of their patients' rehabilitation and parenting their patients' children. Support systems also worked beyond their capacity, regularly disrupting their normal work schedules and businesses to support the patient's needs and those of the rehabilitation facility. Support systems considered these time constraints to be occupationally imbalanced and to cause significant interruptions to their everyday lives. Additionally, support systems experienced a great deal of mental distress, such as anxiety, psychological distress, and a sense of family shared pain or "compassion fatigue" throughout the long-term and stressful rehabilitation process.

However, despite the many challenges faced by support systems during rehabilitation programs, all were able to develop various coping skills that allowed them to function efficiently. Finding strength through faith in God and through prayer for guidance and support was a major source of support for all family members.

Lastly, during the rehabilitation process, secondary support systems gained many insights; one important insight was the significant role of family support in patient recovery. Family support positively impacts the likelihood of patient transformation. Another important insight was the need for shifting society's view of addiction; a view should be taken that, rather than a moral issue, this disease should be seen as a disease that requires compassion and understanding from society and the healing community. Participants acknowledged that transitioning from a view of addiction as a moral issue to a perspective of addiction as a disease that could be transformed through rehabilitation motivated them to continue to support their loved ones and continue providing support despite the many sacrifices involved.

References

Abdelrehim, M. G., Sadek, R. R., Mehany, A. S., & Mohamed, E. S. (2022). A Path Analysis Model Examining Factors Affecting Burden of Care for Drug Addicts among their Family Caregivers in Egypt. *Journal of Research in Health Sciences*, *22*(3), e00554-e00554.

Bougie, R., & Sekaran, U. (2020). *Research methods for business: A skill-building approach* (8th ed.). Wiley.

Bradley, C. B. (2025). *The relationship of Christian spirituality and sustained recovery from trauma-related substance addiction* [Doctoral dissertation, Liberty University]. Scholars Crossing. https://digitalcommons.liberty.edu/doctoral/6651

Cai, W., & Wang, Y. (2022). Family support and hope among people with substance use disorder in China: A moderated mediation model. *International Journal of Environmental Research and Public Health*, *19*(16), 9786.

Campoamor-Olegario, L., Camitan, D. S., & Guinto, M. L. M. (2025). Beyond the pandemic: physical activity and health behaviors as predictors of well-being among Filipino tertiary students. *Frontiers in Psychology*, *16*, 1490437. https://doi.org/10.3389/fpsyg.2025.1490437

Casiño, R. M. Z., Serrano, L., & Granada, M. I. (2025). Revisiting the Filipino Value Utang na Loob: Contextual Perceptions, Implications and Inputs to Sustaining the Filipino Psychology Discussions. *International Journal of Education and Humanities*, *5*(2), 309–324. https://doi.org/10.58557/(ijeh).v5i2.311

Co, T. A. C., & Canoy, N. A. (2022). The lived experiences of recovering Filipino persons who use drugs (PWUDs) without family support. *Journal of Ethnicity in Substance Abuse*, *21*(4), 1389-1409.

Corey, G. (2020). *Theory and practice of counseling and psychotherapy* (11th ed.). Cengage Learning.

Coutinho Borges, B. E., Dantas, A. C., Machado de Lima, J. P., Bezerra da Silva, C. L., da Conceição Dias Fernandes, M. I., & Fortes Vitor, A. (2025). Analysis of the concept of caregiver role strain in informal caregivers: an approach according to Meleis. *Revista Cuidarte*, *16*(1).

Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed.). SAGE Publications.

Dangerous Drugs Board. (2015). *Nationwide survey on the nature and extent of drug abuse in the Philippines*.

Dangerous Drugs Board. (2017). *Reported cases by type of admission and sex (facility based) CY 2016*. https://www.ddb.gov.ph/research-statistics/statistics/45-research-and-statistics/329-2016-statistics

Dawadi, S. (2020). Thematic analysis approach: A step by step guide for ELT research practitioners. *Journal of NELTA*, *25*(1-2), 62-71.

Dela Cruz, J. M. F., Tomawis, M. C., Filipinas, T. I., Pacong, J. R. T., & Mamauag, M. F. M. (2024). The Impact of Family Dynamics on Suicidal Ideation and Substance Use: Examining Lived Experiences of Persons Who Use Drugs (PWUDs). *Social Transformations Journal of the Global South*, *12*(2), 2.

Dir, A., Batch, B. L., & Aalsma, M. (2025). Intersecting stigma of substance use and child welfare system involvement: Understanding stigma drivers, experiences, and outcomes from a socioecological perspective. *Drug and Alcohol Dependence Reports*, 100386.

Duquesne University. (2023, June 9). *Qualitative research methods: Gumberg Library and CIQR*. LibGuides. https://guides.library.duq.edu/c.php?g=836228

Earnshaw, V. A. (2020). Stigma and substance use disorders: A clinical, research, and advocacy agenda. *American Psychologist*, *75*(9), 1300.

El Hayek, S., Foad, W., De Filippis, R., Ghosh, A., Koukach, N., Mahgoub Mohammed Khier, A., ... & Shalbafan, M. (2024). Stigma toward substance use disorders: a multinational perspective and call for action. *Frontiers in psychiatry*, *15*, 1295818.

Fana, T. E., & Sotana, L. (2021). Exploring the experiences of family caregivers with people with drug-resistant tuberculosis. *Cogent Social Sciences*, *7*(1), 1906494.

Feliciano, A., Feliciano, E., Palompon, D., & Gonzales, F. (2022). Acceptance theory of family caregiving. *Belitung Nursing Journal*, *8*(2), 86.

Glesne, C. (2016). *Becoming qualitative researchers: An introduction*. Pearson. One Lake Street, Upper Saddle River, New Jersey 07458.

Hechanova, M. R. (2020). Family Support as Moderator of the relation between Coping Skills and Substance Use Dependence among Filipinos who use drugs. *Asia-Pacific Social Science Review*, *20*(1), 9.

Hlahla, L. S., Ngoatle, C., & Mothiba, T. M. (2023). Do the parents of the youth abusing substances need to be supported? A literature review study. *CURATIONIS Journal of the Democratic Nursing Organisation of South Africa*, *46*(1), 2401.

Hogue, A., Becker, S. J., Wenzel, K., Henderson, C. E., Bobek, M., Levy, S., & Fishman, M. (2021). Family involvement in treatment and recovery for substance use disorders among transition-age youth: Research bedrocks and opportunities. *Journal of Substance Abuse Treatment*, *129*, 108402.

Jiang, X., Shi, D., Topps, A. K., & Archer, C. M. (2020). From Family Support to Goal-Directed Behaviors: Examining the Mediating Role of Cognitive Well-Being Factors: X. Jiang et al. *Journal of Happiness Studies*, *21*(3), 1015-1035.

Jørgensen, K., Frederiksen, J., Hansen, M., & Dubovcová, M. (2025). Challenges and support for children of parents with mental health and substance use disorders: a scoping review. *Journal of Hospital Management and Health Policy*, *9*, 21.

Kane, E. M., Snethen, J. A., Gwon, S. H., & Oh, H. K. (2023). Affected family members social support experiences when assisting an individual with substance use disorder. *Journal of Nursing Scholarship*, *55*(3), 590-598.

Khan, M. S., Zongyou, W., Rahman, A., Khan, A., & Batool, S. (2026). Socio-economic and psychological factors contributing to drug use among females in Khyber Pakhtunkhwa, Pakistan: A mixed-methods approach. *South African Journal of Psychiatry*, *32*, 2506.

Kitt-Lewis, E., & Adam, M. T. (2025). Nurses' experiences and perspectives caring for people with substance use disorder and their families: A qualitative descriptive study. *International journal of mental health nursing*, *34*(1), e13435.

Kourgiantakis, T., Ashcroft, R., Mohamud, F., Fearing, G., & Sanders, J. (2021). Family-focused practices in addictions: A scoping review. *Journal of Social Work Practice in the Addictions*, *21*(1), 18–53. https://doi.org/10.1080/1533256x.2020.1870287

Kusumawaty, I., Yunike, N., Jawiah, N., & Rehana, N. (2021). Family resilience in caring for drug addiction. *Gaceta Sanitaria*, *35*, S491–S494. https://doi.org/10.1016/j.gaceta.2021.10.079

Makanjuola, O. J., & Ngcobo, W. B. (2025). Caregiver burden and the related factors among family caregivers of older persons with schizophrenia: A mixed methods study. *International Journal of Older People Nursing*, *20*(5), e70047. https://doi.org/10.1111/opn.70047

Manurung, L. (2024). The impact of drug abuse on families and society (Literature review). *MSJ Majority Science Journal*, *2*(2), 239–244. https://doi.org/10.61942/msj.v2i2.168

Manurung, L. (2024). The impact of drug abuse on families and society (literature review). *MSJ: Majority Science Journal*, *2*(2), 239-244.

Mardani, M., Alipour, F., Rafiey, H., Fallahi-Khoshknab, M., & Arshi, M. (2023). Challenges in addiction-affected families: a systematic review of qualitative studies. *BMC psychiatry*, *23*(1), 439.

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

McGovern, R., Smart, D., Alderson, H., Araújo-Soares, V., Brown, J., Buykx, P., Evans, V., Fleming, K., Hickman, M., Macleod, J., Meier, P., & Kaner, E. (2021). Psychosocial interventions to improve psychological, social and physical wellbeing in family members affected by an adult relative's substance use: A systematic search and review of the evidence. *International Journal of Environmental Research and Public Health*, *18*(4), Article 1793. https://doi.org/10.3390/ijerph18041793

Missouridou, E., Segredou, E., Stefanou, E., Sakellaridi, V., Gremou, M., Kritsiotakis, E., Missouridou, E., Segredou, E., Stefanou, E., Sakellaridi, V., Gremou, M., Kritsiotakis, E., ... & Parissopoulos, S. (2022, October). Family recovery from addiction and trauma: an interpretative phenomenological analysis of mothers' lived experience. In *Worldwide Congress on "Genetics, Geriatrics and Neurodegenerative Diseases Research"* (pp. 105-117). Cham: Springer International Publishing.

Moser, A., & Korstjens, I. (2017). Series: Practical guidance to qualitative research. Part 1: Introduction. *European Journal of General Practice*, *23*(1), 271–273. https://doi.org/10.1080/13814788.2017.1375093

Mountain-Ray, S., Simeone, C., Hadland, S. E., Finnell, D. S., Northup, R., & MacLane Baeder, D. (2019). Challenges and new horizons in substance use and addictions: Overview of the 2019 Conference of the Association for Multidisciplinary Education and Research in Substance Use and Addiction (AMERSA). *Substance Abuse*, *40*(4), 389–391. https://doi.org/10.1080/08897077.2019.1695039

Munhall, P. L. (2012). A phenomenological method. *PL Munhall (Ed.), Nursing research: A qualitative perspective*, 113-175.

Naderifar, M., Goli, H., & Ghaljaie, F. (2017). Snowball sampling: A purposeful method of sampling in qualitative research. *Strides in development of medical education*, *14*(3), 1-6.

Naguib, R. M., El-Sheikh, M. M., Alqadi, T. G. E. A. K., & El-Awady, S. A. (2025). Impact of substance use patterns on caregivers' quality of life, mood and burden: A cross-sectional study in Egypt. *Middle East Current Psychiatry*, *32*(1), Article 15. https://doi.org/10.1186/s43045-025-00525-x

National University Library. (2024, May 14). *Annotated bibliography*. National University. https://resources.nu.edu/c.php?g=1007180&p=7392379

Nguyen, H. N., Li, L., Nguyen, D. B., Pham, T. H., & Nguyen, T. A. (2025). Family caregivers of people who use drugs in Vietnam: Perceived burden and coping. *Social Science & Medicine*, 118440.https://doi.org/10.1016/j.socscimed.2025.118440

Polit, D., & Beck, C. (2020). *Essentials of nursing research: Appraising evidence for nursing practice*. Lippincott Williams & Wilkins.

Radfar, S. R., De Jong, C. A., Farhoudian, A., Ebrahimi, M., Rafei, P., Vahidi, M., ... & Baldacchino, A. M. (2021). Reorganization of substance use treatment and harm reduction services during the COVID-19 pandemic: a global survey. *Frontiers in Psychiatry*, *12*, 639393.https://doi.org/10.3389/fpsyt.2021.639393

Rushton, C., Kelly, P. J., Raftery, D., Beck, A., & Larance, B. (2023). The effectiveness of psychosocial interventions for family members impacted by another's substance use: A systematic review and meta-analysis. *Drug and Alcohol Review*, *42*(4), 960-977.https://doi.org/10.1111/dar.13607

Schmidt, T., Juday, C., Patel, P., Karmarkar, T., Smith-Howell, E. R., & Fendrick, A. M. (2023). Expanding the catalog of patient and caregiver out-of-pocket costs: a systematic literature review. *Population Health Management*, *27*(1), 70-83. https://doi.org/10.1089/pop.2023.0238

Scott, P. A. (2017). Ethical principles in healthcare research. In *Key concepts and issues in nursing ethics* (pp. 191-205). Cham: Springer International Publishing.

Slocum, S., Carrington, C., & Pollini, R. A. (2025). "Living in a chronic state of panic": family members' experiences with opioid use disorder. *Journal of Social Work Practice in the Addictions*, *25*(2), 199-215.

Stahl, N. A., & King, J. R. (2020). Expanding approaches for research: Understanding and using trustworthiness in qualitative research. *Journal of developmental education*, *44*(1), 26-28.

Ulfiandi, I. Z., & Wahyuni, E. N. (2024, September). Psychological-Spiritual Approach of Caregivers in Drug Rehabilitation at Sabilul Hikmah Polowijen Islamic Boarding School. In *Proceeding of International Conference of Islamic Education* (Vol. 2, pp. 251-262).

URC. (2024, May 22). *Family support crucial in community-based drug rehabilitation, Philippines*. University Research Co. https://www.urc-chs.com/news/family-support-crucial-in-community-based-drug-rehabilitation-philippines/

You, Y., Lu, S., Tsai, C., Chen, M., Lin, C., Chong, M., Chou, W., Chen, Y., & Wang, L. (2020). Predictors of five-year relapse rates of youths with substance abuse who underwent a family-oriented therapy program. *Annals of General Psychiatry*, *19*(1), Article 21. https://doi.org/10.1186/s12991-020-00269-4

Zhao, M., Kadir, N. B. A., & Razak, M. A. A. (2024). The relationship between family functioning, emotional intelligence, loneliness, social support, and depressive symptoms among undergraduate students. *Behavioral Sciences*, *14*(9), Article 819.