

**PREVALENCE OF SUBSTANCE USE AND ABUSE AMONG BLACK
UNIVERSITY STUDENTS AND THE FACTORS INFLUENCING THEM:
IMPLICATIONS FOR SUBSTANCE ABUSE PREVENTION**

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**Dissertation submitted in fulfilment of the requirements for the
Degree of Master of Social Sciences in the Faculty of Social
Sciences at the University of Fort Hare**

Supervisor : Professor L. C. Simbayi

Date Submitted : November 1996

Dedication

This dissertation is dedicated to the youth of South Africa,
with the hope that it will make some contribution in educating
them about the dangers of substance use and abuse.



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Declaration

I, Noxolo Nyameka Hewana, do hereby declare that the work contained in this dissertation is entirely my own work with the exception of such quotations or references which have been attributed to their authors or sources and that all photographs are made or drawn by me, save where I have acknowledged that another is the author.

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DATED at Alice on this 10th Day of November 1996.

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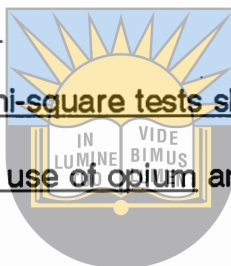
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ABSTRACT

Substance use and abuse is widespread throughout the world, including South Africa. Substance abuse constitutes an individual, a family and a social problem. Because of the dearth of information concerning the extent of the abuse as well as conditions associated with it, particularly among Black Youth in South Africa, the present study sought to fill this gap.

The present study investigated the prevalence of substance use and abuse among Black university students. Firstly, it examined the extent to which the university students abused various substances such as alcohol, tobacco, spirits, sleeping medicine, hallucinogens, barbiturates, whiffers, mandrax, dagga, amphetamines and heroin. Secondly, it investigated the variables that are associated with use and abuse of these substances. The research design used was a questionnaire-based survey. The questionnaire consisted of both open-ended and closed questions, thus it yielded both quantitative and qualitative data. The first part of the survey was essentially descriptive while the second part was analytical. The measuring instrument that was used was a self-report inventory adopted from an existing questionnaire as adopted by Bodisch (1994), Kota (1994) and Stubbs (1994) which was itself based on another questionnaire originally developed by du Toit (1974). A convenient sample consisting of 520 undergraduates Psychology students at the University of Fort Hare was used as participants.

The survey data were analyzed in three ways. Firstly, prevalence rates were

determined through the use of descriptive statistics, namely, frequencies of occurrence in terms of percentages. Secondly, associations between the level of use substances and various personal and social variables were determined through the use chi-square tests. Thirdly, and finally, predictions of the level of use of substances were determined through the use of multiple regression analyses.

The overall results show that alcohol was the most widely used substance, followed by sleeping medicine, spirits and tobacco in that order. However, only tobacco, alcohol and dagga were abused by significant proportions of the sample. All - in - all, the prevalence rates of use and abuse of these substances were fairly moderate ranging from around 30% down to about 5% of the sample. The variables that were associated with the levels of use of these substances were, inter alia, age, gender, year of study, progress at university, church attendance, occupational status and income of parents or guardian, family instability, family history of use and abuse of drugs, love of television and movies, amount of confidence, stress and depression and the ignorance of the effects of drugs. The multiple regression analyses was used to test how well the variables studied actually predicted the levels of use of substances by participants. Among the variables found to predict use of many as six or seven level of use of substance most accurately were occupational status and income of parents or guardians, cousin's use of substances, attitudes towards legalization, lack of family support and use of dagga.

The implications of these findings for the development of the appropriate intervention programmes to alleviate substance use and abuse among this segment of the population are discussed.



1.0 Introduction

Chapter 1 will provide a general overview of the dissertation. It will start by providing the background information of the study, the aims and objectives of the study, the statement of the hypotheses, the rationale of the study and lastly the lay out of the rest of the dissertations.

1.1 Background information of the study

Substance use and abuse is widespread throughout the world including South Africa. Substance is a generic term for chemicals that people take into their bodies in order to alter their mood and cause physical or psychological dependence (Sarafino, 1990). Glantz and Pickens (1992) refer to substance use as "experimentation or low frequency irregular use of illicit drugs and substance abuse as regular or compulsive use of illicit drugs" (p. 3). In the present study the use of the concept is also extended to legal drugs. Glantz and Pickens also believe that substance use and abuse are not independent because one often moves from one to another. However, that does not necessarily mean that all drug users can be abusers. They further believe that substance use is more the result of social influence such as peer pressure factors, whereas abuse is more of a function of biological and psychological processes.

Substance abuse is nothing else but drug addiction. Addiction occurs when a person cannot function normally without repeated use of drugs, and the person cannot control the need of the drug (Capadanno & Chavaria, 1989). Substance abuse constitutes an individual, a family and a social problem. On the individual

level, the use and abuse of a substance disrupts not only the lives of the abusers, but also of those in their social networks, including their families. On the social level, the disruption of families as well as high level of crime associated with substance abuse undermine the social standards (Hawkins, Catalano & Miller, 1992).

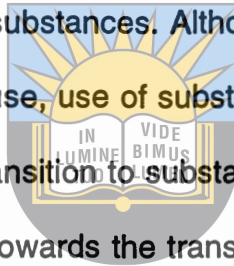
Substance abuse also causes physical, mental and social damage and costs the country millions of rands each year. The spread of diseases like AIDS, lung and heart diseases, kidney damage and so on are partly the consequences of substance abuse. Car accidents and suicide among youth are also mostly the results of substance abuse (African National Congress, 1994).

More importantly, the young adult substance abuse undermines motivation. In other words, the young adult feels hopeless, he or she lacks the drive to do any thing and nothing is exciting about life any more. In a recent review of the relevant literature,

Hawkins et al. (1992) grouped the risk factors for adolescent substance abuse into roughly two categories; namely, broad social and cultural factors and individual and interpersonal factors. The former include laws and norms favourable towards behaviour, availability, extreme economic deprivation, and neighbourhood disorganization, whereas the latter include psychological factors such as self-concept, family alcohol and drug behaviour and attitudes, poor and inconsistent family management practices, family conflict, low bonding of family, early and persistent problem behaviours, academic failure, low degree of commitment at school, peer rejection in the elementary grades, associated with substance abusing peers, alienation and rebelliousness, attitudes favourable to substance use in the

media and early onset of substance use (also see Bailey, 1991, Glantz & Pickens, 1992; Rowe & Gulley, 1987; Townberman & McDonald, 1993).

Schilling (1990) believes that adolescents tend to begin with a certain entry substance such as cigarettes or liquor, then subsequently progresses to dagga and finally harder substances. Kitty Dukakis, wife of former U.S.A. presidential candidate, revealed that if an individual is addicted to one substance, he or she is vulnerable to all of them. Kitty went for treatment for addiction in diet pill in 1982, and in 1989 she was treated for alcoholism. Thus, abuse of one substance often foretells the future abuse of other substances. Although substance use cannot necessarily lead to substance abuse, use of substances and nature of use contribute strongly towards the transition to substance abuse. The two risk factors found to be contributing strongly towards the transition abuse are the early onset of substance use and high frequency use of substances (Glantz & Pickens, 1992).



Bennet, Frankenstein, Keur, Laitman, McCrady and Van Horn (1991) believe that problem substance use in adults may look different from problem use in young adults. For example, young adults alcohol abusers drink heavily on weekends thus seeing themselves as non-problem drinkers because they only use the substance twice a week. Furthermore, the atmosphere is tolerant of excessive drinking and substance use. Equally important is the fact that difficulties in school or emotional problems may also cause substance use.

1.2 Aims and objectives of the present study

The aims of the proposed study were two fold. Firstly it examined the extent to which Black university students abuse various substances such as alcohol, tobacco, dagga, mandrax and other sensual drugs. Secondly, it investigated

variables that are associated with the abuse. The variables included inter-alia, family background, socio-economic status, gender, peer influence, year of study and religiosity. The availability of such information will make it possible to develop appropriate intervention programmes aimed at prevention of drug use and abuse among black university students.

1.3 Statement of the Hypotheses

The central hypothesis was tested in connection with the first aim of the study, which is that there is some widespread use and abuse of substances among black university students. Several hypotheses were tested in connection with the second aim of the study. The hypotheses were as follows;

Hypothesis 1 There is a significant relationship between family instability and the level of drug use.

Hypothesis 2 There is a significant relationship between lack of family support and the level of drug use.

Hypothesis 3 There is a significant relationship between family history of abuse and the level of drug use.

Hypothesis 4 There is a significant relationship between friends abuse of different substances and the level of drug use.

Hypothesis 5 There is a significant relationship between ignorance of the effects of drugs and the level of drug use.

Hypothesis 6 There is a significant relationship between depression and stress and the level of drug use.

Hypothesis 7 There is a significant relationship between lack of confidence and the level of drug use.

- Hypothesis 8 There is a significant relationship between income and status of parents or guardians and the level of drug use.
- Hypothesis 9 There is a significant relationship between occupational status of parents or guardians and the level of drug use.
- Hypothesis 10 There is a significant relationship between poor quality of work at university and the level of drug use.
- Hypothesis 11 There is a significant relationship between year of study and the level of drug use.
- Hypothesis 12 There is a significant relationship between religiosity and the level of drug use.
- Hypothesis 13 There is a significant relationship between church attendance and the level of drug use.
- Hypothesis 14 There is a significant relationship between place of origin and the level of drug use.
- Hypothesis 15 There is a significant relationship between gender and the level of drug use.
- Hypothesis 16 There is a significant relationship between love of television and movies and the level of drug use.
- Hypothesis 17 There is a significant relationship between age and the level of drug use.

1.4 Rationale of the study

The problem of substance use and abuse has emerged as one of the most highly publicized, yet it is one of the least understood phenomena among temporary health and social problems. Substance use and abuse is deviant,

violates laws and it is condemned by most people. It presents the society with numerous other problems. The medically prescribed drugs can also be abused. Drugs do not only damage health, they also result in death. For example, four out of any five cases of cancer are related to smoking (Akers,1991; Mieczkowski, 1991; Oetting,1981; Roche,1990).

Van der Westhuizen (1987) argues that the prime cause of both substance use and abuse, is the society itself, the patients are over demanding, the doctors are over prescribing and the pharmacists are over supplying. Substance use and abuse is also associated with the influence of the community, for example, through things like culture, availability of substances and the influence of peers.

The foregoing illustrates the seriousness of the problems posed by substance abuse to adolescents and young adults. As in the case with most behavioural problems, the adage "prevention is better than cure" also holds true for this problem. Because there is dearth of information concerning the extent of the abuse as well as the conditions associated with it particularly among black youth in South Africa, the present study sought to fill this gap. It is hoped that the information obtained from this study will be helpful in the development of the appropriate intervention programmes to alleviate the use and abuse of substances among this segment of the population.

1.5 The outline of the rest of the dissertation

Chapter 2 provides an introduction to the various classes of psychoactive substances and their effects. This is followed by the a presentation of some of the theories of substance use and abuse in Chapter 3. Chapter 4 provides literature review on both the prevalence of use and abuse and the predisposing factors.

Chapter 5 provides the methodology used in the present study. The results of the present study are presented in Chapter 6 while Chapter 7 provides the discussion. The final chapter, Chapter 8, provides the implications of the results for substance use and abuse prevention as well as the conclusion.



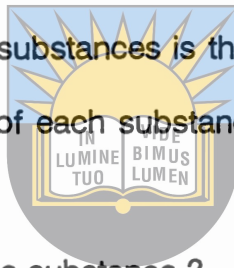
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CHAPTER TWO

PSYCHOACTIVE SUBSTANCES: CLASSIFICATION, EFFECTS AND ABUSE

2.0 Introduction

The chapter starts by explaining what a psychoactive substance is, and then proceeds to focus on the different classes of substances such as narcotics, generalized depressants, mood modifiers hallucinogens and stimulants. This is followed by a discussion on tolerance and addiction. The pharmacological action of both the legal and illegal substances is then presented and the importance of understanding the effect of each substance whether legal or illegal is also addressed.



2.1 What is a psychoactive substance ?

A psychoactive substance is a chemical which has its most direct effect on the central nervous system. While psychoactive substances affect other parts of the body (for instance, narcotics slow the motility of the bowel and thus can be used in the treatment of diarrhoea), their principal effect is on the brain and they influence both mood and perception (Akers, 1991; Bartimole, 1987; Roche, 1990; van der Westhuizen, 1987).

2.2 Types of Psychoactive Substances

According to Akers (1991), chemical substances can be classified into five different categories because of both their chemical structure and their physiological effect. The five categories are narcotics, generalized depressant, mood modifiers, hallucinogens and stimulants. Each category is discussed briefly below.

2.2.1 Narcotics

There are three types of narcotics. Firstly, there are the opiates which are derived directly from the opium poppy (e.g., morphine, opium & codeine). Secondly, the semi-synthetic narcotics which are chemically produced from the opiates (e.g., heroin). Thirdly, the wholly-synthetic narcotics, which have a similar structure and function as the opiates but are entirely man-made (e.g., methadone and meperidine).

Narcotics generally act as depressants on the central nervous system. Because they have the depressant effect, they can be used to allay anxiety and induce sleep. They also produce a euphoric "high" which is greatly valued by many individuals. This high, especially strongly marked when a narcotic is used intravenously, consists of an almost instantly orgasmic "rush" followed by a tendency of causing sleep. Narcotics will help the athlete to perform so well that they can produce physical dependence. They may also cause serious injuries, for example, the weightlifter may rupture his muscles by attempting weight that far exceeds the normal lift capacity if they take narcotics before the attempt. Finally, narcotics have also been use in the treatment of pain, and are still the most effective drugs for this purpose. Dependence can develop if used repeatedly (Akers, 1991; Bartimole,1987; Roche, 1990).

Narcotics alter the perception of pain by multiple actions. They mimic endorphins, bind with some receptors and therefore reduce pain. They activate narcotics receptors located in the brain within the central nervous system - particularly those in the thalamus and midbrain stem, thus modifying both ascending and descending pain pathways.

2.2.2 Generalized Depressants

The second major category of mind-altering substances, which contains a wide variety of drugs, is the generalized depressants. This includes the sedative / hypnotic drugs such as secobarbital, and pentobarbital, ethanol (which is beverage alcohol like beer, wine and distilled spirits), minor tranquilizers such as diazepam (Valium) and diazepam (Valium), and general anaesthetic agents such as solvents, glue gasoline and amyl nitrite.

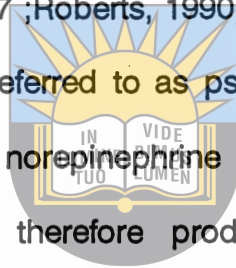
Generalized depressants, as their name clearly suggests, depress central nervous system activities. They are principally used in medicine as calmatives and sleep producing substances. Alcohol is one example of generalised depressants. They decrease norepinephrine, thus they depress the actions of the central nervous system by removing the controlling functions of the system by its depressant actions. The depressant affects the mental functions leading to increase of confidence in the person's own ability, and the person becomes talkative. It also affects the motor function leading to slurred speech, double vision, pupils become dilated, but later contracted, and their reaction to light is sluggish. Drowsiness and sleep occurs later (Sepeika, 1966).

These drugs are also popular with adolescents on the streets often using a combination of with alcohol to get high. Generally, the high is described as being very similar to alcohol-induced drunkenness. Some of these drugs can also be injected, though most are taken by mouth. The overdose can produce coma, and even death especially when used in combination with alcohol. They also produce complete physical dependence and addiction usually occurs with high dosages (Akers, 1991; Bartimole, 1987; Roberts, 1990; Roche, 1990).

2.2.3 Mood modifiers

The third category of psychoactive substances is the mood modifiers. This include the "major" tranquillizer such as Thyroxin, and the anti-depressants such as Alluvial. These drugs are primarily used in patient psychiatric settings for the treatment of psychosis and other major psychiatric disturbances. They are generally not used recreational on the streets. However whenever they are used on the streets they are usually used as downers to counteract stimulants. More importantly, strong dependence can also develop from their continued abuse (Akers, 1991; Bartimole, 1987; Roberts, 1990; Roche, 1991).

Mood modifiers are referred to as psychomotor stimulants or psychic energisers. They decrease norepinephrine and serotonin uptake and thus reduces depression. They therefore produce the toxic effect including overactivity, overexcitement and some can induce serious suicidal risks (Malseed, 1982)



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2.2.4 Hallucinogens

The fourth category of drugs is the hallucinogens. This category includes natural psychedelic drugs such as peyote and dagga (marijuana) as well as manufactured hallucinogens and Phenocyclidine (PCP), an animal tranquillizer, which is often also classified as a hallucinogen although it also has the characteristics of amphetamines and narcotics.

Hallucinogens are mind-altering drugs and they change the sensory perception. They produce perceptual distortions, such as when the body or mind feels light they are used for relaxation and intoxication. The effects of PCP does not only depend on the size of the dosage and the powerfulness of the drug, but also on the social and physical setting and the individual's expectations. PCP

may function as a stimulant, and or analgesic. It can produce irrational and disorientation reactions, hallucinations, feelings of loss of sensory control, speech difficulty and frightening death feelings. In high doses convulsions, psychosis, coma and death are expected.

Dagga is considered a mild hallucinogen. Its active euphorogenic ingredient is (tetrahydrocannabinol (THE). The quantity of THE varies greatly from one dagga plant to another and this fact accounts for the wide variations in user's reaction to "grass". Dagga is often smoked in a form of leaves hand-rolled in commercial cigarette paper. It is also smoked in pipe, although marijuana cigarettes are most common. Generally, the hallucination mood, and perceptual changes vary greatly with the amount of dagga taken.

While marijuana's effects are generally fairly mild as compared to results obtained with PCP, none of the hallucinogenic drugs produce physical dependence and they also cannot be addictive. They result in drowsiness and lower nervous system activity. For the first time user, they may cause vomiting, dizziness and physical reactions such as increased blood pressure, pulse rate and respiration but no dependence can develop whatsoever (Akers, 1991; Bartimole, 1987; Roberts,1990; Roche, 1990).

Hallucinogens affect the central nervous system by producing distortion of perceptions. They interact with serotonin giving rise to hallucinations and behaviour such as may be seen in psychotic patients. In some people, they may trigger panic states. (Malseed, 1982)

2.2.5 Stimulants

The final category of mind-altering drugs is the stimulants. Included in this group are cocaine, amphetamines and methamphetamine. Cocaine comes from the South American cocoa plant. Cocaine and all its derivatives such as crack are considered stimulant - type drugs. Most of these drugs can be taken by mouth (with the exception of crack), although most persons either sniff it through the nose (only those in powder form) the "high" they produce is the same whether they are taken by mouth or nose.

Furthermore, a form of crystal methamphetamines called "crack" or "ice" is also important in this group. These substances are also known as "uppers" because they stimulate the central nervous system, and increase alertness and wakefulness. They produce a "high" which leads to chronic insomnia, fatigue and depression.

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The "high" produced by stimulants is dramatically different from that of narcotics and depressants. Stimulants create high energy levels and intense feelings of "being in control". Some persons even feel that some stimulants, especially cocaine, arouse sexual desire. Eventually if taken regularly over a relatively prolonged period of time, they can cause paranoia. The amphetamines, on the other hand, were once widely prescribed for weight control. The side effects are weight loss, staying awake, fighting fatigue and enhancing mental alertness. Tolerance with cocaine develops with high dosages (Akers, 1991; Bartirnole, 1987; Roberts, 1990; Roche, 1990).

Stimulants act on the central nervous system. They increase the release of norepinephrine and dopamine thus stimulating the brain - especially the central cortex and the medulla. In the cerebrum they produce physical and

sensory functions. The individual is able to think more clearly, fatigue disappears, there is increased capacity for mental and physical work, and work is done more quickly with few errors. On the circulatory system, the heart may be slowed, and blood vessels tend to be constricted from stimulation of the vasomotor centre (Sapeika, 1978).

2.3 Tolerance versus addiction

In order to fully comprehend the effects of drugs, one needs to understand the related physiological processes of tolerance and addiction. Tolerance is a mechanism whereby the body gradually adjusts to the level of drugs ingested. When tolerance to a substance develops, the user must ingest more of that substance to induce the same feeling that previously was obtainable with a smaller quantity. For example, a heroin user initially uses one bag or less, and experiences a high. If the user regularly uses this same amount eventually he or she will cease getting high. Tolerance to that quantity of heroin has occurred. It will now take more than one bag at a time to get high (van der Westhuizen, 1987). This process partially explains why persons continue to use increasing amount of many of these drugs.

Van der Westhuizen (1987) explains addiction as the process whereby the body becomes physiologically habituated to the drug. Users recognize that they are addicted when their bodies react, often fairly violently, to the lack of the drug. This reaction is called the withdrawal syndrome. Symptoms of the withdrawal syndrome vary widely by type and level of drug use, physiological status of the user, and a number of other variables. For example, while withdrawal from narcotics is unpleasant, it is not life threatening, conversely withdrawal from barbiturates can result in death. Withdrawal from narcotics begins with a runny

nose and teary eyes. It then progresses to a feeling of unease followed by stomach cramps, diarrhoea, nausea and vomiting. It also causes involuntary twitching of the legs and arms and severe abdominal pains.

The withdrawal syndrome typically occurs over about a 72 hour period. The most dramatic aspect of this phenomenon is that symptoms disappear almost immediately upon injection of narcotics. This provides a very dramatic hook in "addiction" (meaning it becomes difficult for to user to stop taking the drug even if he wants to). Akers (1991) argued that the withdrawal syndrome is a crucial element in the development of the person's self-concept as an addict. Using the method of analytic induction, he found that the user's association of withdrawal syndrome's discomforts with denial of the drug is a necessary condition for development of a self-concept as "addict". The motivation for using the narcotic changes from "getting high" to avoid pangs of withdrawal. (On the streets addicts refer to this phenomenon as "feeding their habit"). Further he felt that addicts, once they undergo this change in definition of self, develop the characteristic of strong desire for narcotics. Even if they are detoxified from the narcotics, and thus are no longer physiologically habituated, this craving almost inevitably leads to relapse. Interestingly those who do not identify the symptoms of withdrawal as a result of denial of the drug (e.g., hospital patients who are detoxified without their knowledge) do not develop a self-concept as addicts and do not continue to use narcotics (Akers, 1991; Bartimole, 1987; Roberts, 1990; Roche, 1990; van der Westhuizen, 1987).

Most psychoactive drugs produce tolerance. Again this helps to explain why so many heavy and regular users continue to use increasing amounts of drugs. Fewer of the drug categories produce physiological addiction. The

narcotics and the generalized depressants produce recognizable withdrawal symptoms. Even alcohol produces a withdrawal syndrome of which the delirium tremens may be part. It is now widely believed that cocaine and other stimulants are also physiologically addicting. While other drug categories may produce a feeling in the user of being independent on them (what some refer to as "psychological addiction") physiological addiction has not been demonstrated (Akers,1990; Bartimole,1987; Roberts, 1990; Roche, 1990; van der Westhuizen,1987).

2.4 The Importance of understanding drug differences

The pharmacological review is to make a very important point that, while these are all mind altering substances, there are vast differences among them. One cannot simply group them together as a "dope". Rather than dealing with them generically as the legal system, that is not enough one must recognize differences among them. They differ in their chemical effect on the body and brain (Mieczkowski, 1992). Some are physiologically addicting while others are not. Addiction to some of these substances like alcohol usually takes years to establish while physiological dependence to others can occur within a matter of weeks. The physiological and psychoactive effects of some of these drugs like marijuana, are very mild while others such as stimulants induce paranoia and can produce life endangering reactions. The types of euphoria produced are often dramatically different. Some can be injected while others cannot.

A more detailed illustration of the drug differences can be made when we compare a drug such as heroin, thought to be one of the most to cause crime, with a substance such as tobacco. Both are highly addicting substances, yet, that is where the similarity ends. Heroin, an illegal drug, is also a dangerous

one. It has more pronounced effects on mood than does tobacco, and of course, there is always the danger of death due to overdosage. Yet research has not established that heroin produces a serious long-term physiological effects on adults. Besides a temporary decrease in sexual functioning, one of the chronic effects of heroin appears to be constipation (van der Westhuizen, 1987).


Tobacco, a legal substance, is responsible for a wide variety of disease, and cancer of the lung is one of them. Looking at heroin, it is penalized while tobacco on the other hand only suffers mild social disapproval and yet both are destructive. There are differences between the two substances, but does an informed knowledge of the difference justify the vastly different ways the substances, and their users are dealt with by the society? (van der Westhuizen, 1987).

In short, we must recognize that psychoactive drugs are dramatically different from one another and any solution developed to deal with the "drug problem in South Africa" needs to acknowledge these differences. It is important to recognize the differences both in the emotional and physical effect on the user. However, most centrally, it must be recognized that these differences are profoundly influenced by the social and cultural values which shape our reactions to the various substances.

Indeed, our cultural values shape our very use of the term "abuse." Many people consider those who use illicit drugs even if once, as drug abusers. Yet those who smoke a pack of cigarettes a day or occasionally consume a few beers, are not deemed "abusers". The criteria for differentiating between the two is not known. Perhaps this is because those that are seen as legal are not seen as drugs as opposed to the illegal ones.

2.5 Substance, set and setting

The knowledge of the chemical and physiological effects of these drugs are important, the nature of the substance used is only one of the three "s" variables crucial to understanding why people use drugs. The other two equally important "s's" are set and setting. Set refers to the users expectation of what effects the drug will have on them. In other words, the type of "high" the users experience are to some extent shaped by their expectations. Set can create "drug - related" reactions even if no chemical has been taken by the individual (Bartimole, 1987).



Setting refers to the context in which the drug is taken. The importance of set and setting in becoming a marijuana user is that the setting helps to shape the beginner user's set. One becomes a marijuana user in three steps. First, one must learn how to achieve the effect. Other more experienced users must teach the beginner the proper way to inhale marijuana smoke to maximize the amount retained in lungs. Second, one must learn how to recognize the drug's effects, those more familiar with the drug must point out the mood changes the naïve user undergoes. Finally, the experienced user need to define these perceptual and mood changes as favourable. These changes need not be inherently pleasurable. They are made enjoyable by others defining the experience as pleasant or beneficial. In other words the beginner user's set is shaped by positive setting provided by more experienced users (Akers,1991; Bartimole,1987; van dler Westhuizen,1987).

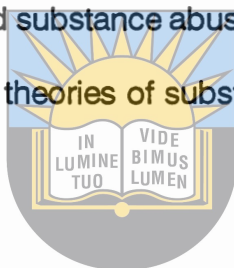
2.6 Substance Abuse

The over usage of any substance is called the substance abuse. Substance abuse has three criteria according to Sarafino (1990). Firstly, a heavy

daily use and an inability to stop or decrease use. Secondly, problems in social setting due to substance use, and when the person loses friends or jobs repeatedly because of it. Thirdly, the existence of pathological use for at least a month. Individuals meeting all three criteria are diagnosed as abusers. The second criterion applies to alcohol and drug use, and not tobacco.

2.7 Summary

The chapter provided a description of psychoactive substances and their classification. It also provided a discussion on tolerance and addiction, substance set and setting and substance abuse. The following chapter, Chapter 3, will provide information on theories of substance use and abuse.



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CHAPTER THREE

THEORIES OF SUBSTANCE USE AND ABUSE

3.0 Introduction

This chapter examines the various theories to explaining the causes of both the use and abuse of various substances. It begins by presenting three major models, namely, the genetic disease model, the emotional diseases model and the socio-cultural model. The socio-cultural model has subdivisions such as anomie or strain theory, social control or bonding theory, labelling theory, socialization theory and social learning theory, masculinity and dichotomous thinking. In addition to these models, a number of theories have been developed by Akers (1991), Mieczkowski (1991) and Roche (1990). They include the physical and emotional changes and the parents as models.

3.1 Genetic disease model

According to this model, addiction to a psychoactive substance is a physiologically-based disease. In particular substance abuse is genetic and can be passed from one generation to the next. To support this view a lot of work has been done in the field of alcoholism. Through the studies of alcoholism in families, it has been demonstrated that people who come from alcoholic families stand a much greater chance of becoming alcoholics than those whose families are not alcoholics. Therefore somewhere the disease is passed through the family (van der Westhuizen, 1987). Out of 10 families that were investigated, seven proved that the plant of drug use has the chance of developing branches

through families. Some believe that there is a genetic marker for alcoholism or drug abuse and it somehow expresses itself in later generations. Secondly, there are those people who are abnormally tolerant to alcohol so that it takes more alcohol to achieve euphoria. Such individuals are prone to using alcohol regularly and thus become alcoholics. Some individuals undergo metabolic changes once they use narcotics so that they must continue to take narcotics in much the same way that diabetics need to continue taking insulin (Akers, 1991; Bartimole, 1987; Roche, 1990 ; van der Westhuizen, 1987).

3.2 Emotional Disease Model

Van der Westhuizen (1987), views drug abuse as an emotional disorder so does the Diagnostic Statistical Manual of Mental Disorders, Fourth Edition (DSM IV). Drug abuse is a response to unresolved problems. People use drugs because they encounter stress in daily living. They cannot cope with this stress and use psychoactive substance as a means of escape. Drug abusers are seen as people with defective personalities. They commit anti-social behaviours and yet do not show a shame of guilt for their behaviours. They are diagnosed as having "addictive personality". An addictive personality lacks self- control, has low self- esteem, is often depressed, and lacks the ability to plan for the future. Such a personality to turn is associated with compulsive use of substances such as drugs or alcohol in order to cope with daily life stress they encounter.

3.2.1 Confusion due to physical and emotional changes

Adolescents and young adults use and abuse different substances because they cannot cope with the transition from youth to adulthood. The increased rate of growth of the body size, rapid development of the reproductive

organs and other secondary sexual characteristics, make it difficult for them to cope and they resort to use of substances. The adolescents also develop the new power of abstract thought that allow them to formulate and test hypotheses, challenge ideas and to think creatively. The fact that both the physical and emotional changes occur at the same time, frightens them and they resort to substance abuse (Bailey, 1991).

3.2.2 The negative - self

van der Westhuizen (1991) believes that substance use and abuse is associated with the development of the positive self. Most of the adolescents and young adults who are negative about themselves depend on substances to make them feel positive about themselves. For example, when the adolescent has to perform in front of the public and he/she does not believe in her or his competence, the substances will make him or her to believe in himself or herself. The disadvantage is that the individual becomes dependent to drugs.

3.2.3 Self-Esteem / Derogation Theory

Akers (1991), Mieczkowski (1991) and Roche (1990) explain that the self-esteem motive refers to individual's attempt to minimize negative self-attitudes and maximize positive self-attitudes. They also believe that drug use among adolescents is associated with an attempt to fight against the self-rejection attitudes. The loss of self-esteem is caused by conforming in groups, which later lead to the development of self-rejection. If one's experience with the group are such that the person is unable to adapt to self-devaluing reactions of others, the motivation to conform to the group norms is lessened and motivation to deviate from the normative patterns with which the distress is associated is increased.

The social control of conforming groups that the individual associates with rejection becomes less effective. The deviant behaviour becomes an alternative with the hope of enhancing self-esteem if only it is perceived as offering the positive self. The previous negative self is substituted by the positive one. The self-derogation is therefore associated with drug use and abuse. The deviant activity promotes self-esteem by allowing the adolescent to get around conventional expectations by which s/he has failed, and there making drug use and abuse acceptable.

3.3 The Socio-Cultural Approach

Substance use and abuse is regarded as a complex phenomenon which results from a number of factors. Most of the theories of addiction have focused on heredity, personality, and the experience that led to the use and abuse. In the new model of addiction, the biological, psychological and spiritual process in the individual has its roots in, and is shaped by culture in which the individual lives. Culture is defined as that pattern of values, beliefs, customs, and symbols that are shared by a common group and provide meaning for their existence together.

In order to deal with substance abuse problems, Sociologists are focusing on the socio-cultural context in which the drugs are taken. They discovered that addicts view addict life as good and non-addicts as hopeless. Heroin use is associated with the lower-class residents, because it help them to develop positiveness about life. Most addicts feel that they are the victims of racism and social class bias. They argue that the drugs that are used by the middle-class people, such as the alcohol, tobacco, and the anti-anxiety drugs that are

prescribed by the physicians, are legal and they are accepted by the community and yet their choices such as dagga are said to be illegal and deviant. Thus, they develop anti-social and criminal behaviours. These individuals become street addicts through the same normal learning processes applicable to us all.

3.3.1 Anomie / Strain Theory

Anomie refers to a condition of society or some part of society in which there is disequilibrium, disorder, social disorganization, lack of social integration, or lack of normative consensus (Akers 1991; Mieczkowski, 1991; Roche 1990). According to the anomie or strain theory, the lower-class in large slum area cities are described as anomic or socially disorganized because of the lack of neighbourhood cohesion, breakdown of informal social controls, incomplete and broken families, poor housing and conflicting groups.

In strain theory, the form of anomie that produces deviant behaviour results from the mal-integration of cultural ends (goals) and societal means. The theory views the society as overstressing high achievement and material success while under emphasizing that this success should be attained through socially approved educational and occupational means. Furthermore anomie affects certain segments of the society more than others. This results from the fact that while all are taught to aspire dreams of success, those at the bottom of the social-class structure and members of disadvantaged minority groups have unequal access to the legitimate educational and occupational opportunities and means to fulfil those aspirations. This places disproportionate strain on lower-class. Anomie theory expects higher rates of deviant drug use in the lower class than in the middle class (Akers, 1991; Mieczkowski, 1991; Roche, 1990).

In contrast, Bartimole (1987) argues that not all the residents of the slum area resort to substance use and abuse due to their failure in life. There are those who work very hard for success and are able to manage under those adverse conditions. He also believes that use and abuse of different substances disrupts not only the lives of the abusers, but those in their social networks.

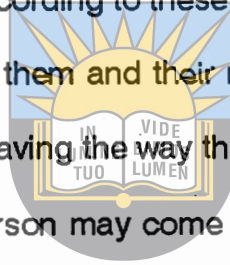
3.3.2 Social Control/ Bonding Theory

In social control/ bonding theory, drug use and abuse can be expected to the extent that social controls are weakened. According to this theory, the members of a group are joined together by the rules they have to follow and it is these rules that keep them and also help them to behave as expected. (For example, one of the rules in a youth club could be no smoking in public). If these bonds are strong enough, the external pressure becomes weak (Akers, 1991; Mieczkowski, 1991; Roche, 1990).

According to this theory, there are four elements that keep the group together namely, attachment, commitment, involvement and beliefs. Attachment refers to the strong emotional ties that one has with the group, and the group may be the family, friends and so on. Commitment refers to the investment of time energy and ambitions by the individual. Involvement refers to the engagement in productive acts so that there is no available time for deviant activities. Beliefs refer to the values, norms and moral beliefs that are shared by the members of a group be it a family or any group. The stronger these bonds the lesser the chances are to use and abuse drugs because it is seen as deviant by the group.

3.3.3 Labelling Theory

Akers (1991), Mieczkowski (1991), and Roche (1991) argue that the adolescents and young adults become addicts because they have been labelled as addicts. The community plays a very important role in shaping the behaviour of the adolescent and young adults. They also believe that "you are what the society thinks you are". This approach views deviance as an interactive process between those who are believed to have committed deviant acts and others who define the acts as deviant. According to these authors, some individuals accept the enforcement of norms to them and their reaction will be to be ashamed to repeat their actions, thus behaving the way the society wants them to, that is as deviant. The stigmatized person may come to adopt a stabilized deviant role and self-identity and may begin to see themselves as others have labelled them, as deviant Bailey (1991).



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3.3.4 Selective Interaction / Socialization Theory

The level of use of substances according to this theory is associated with participation and socialization in a drug subculture. Selective interaction means that, the adolescent is only attracted to certain individuals and circles. The attraction is caused by the similarity in values. The values they share are not confined to similar views and use of drugs only, they include religious alienation. Once the adolescent is in the group, she or he is further socialized through interaction with group members into drug use and values that are supportive to drug use. Socialization is continued through imitation and reinforcement of drug use and values and produces further involvement in stronger drugs such as

heroin (Akers,1991; Mieczkowski,1991; Roche,1990).

Bennette, McCrady, Frankenstein, Laitman, van Horn and Keur (1991) argue differently, they believe that there positive cultural groups that people are also attracted to because they share similar values, that discourage substance use and abuse. The members are taught about the dangers of using and abusing drugs. The stronger the bond the lesser the chances of engaging in drugs.

3.3.5 Social learning theory

Akers (1991), Mieczkowski (1991) and Roche (1990) believe that the adolescents learn the behaviour from the society they live in, by imitation, reinforcement and so on. The behaviour can take any it can be negative or positive. Primary groups such as the family, peer groups, school and other social groups are very important in shaping the behaviour of the adolescents.

3.3.6 Masculinity, femininity and addiction

The interaction of both men and women with the androcentrism of their culture is suggested to be the foundation of substance use and abuse. Substance abuse and addiction are the results of longing for wholeness. This wholeness is achieved by an integration of the masculine and feminine of human existence, an integration that is destroyed by androcentric societies (Akers,1991; Mieczkowski,199; Roche 1990). Although in agreement with this point of view, Bailey (1991):Instead he argues differently, that females use and abuse different substances because they are seen as inferior to males, they want to fulfil that holeness. He does not believe on the integration of both the masculine and feminine for the achievement of the wholeness.

Substance use and abuse is regarded as a complex phenomenon which results from a number of factors. Most of the theories of addiction have focused on heredity, personality, and the experience that led to the use and abuse. In the new model of addiction, the biological, psychological and spiritual process in the individual has its roots in, and is shaped by culture in which the individual lives. culture is defined as that pattern of values, beliefs, customs, and symbols that are shared by a common group and provide meaning for their existence together.

3.3.7 Polarities and Dichotomous Thinking

The human beings think of the world in terms of opposites (polarities). Polarities exist on both the universal world and human scale. In the human scale there is male and female, mind and body and so on. In human culture, the polarity of male and female is a symbol of all polarities. Masculine is associated with the rational and active pole, feminine with the emotional and passive pole. Masculinity is associated with males and femininity is associated with females. It is therefore this polarity that leads to addiction mostly in females (Akers,1991; Mieczkowski, 1991; Roche,1990).

van der Westhuizen (1987) argues differently from this view, he believes that substance use and abuse affects every one. It is a problem that needs to be attended to. According to him, the contributing factors to the use and the abuse are, family instability, availability of drugs and peer groups.

3.3.8 Androcentrism

In an androcentric society, male superiority is both explicit and implicit.

Man is considered masculine and superior and females as inferior and feminine. The female is defined as lacking because it is not male, and is therefore inferior to males. Addiction research has been dominated by androcentrism. It was also discovered that female addicts are harder to treat because they lack something in them namely, the masculinity thus they end up being addicts. Cultural pressure was found to be the cause of substance abuse. It was also discovered that men drink to satisfy their need for power they drink to feel strong. Women on the other hand drink to increase their feeling of womanliness which they perceive as inadequate (Akers, 1991; Mieczkowski, 1991; Roche, 1990).

3.3.9 Parents as Models

Parents are models of their children. The parents use and abuse of different substances ,lead to the children's use and abuse of different substances. The children who grew up in families where the parents use and abuse different substances follow suite. Some because they think that their parents are always right, and always do the right things. Others are only imitating their parents without any reason behind, they just want to be like them (Emanuel & Olivier, 1995).

3.3.10 Poor Discipline from parents and poor utilization of leisure time

Adolescents and young adults use and abuse different substances because their parents fail to discipline them, to be firm and strict and to make them to be able to differentiate between right and wrong. The parents always see their children as angels and they always blame their friends as bad and influential, to them their children are always right. The love they have for their children is so misleading that they cannot see when they are misbehaving. On the other hand adolescents engage in different substances because they have

nothing to do instead of engaging in sport or other extramural activities. In one of the studies carried out in the PWV area, 60% of the adolescents use and abuse different substances because they do not have anything to do (Fourie, 1982).

3.4 Summary

The chapter provided brief reviews of theories of both the use and abuse of substances extensively. The following chapter, Chapter 4, will provide the relevant literature for reviewing prevalence of substance use and the predisposing factors including the statistics.



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CHAPTER 4

LITERATURE REVIEW

4.0 Introduction

This chapter will provide a review of the relevant literature on prevalence of both use and abuse of substances as well as the predisposing factors.

4.1 Prevalence of Substance Use and Abuse

In view of the large number of studies which have been conducted on substance use and abuse both internationally and locally, a review of these sources will be done separately below in order to accentuate the differences and similarities.

4.1.1. International Studies

A considerable number of studies have been conducted internationally in an attempt to estimate the prevalence of substance use and abuse. These studies have been carried out largely in England and have produced figures ranging from surveys of 61,7% and more, of alcohol abusers and other substances (Cohen,1983). Unlike the present study however, no distinction is made between the use and abuse *per se* in these studies, and therefore the review will also obfuscate over this issue.

A similar study was carried out in the USA in 1980, in which it was found out 9 million adolescents ranging between ages 18 -25 were abusers (Cohen, 1983). Two years later, the approximation dropped to 6 million, and in 1984 the death rate due to substance abuse was estimated at 40% (Cohen,1983).

Overall levels of use and abuse of substances among adolescents ranging between ages 13 to17 in the USA were as follows: 20% had serious drug

problems, 93% had at least tried alcohol before graduation. Between 1978-82, 16% of 13 year-olds had used dagga (Cohen,1983). In 1982, 17% high school seniors had used cocaine at least once, while about three of every Americans will try illegal drug by the age of 25 (Cohen,1983).

Among the many statistics of health hazards of smoking is the estimate that 30 to 35 year-old two pack - a - day cigarette smokers have a mortality rate twice that of non-smokers (Davidson & Neale, 1986). According to these authors, when taken together with alcohol, the socio-economic cost of smoking to society at large is considerable in that smokers make each year over 80 million extra days of lost work and 145 million extra days disability. Health costs associated with cigarettes in the United States is about \$30 billion annually, and about 350,000 people die prematurely each year as a result of smoking. And yet 54 million America adults still smoke about 620 billion cigarettes a year.



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The hospitals responsible for treatment of narcotics addicts in U.S.A. give evidence that more than 75% of the addicts discharged from hospitals resume taking narcotics within a few months after their release. Estimates of a permanent cure range from 1% -15% (Encyclopaedia International, 1979).

In one major study conducted by a number of researchers led by Levine (1978), they employed a scale based on Guttman's scaling techniques which measured the developmental sequence of substance use, indicators of polysubstance abuse, and relations of substance use to family relationships. The results of this study showed that out of 756 adolescents 73,2% had used alcohol, 54,7% had smoked cigarettes, 34,9% had smoked dagga and 14,2% had used at least one hard drug. The research also indicated that most hard drug users had

first used alcohol, cigarettes and dagga in their lifetime. About 10% of the participants tried drugs in a pattern that was not consistent with this, the "error types" were those who had smoked cigarettes, but had not tried alcohol and those who had tried alcohol and dagga, but not tried cigarettes (Levine, 1978).

4.1.2 Local studies

As specified earlier, variety of studies have also been carried out in South Africa on prevalence of substance use and abuse. According to Fourie (1982), the statistics of users of alcohol and other drugs were as follows: whites -males 91%, females 76%, coloureds - males 60%, females 20%, Indians -males 45%, females 22%. In 1983, dagga abused by 73% of the total population (Emanuel & Olivier, 1985).

In another study carried out in 1985 on alcohol use / abuse among Blacks in the Pretoria, Witwatersrand - Vaal Triangle, also by Emanuel and Oliver, 37% of males and 72% of females in rural areas and 38% of males and 71% of females in the PWV area were found to abuse the substances. Rocha-Silva (1990) had opposite findings: 63% of rural-males and 29% of females were found to be abusers of substances and in the PWV - males 62%, and females 29%.

In another study carried out by the HSRC on alcohol and other substances use by Blacks in South Africa in both rural and urban areas, it was discovered that male's substance use in towns and squatter camps ranged between 59,3-72% while that among females in the same setups ranged from 16,4%-20,2%. It was also estimated that dagga was smoked by about 22,3% of the males in the squatter camps, 12,8% of these in metropolitan areas. About 17,8% of the males in towns used LSD while 17,2% used cocaine. In the case of females in towns, 8,7%

used LSD and 10,5% cocaine. Furthermore, 12,4% of females in towns had admitted their use of heroin while only 10% of the males admitted doing so too (Rocha-Silva,1991).

In a recent study carried out by the HSRC in 1995 in different factories in South Africa, it was discovered that 6 to 15% of workers abuse alcohol and other substances (Emanuel & Olivier, 1995).

4.1.3 Comparison between international and local prevalence data

From the review of both international and local literature above, it is clear that previous research has shown relatively high levels of use both here and abroad. International studies revealed that substances like alcohol, cigarette smoking, narcotics, dagga and stronger drugs like heroin are a serious problem see (Fourie, 1982; Cohen, 1983, 1985).

Studies conducted among Whites in South Africa (Bezuidenhout & Rip,1988; van der Burgh,1975,1984,1988) have generally revealed high prevalence rates of alcohol use and /or abuse akin to those reported in American and British studies of 70-90% (e.g. see Cohen,1983, 1985). Those carried among Blacks have tended to show relatively moderate prevalence rates of 40% (Rocha-Silva,1990,1991). Although prevalence rates of use and abuse of other substances such as dagga, LSD, and heroin are much lower than for alcohol, results similar to those mentioned above herein have also been observed among them.

International studies also revealed that cigarette smoking is a serious problem. A number of people die each year because of smoking. Narcotics were also discovered to be widely used. These differences of substances use and /or abuse can partly be explained by the socio-economic inequalities which existed in

South Africa prior to the 27 April 1994 general elections, which saw the installation of a truly democratic government led by Nelson Mandela as a consequence of the apartheid policies of the previous government, whereby Whites who are in the minority controlled every aspect of life in the society which was modelled along western values and norms, as well as legally entrenched racism which was its main hallmark.

4.2 The Predisposing factors of both use and abuse

In a recent review of relevant research literature Hawkins, et al (1992) grouped the risk factors for the adolescents substance use and abuse into roughly two categories, namely, the social and cultural factors and individual and personal factors. The former include laws and norms favourable towards behaviour, availability, extreme economic deprivation, and neighbourhood disorganization, whereas the latter include psychological factors such as self-concept, family alcohol, and drug behaviour attitudes, poor and inconsistent family management practice, family conflict, low bonding of family, early and persistent problem behaviour, academic failure, low degree of commitment to school, peer rejection in elementary grades, associating with substance abusing peers, alienation and rebellious, attitudes favourable to substance abuse in the media and early onset of substance use.

4.2.1 Family instability

Bailey (1991) argues that family instability is associated with both use and abuse of different substances. Whether the conflict was present while the child was growing or presently, the problem is the same. The family incompleteness as a result of death or divorce which result to loss of parental control, or overprotection

by a single parent, lead to substance use and abuse by the adolescents and young adults.

Plant, et al. (1985) also pointed out that positive family relationships, involvement and attachment appear to discourage the initiation into drug use. In another study conducted in South Africa by Bezuidenhout and Rip (1988), it was discovered that unstable and disturbed family relationships were linked with incidence of dagga use and adolescents from broken homes were both users and abusers as compared to those from stable homes.

Most of the youth and young adults engage in the use of different drugs because they feel lonely. They discover a friend from the substance, and this friend make them to feel good and that they are not alone anymore. Some runaway from their disorganized homes to the street and this is where they meet this friend "substance". Some do not runaway from their families, they use different substances while they are staying with their unstable families (Levine,1978).

Capadano and Chavaria (1989) argue that substance use and abuse among adolescents and young adults is associated with peer pressure, family instability, academic failure, anxiety, stress and depression. Children who have not identified with parental figures or have not incorporated their values and standards may be at greater risk for substance abuse. With gaps in attachment to adult role models and dissatisfaction with support received at home, these youngsters are more likely to associate with youth experiencing similar difficult home lives. According to these authors, bonds are generally formed within the family, school and peer groups. In each of these context, three variables influence behaviour patterns: the

opportunities and influences to which one is exposed, the skillfulness with which one performs and the relative balance of rewards one receives. The variables determine whether a youth's participation in that context will contribute to the development of a positive attachment with the family, school and peer group, and increase the likelihood that adolescents will develop a sense of efficacy and control in their interactions.

In the family where this process begins, youngsters must be provided with opportunities for family involvement, to develop the required skills, to behave as expected and be rewarded consistently. Positive attachment to school depends on the strength of the attachment to the family, as well the extent to which the child experiences the opportunities for involvements, develops skills and is rewarded. The stronger the attachments to families and school, the less likely it is that youth will develop attachments to drug using peers.

Alcoholism has its origin in a disturbed family situation in which the mother is typically overprotective and indulgent. As a result, the youngster make excessive demands from emotional contacts that are doomed to frustration, especially when the adolescent begins to function in the outside world. The patterns persists to adult life. The alcoholic becomes disappointed in and enraged at persons who fail to agree with his demands. He expresses his anger in various ways that leave him with guilt feeling. The guilt leads to depression, and finally relief may be sought through alcohol. The choice of alcohol as means of relieving the tension and frustrations may be influenced by an alcoholic father or by an environment in which social drinking is common. Alcoholism is much less likely to develop in a teetotal culture (Cohen, 1983).

4.2.2 Stress

Stress has been discovered as one of the precipitating factors for drug use and abuse. Researchers have identified several categories of stress and have mentioned their role in the development of problem behaviours. Included are major life events, daily hassles, enduring life strains and developmental transitions.

The first category consists of life events such as car accidents or death of a parent. These events usually occur suddenly and entail a period of shock which is followed by gradual adjustment. During these events the adolescents have no control over themselves. They may therefore turn to drugs as a means of coping.

The second category of stress consists of everyday problems or daily hassles such as argument over the use of car. The social scientists suggest that adolescents' problem behaviours are more related to level of day-to-day conflicts and pressure than more isolated stressful life events.

The third category of stress consists of life strains such as difficulties in family or at school. These stressors usually persist over time and are not easily resolved. For example, insufficient opportunities for recreation and employment, or if school is the place where the youngster can obtain few successes and the opportunity provides few models of competent coping, the adolescents may have less in his or her chances of success. To these youth societal standards of success may appear unteachable and risk-taking behaviours become more attractive and appealing.

The fourth category of stressors faced by the adolescents include life transitions that require adaptation over time such as transition to a new school,

obtaining one's first job, or getting married. Such transitions may be particularly stressful if they involve interruptions in peer relations. For example, when a family moves to a new school, an adolescent is often faced with the difficult task of entering a new school system and to make new friends. Drugs may facilitate acceptance into a new peer group.

Developmental changes during adolescence, for example, puberty, adherence to group norms, changing alliances from family to peer, are stressful events and can be considered a fifth type of stressor. Reduction in self-esteem, pressure to fit in with peers and striving towards independence can all often lead to the initiation of substance use among adolescents (Akers, 1991).

4.2.3 Peer pressure

Peer pressure has been found to be a strong influential group in the development of drug behaviour. Having friends who use and abuse different substances is one of the reasons for both use and abuse of different substances among youth and young adults. There is no reason behind the use, the adolescents just go along with friends as they do not want to be old fashioned (Akers, 1991).

Drug use and experimentation starts at an age when peers and older siblings exert greater impact on shaping behaviours as opposed to parents. There is a group leader and his or her responsibility is to mould the adolescents into certain attitudes and values. It is within the group that the adolescents learn how and what to inhale, smoke and shoot. The desire to identify with and belong and the group's demand for conformity make the use of the group's favourite drugs. If the adolescent have friends who are heavy drinkers, the chances are that they will

try to make the adolescent a heavy drinker too because the heavy drinkers often feel threatened by those who drink moderately since they are secretly worried about their heavy drinking (Gale & Tara, 1989).

In a study carried out in South Africa by van der Burgh (1985), he also discovered that substance use and abuse is associated with friends and peers. Most of the adolescents who use drugs do so because their friends are drug users. They just imitate their friends and do not have any concrete reasons for doing so.

4.2.4 Love of television and movies

A 1987 study conducted by a group of researchers, determined that the way drugs and alcohol are depicted on television and the movies to be the most influential factor in shaping the behaviour of the adolescents. It certainly should not be surprising to find the media plays such an influential role in shaping the adolescents attitudes because of the way drugs are portrayed in media. The hard-drinking, fast-talking successful businessman and wealthy young persons recreational use illegal drugs (Bartimole,1987).

Too often, drugs are associated with success in media. For proof, look no further than the beer commercials on television. Beer is always associated with good times, memorable occasions, and special people. Thus, beer and good times are seen as synonymous. Similarly the message is often carried in the media that there is indeed "a pill for every illness". Advertisements after another tells us how to relieve pain and discomfort. Apparently youngsters tend to believe that they in fact should feel nothing except pleasure (Gale & Tara, 1989).

4.2.5 Family history of use and abuse

The theory of genetic determination of alcoholism has been the subject of considerable research. Results have shown that 20-30% of parents who are alcoholics tend to have children who are alcoholics. Alcoholism has also been proven to move among families, parents, relatives including aunts and uncles then to the children. It can also move as far back as grand parents. Although heredity has an influence in drug use and abuse, the psychological and physiological variables must not be left out (Cohen, 1983).

In one of the studies carried out in 1978 in U.S.A, it was discovered that student's drinking was associated with their parent's drinking behaviours (Bartimole,1987). For example, 59% of drinking students were found to be influenced by their families, where either a brother or sister was drinking. Similarly, 89% of drinking students was found to be influenced by at least one parent, either a mother or a father. Furthermore, 9% of the drinking students depicted the regular drinking of parents. Obviously, what the child sees at home has a profound impact in his/her perceptions.

Influential too is the adolescent's perception of parental attitudes towards drinking. The survey referred to above showed that boys who said that their parents approved of teens drinking were twice as likely to be heavy drinkers than boys who said that their parents disapproved of teens drinking (17%). Similar results were found among girls.

The truth of the matter is that there is no reason that teens begin drinking or abusing other drugs but rather several contributing factors. Teens see their friends drinking and perceive that friends expect them to drink also. The image is so

convincingly portrayed by the media that drinking is part of being an adult, others think that abuse is part of their maturation into adulthood. The adolescents copy the dress, speech, drinking-using patterns of admired role models such as parents and teachers. The desirable social behaviour are then acquired in this stage (Bartimole, 1987).

Some researchers of alcoholism suggest that certain people become addicted to alcohol easily for genetic reasons. This approach emphasizes that such persons are allergic to alcohol; the symptoms of the allergy include rapid loss of inhibitions while drinking, total inability to drink in a controlled manner, and an intense compulsion to drink (Cohen, 1983).

4.2.6 Gender and Age

Young people are less concerned with future consequences than older persons. They are also less inclined to delay gratification including drug-induced euphoria. In North America among the adolescents between the ages of 16 to 25, 95% of them have tried alcohol, 63% have tried dagga and the use of heroin in this age forms 35% of the population (Cohen, 1983).

It was discovered that in the U.S.A. in the early 70s alcoholism was more common in males as compared to females. The reason was that women who drank in public were stigmatized. However, the pattern has now changed because society is tolerant of women drinkers. The number of women seeking treatment for alcoholism is increasing dramatically. There rather is a pressing question as far as increasing use and addiction to alcohol among women: is it because women are experiencing greater role conflicts and frustrations than they did in the past, or is it because they are asserting their rights to enjoy the same privileges that men

have traditionally exercised in using alcohol and tobacco? (Baer, 1987).

A study was carried out in California in 1984 comparing substance abuse between ages and gender. The younger group ages (18 -25) showed more drug use (55%) than older ages (34%). Also males abused drugs more (45%) than females (25%) (Bartimole, 1987).

In another study carried out in U.S.A. in 1980 among youth between ages and gender on substance use and abuse. The results showed that males between ages 18 to 20 abused alcohol more as compared to females with 95%, of them doing so compared 69%. Between ages 21 to 34 85% males and 77% females did it. Between ages 35 to 49 of it was 74% males and 67% females. Finally, for ages 50 and above 53% of males and 32% of females were abusers. Thus, people of both sexes aged between 21 and 34 as well as those between 35 and 49 used/ abused alcohol more frequently.

In one of the local studies conducted by Rocha-Silva (1990,1991) among South African Blacks in both rural and urban areas, it was found that the use of substances by males was significantly higher than for females. Similar gender differences have also been previously reported in some international studies (Baer, 1987; Cohen,1983);

4.2.7 Income and occupational status of parents or guardians

The social stress explanation has also been used to account for the high rate of alcohol consumption among many Black American groups. The stressors include poverty, poor nutrition, unemployment, generalized anxiety and anger to intense socio -economic conditions. The researchers believe that because the Black Americans are disadvantaged, anxious and live in conflict with the high

class, they drink alcohol to cope with the conditions they live under (Baer, 1987).

It is as though the lifestyle that accompanies poverty can induce negative emotional states that drive one towards drug use and consequently to abuse. The young adults and adolescents becomes victims because they tend to lose their goals and their way. Superficially it would seem that being poor might offer some protection against the over use of drugs. But this is not so, the highest priority is given to the purchase for drugs (Cohen, 1983).

4.2.8 Amount of confidence

Young adults and adolescents who feel negative about themselves take drugs to make them confident about themselves. They drink for confidence in special occasions such as making a speech at a wedding, and those who feel shy and uncomfortable. The cigarette is a symbol of strength, status and well-being. It is believed that people who are successful in life whether male or females display confidence and sophistication when lighting up and exhaling smoke (Baer, 1987).

A majority of smokers believe that smoking is pleasurable, helps them to relax and reduces negative affect. Many smokers reported smoking for the purpose of stimulation and to help them think and concentrate. Experimental studies also support the view that smoking and other drug consumption reduce the negative affect (Baer, 1987).

4.2.9 Ignorance of the effects of drugs

Youth is a time of exploratory activity for accelerated learning. A "hunger" for new stimulation and sensation will be observed at this time. They are exploring also in the drug field without knowing exactly what position they put themselves in. They do not even bother to know the side effects of drugs. Curiosity and search

for new experiences and to explore those altered states of awareness evoked by certain drugs is what they are looking for (Baer,1987).

The rewarding aspects of drug use, especially at the onset, provide positive conditioning to continue the pleasurable experience. It might be imagined that loss of health due to over use of drugs will lead to cessation, but it is not quite so. Instead this misery lead to continued use. Risk taking is the characteristic of young adults. This quality promotes drug usage patterns that might be avoided by more matured individuals. Too many valuable youngsters are lost because of their underdeveloped ability to control their impulses (Baer, 1987).

Adolescents and young adults use and abuse substances because they are not aware of the harm they can cause to their bodies, they only enjoy the fact that they feel good after they have taken the drugs. One of the studies carried out in rural areas in 1985 showed that ignorance of the adolescents as far as the drugs are concerned. The adolescents emphasized that they take different substances to make them feel good and to forget about their worries and bad dreams so much that they cannot cope without them (Emanuel & Olivier,1995).

4.2.10 Year of study and progress at University

School and social failure tend to encourage drug experimentation. This probably constitutes a search for rewarding experiences that are not available at school. The anger and frustration caused by failure and inadequacy lead to drug use and abuse. Alcohol, for example, allows the expression of rage and offers an excuse for it.

Escaping to drug abuse may also come from a person's effort to avoid anxiety-related uncertainty, insecurity, new and frightening demands and certain

life crises. These feeling of anxiety produce unpleasant and threatening situations. When a person feels such anxiety, s/he may turn to drugs as a means of escaping the real threat. The drugs therefore produce a temporal relief from the unpleasant situations, giving them a sense of control over their destiny (Burkhalter, 1975).

Roberts and Heather (1987) believe that the first year students tend to use drugs more than the senior students. The reason is that they are enjoying the freedom of taking control over their own lives. The parents are not around to say no to them. Furthermore, because they are not that committed to their books as the senior students, they are in a stage of adjustment they do not know what it is they want.

However because they are not matured enough to take responsibility of their future, they just take drugs to go along with friends and they are not aware of their consequences. A study carried out in South Africa at the University of Port Elizabeth by Kota (1995) confirmed this view.



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4.2.11 Depression

Adolescents and young adults use and abuse drugs to escape from depression. Depression fosters the need for relief but the behaviour associated with alcoholism creates further depression. The stages of depression can be viewed as the initial stimulus to drink in order to relieve depression, and high doses of drugs are consumed. Unfortunately, however, self-designed treatment is not effective because it only serves to heighten feelings of depression.

Excessive drinking develops because the alcoholic becomes aware that the behaviour and relationships with others are changing, and usually for the worse. Depressive feelings intensify, and it is this type of depression that promotes denial

of the maturing problem. In an effort to decrease depression, continuation of drinking is observed. Unfortunately the continued drinking practices do not succeed in relieving depression, instead depression increases (Burkhalter, 1975).

4.2.12 Place of origin

Social scientists believe that substance use and abuse is associated with place of origin. Young adults and adolescents who come from urban areas are prone to drug use and abuse as compared to rural areas adolescents. The main reason for this is because urban youth are more exposed to different drugs than rural youth. They socialize in groups and this is where they are taught to use different drugs. Also because the drugs are easy to find and they are cheap. The adolescents from the rural areas, on the other hand, are not as widely exposed to drugs because they are not easy to find. Drug abuse therefore becomes more common in urban areas (Burkhalter, 1975).

In one of the local studies by Rocha - Silva (1990,1991) among South African Blacks in both rural and urban areas, it was found that the use and abuse of substances by males was significantly higher than among females, as well as the fact that the use of LSD and heroin was mainly an urban affair.

4.2.13 The influence of church

The church plays a very important role in shaping the behaviour of the adolescents and young adults. It has some norms and rules that keep the members together. Each member has to follow the rules of the church if he or she wants to stay a member. Drug education is offered to adolescents including the dangers of both use and abuse. Drug education programmes provide the youth with information regarding to health hazards and social consequences of drug

taking. The adolescents in this approach need to be provided with necessary factual information.

Once they are aware of the relevant facts, they can, and presumably, will choose to adopt healthy lifestyle patterns. The use of drugs by the member of the church is unacceptable. The regular attendance of the youth groups in the church provides awareness as far as the dangers of drugs are concerned. One study carried out in U.S.A. in 1980 among the college students the non-drug users gave the reason that substance use and abuse was discouraged in church (Roberts & Heather, 1987).

4.2.14 Use of other drugs as a predisposing factor

The use of one substance leads to the use of others. Schilling (1990) believes that adolescents begin with a certain entry of substance such as alcohol or cigarettes, then subsequently progress to dagga and finally harder substances.

In one major study conducted by a number of researchers led by Levine (1987), it was discovered that most hard drug users among adolescents and young adults had first used alcohol, cigarettes and dagga, although there were those who had smoked cigarettes, but had not tried alcohol and those who had tried alcohol and dagga, but not cigarettes and they were referred to as "error types".

4.3 Summary

Chapter 4 provided a review of the prevalent data on substance use and abuse of alcohol and other substances as well as predisposing factors. The statistics showed that there is some widespread of different substances internationally and in South Africa and that multiple risk factors might be involved.

The following chapter, Chapter 5 will provide the methodology that was used in the present study.



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CHAPTER FIVE

METHODOLOGY

5.0 Introduction

This chapter will provide the research methodology that was used in the study. The aim of this section is to make the reader aware of how the research was carried out. The methodology includes the subjects, the research instrument, the research design, the procedure and data analysis.


5.1 Subjects

Altogether, a convenient sample consisting of 520 Black university students studying at a medium-sized tertiary institution of learning found in the Eastern Cape took part in the study. Psychology students were chosen because almost all the faculties in the university are represented among them. While the majority of the students were from the Faculty of Arts, the rest were from the Faculties of Science, Commerce, and Education (see Table 1).

Only students from the Faculties of Law and Agriculture were excluded altogether from the study because they constitute a very small proportion of the student population at the university concerned. Sixty-eight percent of the subjects were females and 32% were males. Tables 2 to 3 show the breakdown of the sample according to age, home language and religion. Half of the sample (50%) were between the ages of 19 -24 years, 44% were older than 25 years and the remainder (6%) were 18 years old and below. Half the sample (50%) were in their first year of study, 23% in 2nd year, and the rest (27%) were 3rd year students.

Table 1

The distribution of respondents in terms of degrees registered for
(n= 520)



<u>Degree</u>	<u>Percentage (%)</u>
B. A University of Fort Hare	46
B. A (SW)	23
B. A (Communication)	11
B. Ped	10
B. Sc	5
B. A (Library Science)	3
B. A (Personnel Management)	0.2
B. Com	0.2
<u>TOTAL</u>	<u>100.00</u>

Table 2

The distribution of respondents in terms of their home language (n = 520)

<u>Home Language</u>	<u>Percentage (%)</u>
Xhosa	84
Zulu	6.3
Sotho	4
Tswana	3.7
Shona	1
English	0.8
Afrikaans	0.6
Pedi	0.4
<u>Ndebele</u>	<u>0.2</u>
<u>TOTAL</u>	<u>100 .00</u>



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Table 3

The distribution of respondents in terms of religion (n =520)

<u>Name of Church</u>	<u>Percentage (%)</u>
Methodist	28
Ethiopia Order	24
Presbyterian	13
Roman Catholic	8
Anglican	7
Baptist	5
Zion Assemblies of God	3
Seventh - Day Adventist	2
Non - members	7
TOTAL	100.00



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5.2 Research Instrument

The measuring instrument was a self - report inventory adopted from an existing questionnaire developed by Bodisch (1994), Kota (1994) and Stubbs (1994) from questionnaires originally developed by du Toit (1974) and Plant et al. (1986). The questionnaire consisted of both open-ended and closed questions. The questions sought to ascertain the biographical details of each participant, the quality of relationship with the family and the family background, the type of substances used, the frequency of use, the onset of use and the motivation behind the use. The data was coded and analysed using the Statistica statistical computer based package. Closed - ended questions were coded according to pre-determined categories of responses. Open-ended questions were coded according to key themes in responses (this entailed a shortened type of content analysis).

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Due to the fact that the measuring instrument was not being used for the first time, conclusions can be made about its validity. The measuring instrument does have satisfactory validity as a number of experts including du Toit (1974) and Plant, et al. (1986) as well as the supervisor of this project agree on the fact that the chosen items adequately represents the tasks in the universe as defined by the researcher and also that the written items indeed require the execution of these tasks (see Huysamen, 1983). However, previous studies by Bodisch (1994), Kota (1994) and Stubbs (1994) did not establish any form of reliability, the present study also failed to establish the reliability of the research instrument using test - retest method.

5.3 Research Design

The research design was an exploratory questionnaire-based survey. The questionnaire consisted of both open ended and closed questions, and thus yielded both qualitative and quantitative data. Such a combination of methods is referred to as triangulation (Leedy, 1993).

Bezuidenhout and Rip (1988) explain that survey research uses self-report measurement technique to question people about themselves concerning their attitudes behaviours, demographic details and the like. This method can provide a highly accurate description of an entire population, provided that random sampling techniques are employed.

Survey research may make use of either a questionnaire or interviews to ask people about themselves. Generally the questionnaire approach is more cost-effective than the interview approach as questionnaires can be administered to groups of subjects at a time. Questionnaires also allow for anonymity of the subjects. The disadvantage is that questionnaires need subjects that can read and write and understand the questions. In addition to this many people may find it boring to sit down by themselves in order to read and write down their responses and therefore there may be a problem of motivation on the part of the subjects (Cozby, 1989).

The first part of this survey was descriptive while the second part was analytical. According to Cronbach (1990), a descriptive survey attempts to describe existing behaviours, opinions or attitudes of the group under study. The descriptive component of the study described prevalence of substance use and abuse among Black university students. The advantage of the descriptive study

is the large amount of information that can be gathered. The disadvantages are that no cause - and - effect conclusions can be drawn and self-report measurements may be affected by bias factors such as social desirability of particular responses sets. An analytic study, on the other hand involves the use of statistical techniques in order to examine possible relationships among variables. The analytic component of the study was to find out if there is any significant relationship between the level of substance use and family instability, lack of family support, family history of use and abuse, friends use and abuse of substances, ignorance of the effects of substance use and abuse, depression, lack of confidence, poor quality of work at university, stress, religiosity, place of origin, gender, love of television and movies, parental status of employment and the income of the parent or guardian on the other, all respectively.

5.4 Procedure University of Fort Hare

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Permission was sought and obtained from the Head of Department of Psychology at a historically disadvantaged university to conduct the survey among psychology undergraduates. The questionnaire was administered over three days. For the second- and third-year students, the questionnaire was administered during their respective practical periods during afternoons. However, for the first years it was administered during a single 40-minute lecture period. The subjects were first briefed about the study and then they were given a chance to ask some questions if they needed any more clarification as far as the study was concerned. They were given informed consent forms to make them aware of their rights. The informed consent forms were only signed by those who were willing to take part in the study. The subjects were not coerced in taking part in

the survey. They were even free to discontinue or to withdraw from the study at any stage if they so wish. Thus, ethical principles of research were upheld. All subjects were instructed to complete the questionnaire within 40 minutes. A pilot study was conducted on a small group of about 30 first year students to pretest the questionnaire. The pilot study showed that the questionnaire was easily comprehensible and therefore no alterations whatsoever were made to any of the questions therein.

5.5 Data analysis

The data were collected and analyzed using the STATISTICA COMPUTER- BASED STATISTICAL PROGRAMME available at the Statistics Department of the University of Fort Hare. The data pertaining to prevalence were analyzed using descriptive statistics, mainly as frequencies of occurrence and percentages. Data concerning possible relationships between variables and the level of use of substances were assessed using chi-square tests." Due to the fact that the shape of the distribution of the dependent variable scores (i.e., the level of substance use) was extremely skewed, the use of parametric multivariate statistics such as multiple regression and /or discriminant analysis was deemed unsuitable. Instead log-linear analysis was opted for. However due to its non-availability on the STATISTICA programme as well as at other sister Psychology Departments at universities found in the Eastern Cape, multivariate statistica were omitted completely from the present analysis".

5.6 Summary

This chapter presented the methodology that was used in the study. The tables were presented for a clear picture. The following chapter, Chapter 6, will provide the results that were obtained in the study.

CHAPTER SIX

RESULTS

6.0 Introduction

Chapter 6 will provide a systematic account of the results obtained from the study and their analyses. Firstly, data pertaining to prevalence which were analysed using descriptive statistics, mainly as frequencies of occurrence or percentages are presented. Secondly, the results of chi-square tests which were used to analyze data concerning associations among variables are then presented.

6.1 Prevalence of Substance Use and Abuse

The overall results depicting prevalence of substance use and abuse are shown in Table 4. The table shows that alcohol is the most widely used substance followed by sleeping medicine, spirits and then tobacco, in that order. However, only alcohol, tobacco and dagga were abused by significant proportions of the participants of the sample. Equally interesting is the fact that substances like amphetamines, barbiturates, whiffers, heroin, mandrax and opium were hardly used and abused by the participants.

When asked if they were currently using any prescribed drugs (Question 15), only 7% (n = 39) of the participants indicated that they were doing so while the remainder (93%) were not. The majority of those who were on prescribed drugs said that the drugs involved were steelpain (2,0%), aldomet (1,9%) and panado (3,1%). When asked about the frequency of use of the prescribed drugs per month (Question 16), 1% of the participants indicated that they did so daily, 2% once per week, 2% twice per week and the last 2% when necessary.

Table 4. Prevalence (%) of Substance Use and Abuse in the present study (n=520)

Substance	Never use	Use	Abuse	Total
Alcohol	73	22	5	100
Tobacco	87	4	9	100
Spirits	93	6	1	100
Amphetamine	99	0.5	0.5	100
Barbiturates	98	1	1	100
Hallucinogens	96	3	1	100
Whiffers	98	1	1	100
Sleeping medicine	80	18	2	100
Dagga	95	2	3	100
Heroin	99	1	0	100
Mandrax	99	1	0	100
Opium	99.8	0.2	0	100

When asked whether they saw their own level of usage of any of the substances as problem (Question 36a), 84% indicated that they did not, while 26% did see it that way. When those who saw their level of usage as problematic were asked to specify substance(s) concerned as well as to motivate their substances. Alcohol and spirits were indicated as problematic the reason being that the participants were totally dependent on them.

When asked about who had introduced them to drugs (Question 37), 74% indicated that they never used drugs, 6% of the participants were introduced by friends from neighbourhood, 6% were introduced by friends from another city, 4% were

205 $\frac{5}{20} = \frac{5}{20} \times 100 = 25\%$

introduced by friends from rural areas, 7% were introduced by friends from school and 3% were exploring on their own.

When asked how many of the three people they consider their best friends at home or university have used or were currently using illegal drugs (Question 38) 63% did not use any illegal drugs, 6% admitted that one of their best friends were currently using illegal drugs, 7% admitted that two of their best friends, 8% admitted that three of their best friends, 14% did not know if any of their best friends did used or were currently using illegal drugs and 1% did not respond to the question.

When asked if they were currently or had previously used alcohol, tobacco and illegal drugs (Question 39a, 40a and 41a), see table 5 below.

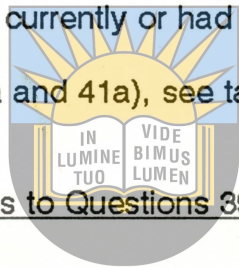


Table 5. Summary of responses to Questions 39a, 40a and 41a (n = 520)

Substance	Percentage of participants who are currently or have previously used the substance	Percentage of participants who have never used the substances
Alcohol	27	73
Tobacco	13	87
Illegal drugs	5	95

In order to further check the reliability of the responses of the participants concerning prevalence of use of substances, the results from Table 4 on both alcohol and tobacco were the same, but there was some inconsistency as far as the illegal drugs were concerned. When asked when had they stated using substances (Question 39b, 40b and 41b), the highest proportion of those who were currently or had previously used alcohol, tobacco and illegal drugs indicated that they had done so while at high school. Interestingly again, the level of present or previous use of these substances

matched those reported in Table 4. See Table 6 below for the results.

Table 6. Summary of data obtained from Questions 39b, 40b and 41b (n=520)

Place of onset of use	Alcohol (%)	Tobacco (%)	Illegal drugs (%)
High School	25	13	6
University	4	2.5	1
Elsewhere (e.g., at parties)	1	0.5	0
No response	70	84	93
Total	100	100	100

When asked when was the last time that they had used alcohol, tobacco and illegal drugs (Questions 42, 43 and 44 respectively), the level of use of substances matched the data in Table 4, see Table 7 below.

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Table 7. A Summary of the data obtained from Questions 42, 43 and 44 (n =520)

Time when substance was last used	Alcohol (%)	Tobacco (%)	Illegal Drugs (%)
Never used	70	84	93
Within the last week	11	10	4
Within the last month	6	1	0
One or two years ago	4	1	0
Six months to a year ago	2	2	1
More than a year ago	6	1	2
Today	1	1	0
Total	100	100	100

In order to further check for the reliability of the responses concerning prevalence of use and abuse of some of the substance on the questionnaire, Questions 45,46 and 47 served as check items for the items in Question 35, whose responses were presented in Table 4. The responses to the three questions are shown in Table 8. Overall, the responses to all three questions were quite consistent with those shown in Table 4.

Table 8. A Summary of the Data obtained from Questions 45-47 of the questionnaire (n= 520).

Frequency of use of substance	Alcohol (%)	Tobacco (%)	Illegal Drugs (%)
Never used	73	87	95
Daily or more	1	8	2
Once a week (not everyday)	13	2	0
Once to three times a week	2	0.5	0
Two to three times a week	1	0.5	0
Two to three times a year	5	1	2
Once a year or less	5	1	1
Total	100	100	100

When asked what were the reasons to discontinue the use of substances, alcohol, tobacco and illegal drugs. (Questions 48-50) the responses are summarised in Table 9 below. The fear of the physical damage and loss of interest were cited by significant proportions of the the sample.

Table 9 A Summary of data obtained from Questions 48-50 of the questionnaire
(n =520)

Reasons to discontinue use	Alcohol (%)	Tobacco (%)	Illegal Drugs (%)
Waste of money	2	1	1
Lost interest	3	1	1
Fear of physical damage	5	4	3
Fear of addiction	1	1	2
Quarrel with friends	1	0	40
Change of life style	1	1	3
Never used	37	40	20
No response	51	52	30
Total	100	100	100

When asked for the reasons why they had done so if they had ever used dagga and mandrax before (Questions 51 and 52 respectively), the responses given by the respondents are shown in Table 10. The table shows that motivation for use of each of the two drugs were surprisingly of equal magnitude for each of the listed reasons such as curiosity, to get some "kicks", escaping from problems, social pressure, increasing self-awareness and relaxation.

Table 10. A Summary of the data obtained from Questions 51 and 52 (n=520)

Reasons for use of substances	Dagga (%)	Mandrax (%)
Have never used it (question does not apply)	69	91.2
Curiosity, just to find out what it's like	6.5	1.7
"Kicks", an enjoyable experience, to feel good	6.7	1.9
Escape from problems or depression	6.0	1.2
Boredom, for something to do	0.0	0.0
Social pressure, to go along with friends, to be "in"	5.8	1.2
To increase self-awareness or self-understanding	4.6	1.3
Relaxation	2.1	1.5
Total	100	100

When asked for reasons why they had not used dagga or mandrax before (questions 53 and 54 respectively), the responses given by the respondents are shown in Table 11. The reasons for no use included things like: no access to drugs, not interested, influence of friends and parents, risk of being caught for legal violation, contrary to moral or religious values and risk of physical and mental damage.

Table 11. A Summary of data obtained from Questions 53-54 of the questionnaire
(n=520)

Reasons for not using the substances	Dagga (%)	Mandrax (%)
Have used it (question does not apply)	8.2	2.3
Not interested or curious	79.8	83
No access to drugs	35.9	43
Influence of friends	22.3	25
Influence of parents	29.2	3.5
Risk of being caught for legal violation	32.5	34.2
Contrary to moral or religious values	40.9	43.4
Risk of physical or mental damage	36.1	53.7
Total *	?	?

** some respondents provided more than one response*

When asked about the risk factors taken by anyone using the drugs (Question 55), the responses were as follows: damage to health 89.4%, psychological dependence 68%, addiction 65.1%, may lead to use of stronger drugs 39.6%, and use of drugs may lead to mental illness 3.0%.

When asked about their hobbies as related to use of different substances (Question 56), the responses were as follows; love of television 88.2%, reading magazines, writing and drawing 78.8%, love of music and dance 83.4%, socializing and sharing ideas 52.1%, love of sport 61.3%, love of parties and picnics 9.8%, religious activities 11.7%, gardening and fixing cars 2.3% and cleaning and cooking 2.5%.

When asked for the reasons for using illegal drugs (Question 57) the responses of the respondents were as follows; ignorance or peer pressure 76.9%, escape from problems 65%, boredom 60.4%, to increase self-awareness 66.9%, to reduce stress and frustrations 32.3 %, family conflicts and poverty 14.8%, loss of loved ones 29.2 %, availability of drugs 23.3 %, influence of movies 3.7 % and poor progress at university 18.6%.

When asked about the legalization of the illegal drugs (Question 58a), only 17.7% felt that the illegal drugs should be legalized, the majority of the respondents did not feel that way and they comprised 82.3 % of the sample. When asked which of the illegal drugs they felt should be legalized (Question 58b) 18.7% felt that mandrax should be legalized and 81.3% felt that dagga should be legalized. When asked of the reasons for the reasons for the legalization of these illegal drugs (Question 58c), 50.7% felt that they should be legalized for medical purpose and 49.3% felt that they should be legalized for financial purpose.

When asked if they have any comments on both the use and abuse of substances (Question 59), 52.6% of the sample felt that youth and young adults should abstain from substances and 47.4% of the respondents felt that drug education should be offered to the adolescents as some of them are not aware of the dangers of both use and abuse.

6.2 Associations between various personal and social variables and the level of use of various substances

Possible relationships between the levels of substance use and various personal and social variables mentioned in the hypotheses specified in Chapter 1 were tested using chi-square tests. The results of these analyses are presented below separately for each substance.



6.2.1 Alcohol

The results of the chi-square tests performed to test the degree of association between the levels of alcohol use and the other variables are shown in Table 12. This table shows that there were significant relationships between the level of use of alcohol and age, gender, year of study, attendance of church, family instability, father's and mother's use of alcohol, cousin's use of alcohol, uncle's and aunt's use friends 's use, amount of confidence, stress and depression, ignorance on the relationship of drugs with mental illness, attitude towards legalization, family support, love of television, income of the parents, tobacco, spirits, dagga and sleeping medicine use.

6.2.2 Tobacco

The results of the chi-square tests used to test the degree of association between the levels of tobacco use and the other variables are shown in Table 13. The table shows that there were significant relationships between the level of use of tobacco and gender, year of study, church attendance, family instability, occupational status of parents or guardians, income of parents, father's use of tobacco, cousin's use of tobacco, uncle's and aunt's use, friends's use, amount of confidence, stress and depression, attitude towards legalization, family support, love of television, alcohol, spirits, sleeping medicine and dagga use.

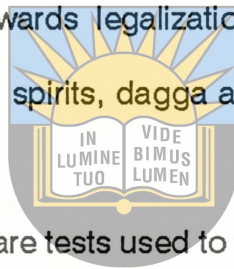


Table 12 : The level of use of alcohol as related to the various personal and social variables stated in hypotheses in Chapter 1.

Variables	chi-square	df	p	s	ns
1. Age	17,223	6	.00	1	
2. Gender	67,855	3	.00	1	
3. Year of study	25,065	6	.00	1	
4. Progress at university	16,956	21	.713		1
5. Place of origin	2,391	3	.495		1
6. Religiosity	31,036	27	.269		1
7. Attendance of church	43,626	9	.00	1	
8. Family instability	33,531	9	.00	1	
9. Occupational status of parents or guardians	36,998	28	.199		1
10. Income of parents or guardians	590,59	20	.00	1	
11. Family history of abuse	44,115	9	.00	1	
a) father's use	12,324	9	.00	1	
b) mother's use	3,324	9	.175		1
c) sister's use	37,282	9	.950		1
d) brother's use	45,205	9	.00	1	
e) cousin's use	41,195	9	.00	1	
f) uncle and aunt's					
12. Friend's use and abuse	43,015	9	.00	1	
13. Amount of confidence	71,444	9	.00	1	
14. Stress and depression	20,074	3	.00	1	
15. Ignorance:					
a) Awareness of use of mild drugs leading to use of stronger drugs	3,974	3	.264		1
b) Awareness of psychological dependence	4,2992	3	.230		1
c) Awareness of addiction	3,5345	3	.316		1
d) Awareness of damage to health	0,8597	3	.835		1
e) Awareness of relationship with mental illness	20,236	3	.00	1	
f) Attitude towards legalization	21,324	6	.00	1	
16. Family support	17,223	3	.00	1	
17. Love of television	729,16	6	.02	1	
18. Alcohol as related to other substances:					
a) tobacco	672,58	16	.00	1	
b) spirits	43,73	12	.00	1	
c) amphetamines	1,384	4	.984		1
d) hallucinogens	1,665	8	.994		1
e) barbiturates	0,669	8	.999		1
f) whiffers	23,870	8	.999		1
g) sleeping medicine	68,672	12	.02	1	
h) dagga	8,107	12	.00	1	
i) mandrax	0,376	12	.989		1
j) opium	0,303	4	.776		1
k) heroin	0,356	4	.984		1

S - significant at P < 0,05

Table 13 The level of use of tobacco as related to various personal and social variables stated in hypotheses in Chapter 1.

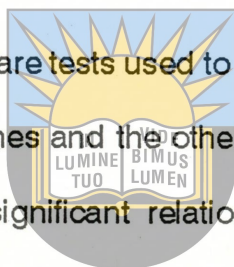
Variables	chi-square	df	p	s	ns
1. Age	2,28069	6	.894		1
2. Gender	85,56958	3	.00	1	
3. Year of study	29,51668	6	.00	1	
4. Progress at university	24,1840	21	.284		1
5. Place of origin	72,1304	3	.868		1
6. Religiosity	24,3949	27	.608		1
7. Attendance of church	27,7905	9	.00	1	
8. Family instability	33,5318	9	.00	1	
9. Occupational status of parents or guardians	33,2006	28	.00	1	
10. Income of parents or guardians	543,744	20	.00	1	
11. Family history of use:					
a) father's use	30,34966	9	.00	1	
b) mother's use	4,604666	9	.875		1
c) sister's use	2,340167	9	.984		1
d) cousin's use	28,87112	9	.01	1	
e) uncles's and aunts'	30,80451	12	.00	1	
12. Friend's use and abuse	27,90191	3	.00	1	
13. Amount of confidence	71,44466	12	.00	1	
14. Stress and depression	20,07450	6	.00	1	
15. Ignorance of use:					
a) awareness of use of mild drugs leading to use of stronger drugs	3,008356	3	.390		1
b) awareness of psychological dependence	1,173759	3	.759		1
c) awareness of addiction	1,096487	3	.777		1
d) awareness of damage to health	3,676849	3	.298		1
e) awareness of relationship with mental illness	3,333099	3	.343		1
f) attitude towards legalization	9,123581	3	.02	1	
16. Family support	17,223	6	.00	1	
17. Love of television	9,65257	3	.02	1	
18. Tobacco as related to other substances:					
a) alcohol	729,1628	16	.00	1	
b) spirits	644,8276	12	.00	1	
c) amphetamines	,1587	4	.997		1
d) barbiturates	14,59707	8	.06		1
e) hallucinogens	14,65025	12	.261		1
f) whiffers	,9641	8	.998		1
g) sleeping medicine	22,34124	12	.03	1	
h) dagga	96,64999	12	.00	1	
i) heroin	2,490859	4	.646		1
j) mandrax	7,187833	12	.844		1
k) opium	,1584339	4	.997		1
s-significant at p <0,05					

6.2.3 Spirits

The results of the chi-square tests used to test the degree of association between the levels of spirits use and the other variables are shown in Table 14. The table shows that there were significant relationships between the level of use of spirits and gender, year of study, occupational status of employment of parents or guardians, income of parents or guardians, family instability, brother's use of spirits, uncle's and aunt's use of spirits, family support, love of television, ignorance on the relationship of drugs with mental illness, friend's use, alcohol, tobacco, sleeping medicine and dagga use.

6.2.4 Amphetamines

The results of the chi-square tests used to test the degree of association between the levels of use of amphetamines and the other variables are shown in Table 15. The table shows that there were significant relationships between the level of use of amphetamines and religiosity, attitude towards legalization of drugs, barbiturates and hallucinogens use.



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6.2.5 Barbiturates

The results of the chi-square tests used to test the degree of association between the levels of use of barbiturates and the other variables are shown in Table 16. The table shows that there were significant relationships between the level of use of barbiturates and church attendance, family instability, occupational status of parents or guardians, sister's use of barbiturates, cousin's use of barbiturates, family support, love of television, amphetamines and hallucinogens use.

Table 14. The level of use of spirits as related to the various personal and social variables stated in hypotheses in chapter 1.

Variables	Chi- square	df	p	s	ns
1. Age	1,33830	4	.845		1
2. Gender	43,08580	2	.000	1	
3. Year of study	17,06366	4	.000	1	
4. Progress at university	22,51541	14	.068		1
5. Place of origin	5,260170	2	.070		1
6. Religiosity	9,786362	18	.938		1
7. Church attendance	7,157998	6	.300		1
8. Occupational status of employment of parents or guardians	38,67735	21	.010	1	
9. Income of parents	521,3137	15	.000	1	
10. Amount of confidence	3,682253	12	.988		1
11. Stress and depression	9,456292	6	.149		1
12. Family instability	9,652573	3	.020	1	
13. Family history of abuse					
a) Fathers's use	8,607439	9	.196		1
b) Mother's use	6,624968	9	.356		1
c) Sister's use	7,343575	9	.920		1
d) Brother's use	22,72057	9	.000	1	
e) Uncle's and aunts use	59,71439	12	.000	1	
f) Cousins's use	23,93609	9	.000	1	
14. Family support	3,02441	3	.020	1	
15. love of television	3,02689	3	.040	1	
16. Ignorance of use:					
a) Awareness of use of mild drugs leading to use of stronger drugs	1,090408	2	.579		1
b) Awareness of psychological dependence on drugs	0,959812	2	.953		1
c) Awareness of addiction	1,526010	2	.466		1
d) Awareness of relationship with mental illness	10,14622	2	.000	1	
e) Awareness of damage to health	5,061385	2	.079		1
f) Attitude towards legalisation of drugs	3,96912	3	.137		1
17. Friend's use and abuse	67,88571	2	.030	1	
18. Spirits as related to other substances:					
a) Alcohol	672,5857	12	.000	1	
b) Tobacco	644,8276	3	.000	1	
c) Amphetamines	0,0680323	6	.995		1
d) Barbiturates	0,4113168	9	.998		1
e) Hallucinogens	5,490643	6	.789		1
f) Whiffers	2,0749123	9	.912		1
g) Sleeping medicine	63,22484	9	.000	1	
h) Dagga	99,43188	3	.000	1	
i) Heroin	4,414905	9	.220		1
j) Mandrax	12,07059	3	.209		1
k) Opium	,0678724		.995		1
S - Significant at $p < 0,05$ NS - not significant					

Table 15. The level of use of amphetamines as related to various personal and social variables stated in hypotheses in Chapter 1.

Variables	CHI-SQUARE	df	P	S	NS
1. Age	1,021021	2	.600		1
2. Gender	2,111112	1	.146		1
3. Year of study	,9828983	2	.611		1
4. Progress at university	3,2952296	7	.856		1
5. Place of origin	1,120121	1	.289		1
6. Religiosity	33,66665	9	.00	1	
7. Attendance of church	1,355355	3	.187		1
8. Family instability	2,280281	3	.799		1
9. Occupational status of parents or guardians	2,39397	7	.934		1
10. Income of parents or guardians	0,8450845	5	.974		1
11. Family history of use:					
a) father's use	,3019302	3	.959		1
b) mother's use	,0354035	3	.998		1
c) sister's use	,0796080	3	.994		1
d) brother's use	,5429543	3	.909		1
e) cousin's use	1,125125	3	.771		1
f) uncle and aunt's	,3020302	4	.938		1
12. Friends use and abuse	8,610612	3	.531		1
13. Amount of confidence	6,370371	4	.532		1
14. Stress and depression	1,263263	3	.142		1
15. Ignorance:					
a) Awareness of use of mild drugs leading to use of stronger drugs	8,610644		.667		1
b) Awareness of psychological dependence	0,6436131	1	.144		1
c) Awareness of addiction	2,130887	1	.169		1
d) Awareness of relationship with mental illness	1,886969	1	.862		1
e) Awareness of damage to health	0,298190	1	.730		1
f) Attitude towards legalization	0,1187119	1	.03	1	
16. Family support	4,338338	2	.143		1
17. Love of television	1,333333	3	.643		1
18. Amphetamines as related to other substances:					
a) alcohol	,758759	4	.984		1
b) tobacco	3,77774	4	.997		1
c) tobacco	0,158159	3	.995		1
c) spirits	0,068068	2	.00	1	
d) barbiturates	102,998	3	.00	1	
e) hallucinogens	172,332	2	.994		1
f) whiffers	0,011012	3	.204		1
g) sleeping medicine	4,58589	3	.996		1
h) dagga	0,550551	1	.939		1
i) heroin	,0050006	3	.999		1
j) mandrax	,117117	1	.964		1
k) opium					
S - significant p < 0,05					
NS - not significant					

TABLE 16. The level of use of barbiturates as related to the various personal and social variables stated in hypotheses in chapter 1.

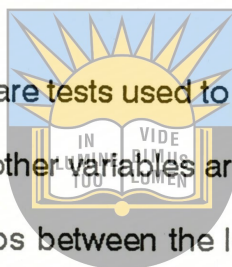
Variables	CHI-SQUARE	df	P	S	NS
1. Age	6,164148	2	.187		1
2. Gender	2,662957	3	.645		1
3. Year of study	4,836825	4	.304		1
4. Progress at university	12,133690	14	.595		1
5. Place of origin	1,466329	2	.408		1
6. Religiosity	19,158040	18	.382		1
7. Attendance of church	27,79055	9	.000	1	
8. Family instability	9,652573	3	.020	1	
9. Occupational status of parents or guardians	61,78009	14	.000	1	
10. Income of parents or guardians					
11. Family history of use:					
a) father's use	12,40609	10	.258		1
b) mother's use	9,397578	6	.152		1
c) sister's use	1,1781335	6	.999		1
d) brother's use	21,13069	6	.000	1	
e) cousin's use	4,785251	6	.571		1
f) uncle and aunt's	17,22829	6	.000	1	
12. Friends use and abuse	1,028812	8	.998		1
13. Amount of confidence	67,88571	2	.030	1	
14. Stress and depression	3,682253	12	.988		1
15. Ignorance:					
a) Awareness of use of mild drugs leading to use of stronger drugs	9,456292	6	.149		1
b) Awareness of psychological dependence	1,436154	2	.487		1
c) Awareness of addiction	2,293153	2	.317		1
d) Awareness of relationship mental illness	,5935149	2	.743		1
e) Awareness of damage to health	,1802982	2	.913		1
f) Attitude towards legalization	,5904295	2	.744		1
16. Family support	,2359331	2	.888		1
17. Love of television	3,02441	3	.020	1	
18. Barbiturates as related to other substances:					
a) alcohol	3,02869	3	.040	1	
b) tobacco	1,384353	8	.994		1
c) tobacco	14,59707	8	.060		1
d) spirits	,4113168	6	.998		1
e) amphetamines	102,9985	2	.000	1	
f) hallucinogen	39,95017	6	.000	1	
g) whiffers	,0711365	4	.993		1
h) sleeping medicine	10,76965	6	.095		1
i) dagga	,3331194	6	.999		1
j) Heroin	,0352917	2	.982		1
k) mandrax	,0116956	2	.994		1
l) opium	,0785650	2	.999		1
s - significant p < 0,05					
ns - not significant					

6.2.6 Hallucinogens

The results of the chi-square tests used to test the degree of association between the level of use of hallucinogens and other variables are shown in Table 17. The table shows that there were significant relationships between the level of use of hallucinogens and progress at university, cousin's use of hallucinogens, uncle's and aunts' use of hallucinogens, ignorance of the relationship of drugs with mental illness, amphetamines, barbiturates, whiffers, sleeping medicine and dagga use.

6.2.7 Whiffers

The results of the chi-square tests used to test the degree of association between the level of use of whiffers and other variables are shown in Table 18. The table shows that there significant relationships between the level of use of whiffers and attendance of church, friends' use of whiffers, dagga, heroin and mandrax use.



6.2.8 Sleeping Medicine

The results of the chi-square tests used to test the degree of association between the level of use of sleeping medicine and other variables are shown in Table 19. The table shows that there significant relationships between the level of use of sleeping medicine and gender, family instability, mother's and sister's use of sleeping medicine, uncle's and aunt's use, cousin's use, family support, love of television, awareness of use of mild drugs leading to use of stronger drugs, ignorance of use of drugs leading to damage to health, alcohol, tobacco, spirits, amphetamines, whiffers, dagga and mandrax use.

Table 17. The level of use of hallucinogens as related to the various personal and social variables stated in hypotheses in Chapter 1.

Variables	CHI-SQUARE	df	P	S	NS
1. Age	1,700945	4	.790		1
2. Gender	1,666240	2	.324		1
3. Year of study	6,025120	6	.420		1
4. Progress at university	66,263080	21	.00	1	
5. Place of origin	4,7555811	3	.190		1
6. Religiosity	24,584330	27	.599		1
7. Attendance of church	6,613039	3	.578		1
8. Family instability	33,43926	3	.124		1
9. Occupational status of parents or guardians	15,71256	2	.785		1
10. Income of parents or guardians	4,994713	21	.712		1
11. Family history of use:					
a) father's use	8,448811	15	.992		1
b) mother's use	1,954707	4	.744		1
c) sister's use	51,61106	9	.212	1	1
d) brother's use	38,05014	9	.00	1	
e) cousins's use	12,72443	9	.00	1	
f) uncle and aunt's	18,97561	9	.02		
12. Friends' use and abuse	12,72443	9	.175		1
13. Amount of confidence	20,04093	12	.07		1
14. Stress and depression	8,610894	3	.541		1
15. Ignorance:					
a) Awareness of use of mild drugs leading to use of stronger drugs	4,357272	2	.552		1
b) Awareness of psychological dependence	1,263299	3	.142		1
c) Awareness of addiction	4,357272	3	.225		1
d) Awareness of relationship with mental illness	7,139287	3	.06		1
e) Awareness of damage to health	10,09161	3	.01	1	
f) Attitudes towards legalization of illegal drugs	,5857592	3	.889		1
16. Family support	2,335786	3	.505		1
17. Love of television	1,211277	3	.750		1
18. Hallucinogens as related to other substances:					
a) alcohol	1,220674	2	.998		1
b) tobacco	6,370983	2	.879		1
c) spirits	1,22067	12	.999		1
d) amphetamines	14,65025	9	.261		1
e) barbiturates	5,49064	9	.789		1
f) whiffer	172,33200	3	.00	1	
g) sleeping medicine	39,95017	6	.00	1	
h) dagga	29,05696	6	.00	1	
i) heroin	16,94023	9	.04	1	
j) mandrax	33,14972	9	.00	1	
k) opium	,144	3	.990		1
S - significant p < 0,05					
NS - not significant					

Table 18. The level of use of whiffer as related to the various personal and social variables stated in hypotheses in Chapter 1.

Variables	CHI-SQUARE	df	P	S	NS
1. Age	6,270727	4	.393		1
2. Gender	2,249797	3	.321		1
3. Year of study	2,883371	4	.577		1
4. Progress at university	20,33280	14	.120		1
5. Place of origin	2,363436	3	.306		1
6. Religiosity	19,231940	18	.377		1
7. Attendance of church	13,4417	4	.00	1	
8. Family instability	2,48711	3	.155		1
9. Occupational status of parents or guardians	16,49339	14	.511		1
10. Income of parents or guardians	3,28669	10	.284		1
11. Family history of use:					
a) father's use	1,32462	3	.973		1
b) mother's use	,7232451	2	.691		1
c) sister's use	,4836219	6	.993		1
d) brother's use	,2150967	6	.999		1
e) cousin's use	,4836219	6	.998		1
f) uncle and aunt's	2,434893	6	.875	1	1
12. Friend's use and abuse	16,82554	6	.00		
13. Amount of confidence	7,261044	12	.508		1
14. Stress and depression	8,610868	3	.531		1
15. Ignorance:					
a) Awareness of use of mild drugs leading to use of stronger drugs	3,911979	2	.431		1
b) Awareness of psychological dependence	4,263299	3	.542		1
c) Awareness of addiction	3,911979	2	.141		1
d) Awareness of relationship with mental illness	2,302936	2	.312		1
e) Awareness of damage to health	3,357270	2	.180		1
f) Attitudes towards legalization of illegal drugs	,1810232	2	.913		1
16. Family support	,7210954	2	.697		1
17. Love of television	5,614868	2	.06		1
18. Whiffer as related to other substances:					
a) alcohol	2,33306	2	.144		1
b) tobacco	1,56723	2	.600		1
c) spirits	,669662	8	.990		1
d) amphetamines	,944188	8	.998		1
e) barbiturates	2,07491	6	.912		1
f) hallucinogens	,011764	2	.994		1
g) sleeping medicine	,071136	4	.999		1
h) dagga	29,05696	6	.00	1	
i) heroin	49,6345	6	.00	1	
j) mandrax	77,05645	6	.00	1	
k) opium	0,354306	2	.982		1
S - significant p < 0,05					
NS - not significant					

Table 19. The level of use of sleeping medicine as related to the various personal and social variables stated in hypotheses in Chapter 1.

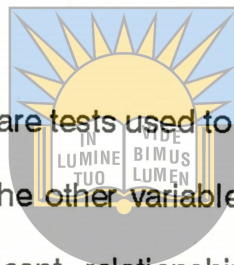
Variables	CHI-SQUARE	df	P	S	NS
1. Age	8,610868	4	.196		1
2. Gender	24,76148	3	.000	1	
3. Year of study	3,847426	6	.697		1
4. Progress at university	16,05468	21	.766		1
5. Place of origin	3,876841	3	.275		1
6. Religiosity	15,54159	27	.961		1
7. Church attendance	12,54091	9	.180		1
8. Occupational status of parents or guardians	44,21559	21	.000	1	
9. Income of parents	10,64529	15	.777		1
10. Amount of confidence	3,682253	12	.988		1
11. Stress and depression	9,456292	6	.149		1
12. Family instability	9,652573	3	.020	1	
13. Family history of use:					
a) Father's use	32,19847	9	.000	1	
b) Mother's use	21,11403	9	.000	1	
c) Sister's use	11,82346	9	.010	1	
d) Brother's use	17,95592	9	.223		1
e) Uncle's and aunts	53,23606	9	.040	1	
f) Cousin's use	29,53004	12	.000	1	
14. Family support	9,652573	9	.000	1	
15. Love of television	3,022689	3	.020	1	
16. Ignorance of use:					
a) Awareness of use of mild drugs lead to rugs	0708639	3	.040	1	
b) Awareness of psychological dependence	1,811373	3	.995		1
c) Awareness of addiction	3,075726	3	.610		1
d) Awareness of relationship with mental illness	10,34501	3	.380		1
e) Awareness of damage to health	3,500499	3	.010	1	
f) Attitudes towards legalization of illegal drugs	7,339733	3	.320		1
17. Friend's use and abuse	67,88571	3	.060		1
18. Sleeping medicine as related to other substances:					
a) Alcohol	23,87062	2	.020	1	
b) Tobacco	22,34124	12	.030	1	
c) Spirits	63,22484	12	.000	1	
d) Amphetamines	4,589488	9	.200		
e) Barbiturates	10,76965	3	.090		
f) Hallucinogens	16,94023	6	.040	1	
g) Whiffers	49,63457	9	.000	1	
h) Dagga	42,32744	6	.000	1	
i) Heroin	,5307529	9	.912		
j) Mandrax	1,282103	3	.998		1
k) Opium	,250481	9	.969		1
S - significant $p < 0,05$					
NS - not significant					

6.2.9 Dagga

The results of the chi-square tests used to test the degree of association between the level of use dagga and the other variables are shown in Table 20. The table shows that there were significant relationships between the use of dagga and gender, church attendance, family instability, brother's use of dagga, cousin's use of dagga, friend's use of dagga, ignorance on the use of drugs leading to damage to health, attitudes towards legalization of the illegal drugs, family support, love of television, alcohol, tobacco, spirits, hallucinogens, whiffers, sleeping medicine, heroin, mandrax and opium use.

6.2.10 Heroin

The results of the chi-square tests used to test the degree of association between the level of use of heroin and the other variables are shown in Table 21. The results shows that there were significant relationships between the use of heroin and occupational status of parents or guardians, attitudes towards legalization of the illegal drugs, dagga, mandrax and opium use.



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6.2.11 Mandrax

The results of the chi-square tests used to test the degree of association between the level of use of mandrax and other variables are shown in Table 22. The results shows that there were significant relationships between the use of mandrax and occupational status of employment or guardians, awareness of damage to health, attitude towards legalization of the illegal drugs, dagga, heroin and opium use.

6.2.12 Opium

The results of the chi-square tests used to test the degree of association between the level of use of opium and other variables are shown in Table 23. The results shows that there were significant relationships between the use of opium and father's use of opium, family support, heroin and mandrax use.

Table 20. The level of use of dagga as related to various personal and social variables stated in hypotheses in Chapter 1.

Variables	CHI-SQUARE	df	P	S	NS
1. Age	.4473669	2	.799		1
2. Gender	27,901191	3	.00	1	
3. Year of study	11,617640	6	.07		1
4. Progress at university	17,55820	21	.676		1
5. Place of origin	4,768448	3	.189		1
6. Religiosity	20,297390	27	.817		1
7. Church attendance	27,79055	7	.00	1	
8. Family instability	9,652573	3	.02	1	
9. Occupational status of parents or guardians	21,07066	28	.454		1
	10,758750	15	.796		1
10. Income of parents or guardians					
11. Family history of use:	7,981178	9	.536		1
a) father's use	.9659373	9	.999		1
b) mother's use	9,518774	9	.390		1
c) sister's use	30,99634	9	.00	1	
d) brother's use	60,62700	9	.00	1	
e) cousin's use	18,75857	12	.09		1
f) uncle and aunt's use	67,88571	2	.03	1	
12. Friend's use and abuse	9,456292	6	.149		1
14. Stress and depression	1,593426	3	.927		1
15. Ignorance:					
a) Awareness of use of mild drugs leading to use of stronger drugs	3,608418	3	.306		1
b) Awareness of psychological dependence	.228713	3	.999		1
c) Awareness of addiction	6,689406	3	.08		1
d) Awareness of relationship with mental illness	12,53651	3	.00	1	
e) Awareness of damage to health	32,59658	3	.00	1	
f) Attitudes towards legalization	3,02441	3	.02	1	
16. Family support	3,02689	3	.04	1	
17. Love of television					
18. Dagga as related to other substances:					
a) Alcohol	68,67265	12	.00	1	
b) Tobacco	96,64999	12	.00	1	
c) Spirits	99,43188	9	.00	1	
d) Amphetamines	.0550962	3	.996		1
e) Barbiturates	.3331194	6	.999		1
f) Hallucinogens	33,14979	9	.00	1	
g) Whiffers	77,05645	6	.00	1	
h) Sleeping medicine	42,32744	9	.00	1	
i) Heroin	74,17030	3	.00	1	
j) Mandrax	122,8391	9	.00	1	
k) Opium	42,33156	3	.00	1	
S - Significant $p < 0,05$					
NS - not significant					

TABLE 21. The level of use of heroin as related to the various personal and social variables stated in hypotheses in chapter 1.

Variables	CHI-SQUARE	df	P	S	NS
1. Age	6,370179	6	.382		1
2. Gender	,001847	1	.965		1
3. Year of study	2,654064	2	.265		1
4. Progress at university	3,298753	7	.856		1
5. Place of origin	2,698078	1	.100		1
6. Religiosity	12,583320	9	.182		1
7. Attendance of church	1,355320	3	.187		1
8. Family instability	2,280692	3	.799		1
9. Occupational status of parents or guardians	20,865710	7	.00	1	
10. Income of parents or guardians	4,333531	15	.502		1
11. Family history of use:					
a) father's use	,9099333	3	.823		1
b) mother's use	,1066717	3	.991		1
c) sister's use	,2398884	3	.970		1
d) brother's use	,3548560	3	.949		1
e) cousin's use	1,297840	3	.729		1
f) uncle and aunt's	1,161809	4	.884		1
12. Friend's use and abuse	8,610868	3	.531		1
13. Amount of confidence	6,370779	4	.532		1
14. Stress and depression	1,263299	3	.142		1
15. Ignorance:					
a) Awareness of use of mild drugs leading to use stronger drugs	,9468362	1	.330		1
b) Awareness of psychological dependence	1,668404	1	.196		1
c) Awareness of addiction	1,382738	1	.239		1
d) Awareness of relationship with mental illness	,0898048	1	.764		1
e) Awareness of damage to health	1,646350	1	.199		1
f) Attitude towards legalization of illegal drugs	4,543210	1	.03	1	
16. Family support	1,333306	2	.143		1
17. Love of television	,7589050	3	.643		1
18. Heroin as related to other substances:					
a) alcohol	,3000339	4	.989		1
b) tobacco	2,490859	4	.646		1
c) spirits	4,414905	3	.220		1
d) amphetamines	,0058365	1	.939		1
e) barbiturates	,3529170	2	.982		1
f) hallucinogens	,1146628	3	.990		1
g) whiffer	,0354306	2	.982		1
h) sleeping medicine	,5307529	3	.912		1
i) dagga	74,17030	3	.00	1	
j) mandrax	315,9932	3	.00	1	
k) opium	172,3320	1	.00	1	
S - significant p <0,05					
NS - not significant					

Table 22. The level of use of mandrax as related to the various personal and social variables stated in hypotheses in Chapter 1.

Variables	CHI-SQUARE	df	P	S	NS
1. Age	1,263299	2	.531		1
2. Gender	,473940	1	.491		1
3. Year of study	6,552283	6	.253		1
4. Progress at university	9,573330	21	.983		1
5. Place of origin	1,358081	3	.715		1
6. Religiosity	29,10343	27	.355		1
7. Attendance of church	1,355320	3	.187		1
8. Family instability	2,280692	4	.119		1
9. Occupational status of parents or guardians	38,53973	12	.01	1	
10. Income of parents or guardians	23,47019	15	.07		1
11. Family history of use:					
a) father's use	1,827120	9	.993		1
b) mother's use	,2141937	9	.110		1
c) sister's use	,4815806	9	.999		1
d) brother's use	5,633560	9	.775		1
e) cousin's use	8,761838	9	.459		1
f) uncle and aunt's	2,330947	12	.998		1
12. Friend's use and abuse	8,610868	3	.531		1
13. Amount of confidence	6,370779	3	.532		1
14. Stress and depression	1,263299	4	.132		1
15. Ignorance:					
a) Awareness of use of mild drugs leading to use of stronger drugs	3,584045	3	.310		1
b) Awareness of psychological dependence	,7724645	3	.856		1
c) Awareness of addiction	4,316692	3	.229		1
d) Awareness of relationship with mental illness	,1802962	3	.980		1
e) Awareness of damage to health	17,42056	3	.00	1	
f) Attitudes towards legalization of illegal drugs	13,54741	3	.00	1	
16. Family support	1,33305	2	.143		1
17. Love of television	,758905	3	.643		1
18. Mandrax as related to other substances:					
a) alcohol	8,107474	12	.776		1
b) tobacco	7,187883	12	.884		1
c) spirits	12,07059	9	.209		1
d) amphetamines	,0117118	3	.999		1
e) barbiturates	,0708565	6	.999		1
f) hallucinogens	,2302011	9	1.0		1
g) whiffer	,0711365	6	.999		1
h) sleeping medicine	1,282103	9	.998		1
i) dagga	122,8391	9	.00	1	
j) heroin	315,9932	3	.00	1	
k) Opium	52,000	3	.00	1	
S - significant p < 0,05					
NS - not significant					

TABLE 23. The level of use of opium as related to the various personal and social variables stated in hypotheses in chapter 1.

Variables	CHI-SQUARE	df	P	S	NS
1. Age	,7500000	2	.678		1
2. Gender	,0	0	0		1
3. Year of study	2,746285	2	.364		1
4. Progress at university	3,005780	7	.884		1
5. Place of origin	,8926251	1	.344		1
6. Religiosity	3,199702	9	.955		1
7. Attendance of church	3,867865	2	.868		1
8. Family instability	2,354678	2	.378		1
9. Occupational status of parents or guardians	2,403315	4	.796		1
10. Income of parents or guardians	16,33147	7	.934		1
11. Family history of use:					
a) father's use	1,918648	5	.00	1	
b) mother's use	,3009954	3	.750		1
c) sister's use	,0	3	.959		1
d) brothers' use	,0143567	0	0		1
e) cousin's use	5,45968	3	.999		1
f) uncle and aunt's	6,998099	3	.908		1
12. Friends use and abuse	3,847413	4	.071		1
13. Amount of confidence	8,610868	3	.899		1
14. Stress and depression					
15. Ignorance	1,552004	1	.212		1
a) Awareness of use of mild drugs leading to use of stronger drugs	1,263299	2	.152		1
b) Awareness of psychological dependence	1,552004	1	.212		1
c) Awareness of addiction	,4698302	1	.498		1
d) Awareness of relationship with mental illness	,5304318	1	.466		1
e) Awareness of damage to health	,0297602	1	.863		1
f) Attitudes towards legalization of illegal drugs	,1185057	1	.730		1
16. Family support	4,438601	1	.031	1	
17. Love of television	1,33308	3	.143		1
18. Opium as related to other substances:					
a) alcohol	2,18976	2	.779		1
b) tobacco	,3763852	4	.984		1
c) sprits	,1584399	4	.987		1
d) amphetamines	,0678924	3	.999		1
e) barbiturates	,0019343	1	.964		1
f) hallucinogens	,0469567	2	.994		1
g) whiffer	,0379972	3	.998		1
h) sleeping medicine	,0474145	2	.994		1
i) dagga	,2504817	3	.979		1
j) heroin	42,33156	3	.00	1	
k) mandrax	172,3320	1	.00	1	
S - significant p < 0,05					
NS - not significant					

6.2.13 All substances taken together

The overall results of the associations between variables and the level of use of various substances showed that gender, family instability, family history of abuse, ignorance of drug effects, occupational status of parents or guardians, religiosity and love of television and movies were most commonly associated with the level of use of substances, while age, progress at university, year of study, place of origin, amount of confidence, depression, stress and parental approval were least associated with the levels of abuse of the substances.



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CHAPTER SEVEN

DISCUSSION

7.0 Introduction

The chapter will provide a discussion on the results that were obtained in the present study. To begin with, the prevalence of use and abuse of the various substances is discussed. This is followed by comparisons between the present results and the previous findings. Next a discussion of the association between various personal and social variables and the levels of use and abuse of the various substances is presented. This in turn is compared previous findings and as well as explained in terms of relevant substance abuse theories. Finally, an evaluation of the study is provided as well as suggestions for future research.

7.1 Prevalence of substance use and abuse

Overall, the present study shows that alcohol is the most widely used substance, followed by sleeping medicine, spirits and then tobacco, in that order. The level of use of alcohol was 22% and abuse was 5%, the level of use of sleeping medicine was 18% and abuse was 2%, the level of use of spirits was 6% and abuse was 1%, the level of use of tobacco was 4% and abuse was 9% and lastly the level of use of dagga was 2% and abuse was 3%. However, only tobacco, alcohol and dagga were abused by significant proportions of the participants in the sample. However, the levels of both use and abuse of the other substances studied such as amphetamines, hallucinogens whiffers, mandrax and opium were mostly negligible. Thus, contrary to the central hypothesis that there was not a very widespread level of use and abuse of substances at all. This is contrary to the findings of a study that was conducted by van der Burgh (1984), in South Africa in which he discovered that South

Africa too was to a large extent a drug-oriented society. Available evidence suggested, for example, that a large proportion of adolescents and adults in South African of all the population groups are involved in substance abuse.

The overall prevalence rate of substance use and / or abuse was found to be relatively low. This was even lower than the rates reported by Roche & Silva (1990, 1991) in studies carried out amongst urban and rural Black South Africans drawn from the general populace, let alone those statistics found in international studies, as well as local studies carried out amongst South African whites. It is possible that this was due to the fact that the sample was mostly female and as shown in previous studies, females tend to use and abuse substances far less than their male counterparts.

7.2 The associations between various personal and social variables and the levels of various substances.

This section will discuss the findings from the second part of the study which tested the various hypotheses about possible relationships between the use and abuse of substances and personal and social variables which were specified in Chapter 1. Several hypotheses were tested against both the use and abuse and the variables, this section discusses the findings from the second part of the study which tested the various hypotheses which were specified in chapter 1.

7.2.1 Age ✓

Of all the substances under investigation in this study, only the levels of use of alcohol was found to be associated with age. The younger participants were most likely to be users as compared to the older ones. Between ages 16 -18 the use of alcohol was 11%, between ages 19-24 it was 12% and 25 years and over the alcohol use was 4%. This finding is in agreement with the observations done by Akers (1991),

Bartimole (1987), Jason and Rhodes (1988) and Mieczkowski (1991) who found that alcohol use and abuse was more common among the adolescents than adults. The younger the individual the higher the chances of use and abuse could be expected. They also believed that substance use and abuse and maturity are related. Although there are obviously some exceptions, it is often the case with the majority of users. The results of the present study, as far as age is concerned, are not in line with those by Cohen (1983), who discovered that among adolescents between ages 16 to 25, 95% of them had tried alcohol, and 35% have tried heroin and dagga. The reason is that young people are less concerned with future consequences than older persons, and they are also less inclined to delay gratification including drug induced euphoria.

7.2.2 Gender

Gender was found to be associated with the use and abuse of alcohol, tobacco, spirits, sleeping medicine and dagga. Females both used and abused these substances more than males did. Alcohol use and abuse among females was 17% and males 10%, tobacco, females 6% and males 7%, spirits, females 4% and males 3%, sleeping medicine, females 11% and males 9% and dagga, females 3% and males 2%. These findings are in agreement with those of Akers (1991), Bartimole(1987), Rhodes and Jason (1988), Mieczkowski (1991) and Roche (1990). According to these authors, females use and abuse substances greater than among males because, among other reasons, a) they are seen as inferior to males and b) the stressful conditions they find themselves in whereby the society expects too much from them they. For example, they are expected to be mothers as well as to provide for their families.

7.2 3. Family Instability

Family instability was found to be associated with both the use and abuse of alcohol, tobacco, spirits, hallucinogens, sleeping medicine, dagga and mandrax. Essentially this suggested that students who came from broken families, had insufficient parental love and their parents marital relationships were disharmonious (which all threaten the child's emotional security), went on to become users and abusers of substances. These findings are in consistent with the observations of Bailey (1991), Glantz and Pickens (1992), Rowe and Gulley (1987) and Towberman and McDonald (1993). All these authors argue that family instability is associated with both the use and abuse of substances, and it did not matter whether the conflict was present while the child was growing or at present, the problem is still the same. They also argue that the family incompleteness as a result of death or divorce which result to loss of parental control, or overprotection by a single parent, leads to both use and abuse of substances by adolescents and young adults. Plant et al.(1985) also pointed out that positive family relationships, involvement and attachment appear to discourage adolescents initiation into drug use. In another study conducted in South Africa by Bezuidenhout and Rip (1988), it was discovered that unstable and disturbed family relationships were also found to be linked with incidence of dagga use, and adolescents from broken homes made more use of dagga as compared to adolescents from stable homes.

7.2.4 Family History of Abuse

The present study discovered that the family history of use and abuse of substances, was associated with the use of alcohol, tobacco, spirits, whiffers, sleeping medicine, dagga and hallucinogens. Thus, the use and abuse of these substances

could be genetic as it also occurred among brothers and sisters, as well as even aunts and uncles. Schilling (1990) also goes along with this view. He argues that the use and abuse of substances by the parents, often predicts the behaviour of the adolescents as far as drugs are concerned. If the mother or the father is using a substance, there are very high chances that the adolescents will do likewise. Plant et al.(1985) also support this view. They even go as far as saying that substance use and abuse move among families from one generation to the next.

Akers (1991) argues that, there are norms and beliefs and values that shape the behaviour of an individual. The individual has to conform with the standards of parents and the family whereby substance use and abuse is regarded as deviant behaviour among the family. The social bonding has therefore to be made so strong so that the growing adolescents do not give in to the external pressure. Akers also believes that the adolescents do not use and abuse substances because there is a family history of use and abuse, but it is because when they begin to use the substance they are labelled as addicts, and according to him the deviant behaviour is encouraged by the labelling theory.

Another divergent viewpoint to the genetic interpretation is that of Langer and Richards (1971) who believe that not all the children whose parents have a history of use and abuse adopt the same behaviours. According to these authors, some offspring of abusers hate the drugs because of the destruction they have caused to their families and also they want to prove to the community that substance use and abuse are not genetic.

7.2.5 The Friend's use and abuse

The present study discovered that friends use and abuse of substances, was

associated with the level of use of alcohol, tobacco, spirits , sleeping medicine, dagga and mandrax. This finding is consistent with that obtained in a similar study that was conducted in South Africa by van der Burgh (1985)who also discovered that substance use and abuse was associated with peers and friend's substance habits. Most of the adolescents who used and abuse substances, had friends that were users and abusers of substances. According to van der Burgh, the users and abusers were conforming to the group and thinking that if they did not do likewise they were going to loose out on their friendships.

Akers (1991), Bartimole (1987), Mieczkowski (1991), Roche (1990) and Rhodes and Jason (1988) do not concur with this abovementioned view. Instead they believe that friends can also develop strong positive bonds, which can protect against the deviant behaviours, such as substance use and abuse. Engaging in substance use and abuse, which is referred to as deviant behaviour, will jeopardize that commitment. The stronger the bond, the lesser the chances to engage in deviant behaviour. The weaker they are, the likely the adolescent is to commit deviant act. Therefore, conformity in the group of students which was studied in the present study had a negative effect on use and abuse of substances.

7.2.6 Ignorance of the effects of drugs

The present study discovered that the participants were not aware of the fact that the use and abuse of legal drugs such as alcohol, tobacco, sleeping medicine and spirits is related to damage to health, leads to psychological dependence, could lead to use of stronger drugs, and ultimately that drug dependence and / or addiction can be caused by their repeated usage. As far as tobacco is concerned the participants were not aware of the fact that the use of mild drugs leads to use of stronger drugs,

addiction, psychological dependence, damage to health and relationship with mental illness. Concerning spirits, the participants were not aware that the use of mild drugs leads to use of stronger drugs, psychological dependence, addiction and damage to health. As far as sleeping medicine is concerned, the participants were not aware that the use of sleeping medicine leads to psychological dependence, addiction and has a relationship with mental illness.

Concerning dagga, the participants were not aware of the use of mild drugs leads to use of stronger drugs, psychological dependence, addiction and relationship with mental illness. As far as amphetamines is concerned, the participants were not aware of the use of mild drugs leads to use of stronger drugs, psychological dependence, addiction and damage to health. Concerning barbiturates, the participants were not aware of the use of mild drugs leads to use of stronger drugs, psychological dependence, addiction, relationship with mental illness and damage to health. As far as heroin is concerned, the participants were not aware of use of mild drugs leads to use of stronger drugs, psychological dependence, relationship with mental illness and damage to health. Concerning mandrax, the participants were not aware that the use of mild drugs leads to use of stronger drugs, psychological dependence and addiction. Concerning opium, the participants were not aware of use of mild drugs leads to use of stronger drugs, psychological dependence, addiction, relationship with mental illness and damage to health. As far as hallucinogens is concerned, the participants were not aware of the use of mild drugs leads to use of stronger drugs, psychological dependence, addiction and damage to health. As far as whiffers are concerned, the participants were not aware of the use of mild drugs leading to use of stronger drugs, psychological dependence, addiction, relationship with mental illness and damage to

health.

These findings are partly consistent with those obtained by Akers (1991), Bartimole (1987), Mieczkowski (1991), and Rhodes and Jason (1988) who discovered that substance use and abuse is high in the lower-class slum area. The main reason being that they are not aware of the damage that is caused by substances, such as damage to health, relationship with mental illness, psychological dependence, addiction and the use of mild drugs leads to use of stronger drugs.

7.2.7 Progress at University

The present study discovered that the progress at university was associated with the use and abuse of dagga (marijuana) and it was used and abused more by students who performed poorly academically. This substance presumably makes them see their poor performance as a minor problem. Bennett et al. (1991) believe that difficulties in school may cause use and abuse of substances because when the students cannot cope at school they resort to drugs. Bailey (1987), Glantz and Pickens (1992), Rowe and Gulley (1987) and Townberman and McDonald (1993) also argued that substance use and abuse is associated with academic failure. According to them, students who make progress at school do not engage in either use and abuse of substances. In fact they associate the use and abuse of different substances with a low degree of commitment at school.

7.2.8 Depression and Stress

The present study failed to find any significant relationships between the level of substance use and stress and depression. There is however a possibility that the measurement of stress and depression as related to substance use and abuse as was done in the present study, was both unreliable and invalid. There is therefore a need

to reinvestigate both these variables but this time using proper and standardised tests.

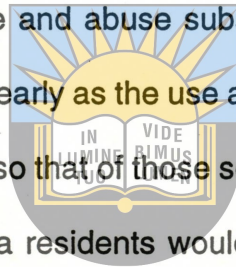
The finding disagrees with the findings reported in a study that was conducted in South Africa by van der Burgh (1985) whereby substance use and abuse was associated with stress and depression and even anxiety. According to van der Burgh, lower-class slum areas such as from where the majority of the respondents in the present study came from were associated with high use and abuse of the various substances because of the stressful conditions they live under. The lack of money to fulfil their aspirations lead to depression and they get relief from both the use and abuse of substances. Bennett et al. (1991) also strongly believe that stress and depression are associated with use and abuse of substances. According to them, the adolescents and young adults that are depressed feel better after they have taken a drug. The drugs act as a form of an activator to them because they become hyperactive after a sip of liquor, and they forget about the depressing issue for a moment. Also the stressed adolescents relieve their stress by taking a drug and they do get some temporary relief from the drug that they have taken.

7.2.9 Occupational status and income of parents or guardians

The present study discovered that there were significant relationships between the income and status of a parents or guardians and the level of use of alcohol, tobacco, barbiturates, heroin, mandrax and opium. More particularly, participants who came from families of low income and low status were more likely to use and abuse these substances. It is possible that the poor conditions that they live in and the poverty they face lead them to both use and abuse of these substances. They use and abuse the substances as a form of escaping from the adverse conditions they live

in. Akers (1991), Mieczkowski (1991) and Roche (1990) also argued that the lower-class slum area is associated with both the use and abuse of substances because of their living conditions, lack of food, lack of money to buy clothing and also lack of money to educate themselves. These over-stressing conditions lead the children to use and abuse substances to get some relief and to feel good. They also do so because they have nothing to do, and thereby keep themselves busy by engaging in drugs.

However, Bartimole (1987) disagrees with this analysis because not all people who live in lower-class areas use and abuse substances, but instead work hard in order to make their lives better. Clearly as the use and abuse of substances disrupts not only the lives of the abusers but also that of those social networks, including their own families, the lower-class slum area residents would be making a serious mistake to think that substance use and abuse is a solution to their problems.



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7.2.10 Religiosity

The present study discovered that there were significant relationships between religiosity and the levels of use of alcohol, spirits, tobacco, hallucinogens and dagga. Probably this was because the use and abuse of substances is discouraged by some churches and therefore against religious rules. In general, participants who were church members and were attending the worship services did not use and abuse these substances as much as did those who were non-church members and those who were not attending any services. This finding is in line with Bennett et al's (1991) findings that churches have values, rules and norms that must be kept by their members including dangers of substance use and abuse. It is these values that prevent the members to engage in drug use and one has to keep the rules if s/he

wants to continue as a member. The social bonding theory that was developed by Akers (1991) also appears to explain this relationship quite well indeed. According to this theory, people are internalized against a deviant behaviour by strong bonds than are developed in a group, and it is these bonds that can help the individuals to fight against the external pressure to engage in any deviant behaviour and hence keeps them away from substance use and abuse.

7.2.11 Year of Study

The year of study was found to be associated with use and abuse of alcohol tobacco and spirits. In particular, the first-year students were most likely to both use and abuse substances than more senior students. This finding is consistent with that obtained from a study that was conducted in the University of Port Elizabeth by Kota (1994) among mostly white students who also discovered that there was a higher rate use of substances among the first years than amongst more senior students. Kota accounted for this as being mostly due to the peer pressure, immaturity and the misuse of the freedom of controlling their own lives.

7.2.12 Place of origin

The present study found no significant association between the levels of use and abuse of the twelve substances that were studied and place of origin. These findings are not in line with those by Olivier (1973) who discovered that substance use and abuse is more rife in urban than rural areas. This is due to the fact that adolescents and young adults from the urban areas are more exposed to both the use and abuse of substances as opposed to those in the rural areas.

In the two local studies conducted by Roche and Silva (1990, 1991) among Black South Africans in both rural and urban areas, it was found that LSD and heroin

were mainly an urban affair. The urban and rural students in the present study were more or less equal, where urban respondents comprised 52% and rural 48%. The reason that there is no significant association between substance use and abuse and place of origin is that today, substance use and abuse is as high in rural areas as it is in urban areas, the conditions such as exposure and availability are similar.

7.2.13 Love of Television and Movies

The present study discovered that there were significant relationships between the love of television and movies and the levels of use and abuse of alcohol and barbiturates only. Both television and movies use exciting adverts for substances and associate the substances with people that are highly respected and in that case they are able to influence the adolescents and young adults. According to Bailey (1987), Glantz and Pickens (1992), Rowe and Gulley (1987), Towberman and McDonald (1993) attitudes that are favourable to substances in the media are the possible causes of early onset of both substance use and abuse. The way the substances are advertised on television, encourage the adolescents and young adults to use and abuse various substances, and this is exacerbated by the fact that in the movies substance use is often associated with people with high prestige. The influence that the television and the movies have on the adolescents and the young adults must not be underestimated. However, the evidence is not completely convincing. As a matter of fact, even though anti-drug education is also on television and in movies it is not as exciting nor formal advertising and hence its ineffectiveness in some cases.

7.2.14 Lack of Confidence

The present study failed to find any significant relationship between lack of confidence and the levels of use the twelve substances that were studied. Thus, this

hypothesis was completely rejected. The above finding disagrees with the observations by Akers (1991) and Mieczkowski (1991) who both believed that there was an association between the lack of confidence and substance use and abuse. According to them, substances maximize positive self attitudes. For example, when the adolescents are to perform in front of the public, they take drugs to build their confidence. They believe that the drugs have a way of dealing with their fears and anxiety. The disadvantage is that they become dependent on the drugs.

7. 2. 15 The Parental Approval

The present study showed that the parental disapproval was not associated with both the level of use of substances. Thus, most of the students that used and abused substances did so irrespective of whether or not their parents approved the habit. This contradicts discoveries of a study that was carried out in the PWV region by Emanuel and Olivier (1995) who revealed that adolescents and young adults use and abuse substances because their parents failed to discipline them. They engage in drugs out of mere curiosity.

7. 2. 16 Use of other substances

The present study also showed that the level of use of one substance may lead to the use and abuse of another although this is not always the case. For example, the levels of use of alcohol was strongly associated with the levels of use of tobacco, sleeping medicine and dagga. Similarly, the levels of use of tobacco was associated with the levels of alcohol, spirits, sleeping medicine and dagga. The levels of use of spirits was associated with that of alcohol, sleeping medicine and dagga. The levels of use of amphetamine was associated with the levels of use of barbiturates and hallucinogens. The levels of use of barbiturates was associated with the levels of use

of amphetamines and hallucinogens. The levels of use of hallucinogens was associated with the levels of use of amphetamine, barbiturates, sleeping medicine, whiffers and dagga. The levels of use of sleeping medicine was associated with the levels of use of alcohol, tobacco, spirits, hallucinogens, whiffers and dagga. Finally, the levels of use of dagga was associated with the levels of use of alcohol, tobacco, spirits, hallucinogens, whiffers, sleeping medicine, heroin, mandrax and opium. These findings agree with Schilling (1990) observations that adolescents tend to begin with a certain entry such as liquor or tobacco, then consequently progress to dagga and finally to stronger and harder drugs like heroin. However, this does not happen to every user and abuser because there are those few that manage to keep their use to a single substance.



These findings are also confirmed by the results from the Guttman Scale carried out by Levine (1978) and whose results were indicated that most hard drug users had used alcohol cigarettes and dagga in their lifetime. There were those participants who had used drugs in a pattern that was not consistent. For example, there were those who had used amphetamines, barbiturates, and hallucinogens only, and those who had started from sleeping medicine then progressed to alcohol then stronger drugs. This also proved the fact that the use of prescribed medicines may lead to use of other drugs. Levine (1978) in his Guttman scale based study also discovered that 10% of his participants tried drugs in a pattern that was not consistent. According to him, there were “error types” of groups, and these were those that had smoked cigarettes but had not tried alcohol and those who had tried alcohol and dagga, but not cigarettes.

7.3 Limitations of the present study

In conclusion, the present study has made a contribution in this area of substance use and abuse especially because it was carried out among Black University students. This is because most of the studies of this kind have mostly been done among White University students and their findings were generalized as if they provided the full picture of South African students when they did not. This issue is particularly important when considering the legacy of apartheid whereby the non-white populace were discriminated against in every way possible: socially, politically, economically and religiously.

Although it was based on a relatively large sample, the present study had several limitations and or shortcomings. Firstly, it failed to find out the source of different substances used/ abused by respondents. In order to keep control of the problem of substance abuse, it is important to know where the students get the drugs from. Secondly, the study did not cover students from all the faculties of the university, although it did include psychology students drawn from majority faculties at the University of Fort Hare. Only two smaller faculties that were excluded. To involve the whole student body in the study is only possible theoretically but not practically. Initially the study had proposed to have convenient sample of about 1000 students, but due to problems that were beyond the researcher's control, that was not possible. The researcher was ready to collect data in September, but unfortunately the students were engaged in class boycotts. The data was therefore collected in October which was not a good month because the students were busy preparing for their final year examinations. Thirdly the study could have been more reliable if the amount of substances taken by each student could be measured in specified units. For example,

the questionnaire should have asked how many bottles of beer or amounts of other substances each student took daily. However, it might not have been easy to get that kind of information. Furthermore the researcher had to rely on the respondents' own assessments of their home environment, their perceived relationship with friends and their self-reporting of the extent of substance use and the like. Clearly, social desirability bias is possible, in that the respondents might have wanted to give the impression that there are good relations among the family so, and therefore reliance had to be made on the accuracy and honesty of the respondents, their extent of use and abuse and other personal attributes. This of course might have placed a further limitation on the generalizability on the findings from this study.

7.4 Suggestions for future research

The present study has paved the way for more research to be done among Black students. It can be seen as a point of departure for more research. More research should be done on specific issues such as depression and stress and personality to see how they are related to substance use and abuse. More research should also be conducted to evaluate the effectiveness of health education in prevention of substance abuse among this sector of the population.

Finally, Black people also need to be educated about the importance of the research in general. They should be made aware that their participation and the information that they provide is very important in building their own country. For example, the successful implementation of the Reconstruction and Development Programme(RDP) will dependent on the research that is conducted.

7.5 Summary

The chapter provided discussion of the results that were obtained in the present study. The prevalence of substance use and abuse was discussed, followed by comparisons between the present results and the previous findings. The limitations and suggestions for the future research were also presented. The following chapter, Chapter 8 will provide possible intervention programmes as well as conclusions that can be drawn from the present study.



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CHAPTER EIGHT

IMPLICATIONS FOR SUBSTANCE ABUSE PREVENTION AMONG BLACK UNIVERSITY STUDENTS AND CONCLUSIONS.

8.0 Introduction

This the final chapter commences with a discussion of the various prevention strategies of substance abuse such as information and education programmes, skill-based strategies, and community-based prevention that take into account the findings of the present study as discussed in the previous chapter. Finally, conclusions are presented.

8.1 Substance Abuse Prevention

Substance abuse prevention is often referred to as "war on drugs". Unfortunately, despite the budgetary allocations, and the media campaign on anti-drug efforts, there are no easy solutions to the problem. Substance abuse among youth remains a complex problem that presents a significant challenge to mental health practitioners. Meeting the challenge will involve incorporating current knowledge concerning the development of adolescents substance abuse into comprehensive primary prevention strategies (Davidson & Neale, 1986).

Primary prevention strategies for children and adolescents include the following:

- a) Information and education programme,
- b) Skills training, and
- c) Community-based prevention programmes.

Each of the strategies and how they can be incorporated into a substance abuse prevention programme are discussed below.

8.1.1 Information and Education Programmes

Drug education programmes provide people with information regarding the health hazards and social consequences of drug taking when using this approach, the adolescents need to be provided with the necessary factual information. Once aware of the relevant facts, they can and presumably, will choose to adopt healthy lifestyle patterns.

The present study discovered that students were ignorant as far as the damage caused by drugs, especially the legal substances. In fact, they did not regard alcohol, tobacco, and spirits as drugs, so this provides the proposed educational programme with a point of departure for intervention.

The education on drugs that is provided by television only caters for those who have television sets and those who can read and understand English because it is mostly presented in English. The people in slum areas who are equally affected by both substance use and abuse are left out. As long as the slum area residents are excluded from educational programme, the problem will still continue. Anti-drug campaigns on radio as well as posters and drama in community institutions such as clinics and hospitals will also assist in this regard.

Although such programmes have led to increase in knowledge, they have been ineffective in decreasing substance usage. Probably the most important reason is that this type of approach does not have a strong impact on adolescents; it does not leave room for discussion of the variety of reasons for which people use alcohol and other substances. Secondly, the problem with this informational approach is that there are contrary findings concerning some of immediate and long-term physical, mental and social effects of some substances. For example, recent research suggested that

moderate alcohol use may actually protect against certain chronic disease and some adolescents may find that the information presented in the educational programmes contradicts their own experiences (Laporte, Cresantas & Killer, 1985 in Rhodes & Jason, 1988).

8.1.2 Skill - Based Strategies.

Skill based strategies aim to enhance the social coping skills of youth in order to discover the influence and pressure to use drugs. Rhodes and Jason (1988) believe that there are three main sources of pressure to smoke in an adolescent environment. Most influential were peer pressure, parental and media messages. By gradually exposing children to social settings where pressure to smoke may exist, they have time to formulate and practice strategies to use in the future when faced with peer pressure to engage in smoking. In these programmes, the emphasis is not on convincing the adolescents not to smoke. Rather through repeated exercises such as role playing and practice, the youth develop skills to resist pressure to smoke (Rhodes & Jason, 1988).

The peer groups must not always be seen as negative. There are those that are positive which share values and beliefs that regard drug use and abuse as deviant. The members develop attachment to the group in so much that even in the absence of other members she or he can say no to drugs. The adolescents therefore must choose good company that will discourage any deviant behaviour.

The adolescents must be taught to be responsible for their own lives, they must not be dependent to their parent, because they will behave differently when they do not see their parents. In the present study the students mentioned that regardless of whether their parents agreed or disagreed with the use and abuse of different substances, they just ignored them. This only shows that the relations between the

parents and their children were not good. The parents should first work on the relations with their children, and create a conducive environment for the children to be free to share whatever problems they have, and in the process the parents can educate the children about the life hazards. However, they must be careful not to dictate too much because this is where the problem starts. Finally, the anti-drug education on television should be presented in all languages to be able to reach the majority of the population, most of whom are illiterate.

8.1.3 Community - Based Prevention.

Community-based programmes attempt to influence not only the adolescents but also the ecological variables that influence substance usage. By integrating preventive efforts in the family, school, the community and the media, this approach addresses the individual as well as the broader social and environmental factors of substance abuse.

In the present study, most of the students started to use drugs at high school. Drug education therefore should form part of the high school curriculum, especially in Black schools where there is lack of knowledge about the danger of drugs to one's health. Bringing drug education into schools may lead to children to comply with the anti-drug message. The children would be able to get some clarification about problems they might have and they may even come up with suggestions on how to make the anti-drug education programmes more exciting.

The problem of television and movies which advertise drugs through exciting and irresistible adverts, should do the same with the call against drugs. They could even do away with the adverts or movies where they associate alcohol and other drugs with people with high prestige.

Adolescents spend the majority of their time outside of school, and most substance abuse occurs outside of school. Youngsters spend most of their time in the home, and this is where poor family management and communication can lead to substance use and abuse. In addition, many young people spend a large portion of their time home watching television, where drug-taking activities are positively portrayed. For these reasons the community must be actively involved in fighting against drug use and abuse.

8.1.4 An alternative approach

A holistic approach should be followed with regard to the prevention as is the case with the treatment. This takes into account the physical, psychological, spiritual, economical, and social dimensions of the human beings as discussed below. Since the present study had proved that the initiation of drugs starts as early as high school, drug education should therefore start at this level. Parents should work together with the teachers in educating the adolescents, also they should be good models for their children. If the society can work together as a system in helping adolescents, positive results can be achieved.

8.1.4.1 Physical Dimension

Promoting a healthy life style should include the responsible use of legal substances and non-use of illegal substances. Harmful effects of drugs on the body and on the mind should also be stressed in health education. The negative effects of alcohol on unborn babies should be taught at high school level in order for every young girl to know the dangers before she falls pregnant. The community health workers should be trained to identify and treat early signs of drug dependence.

8.1.4.2 Psychological Dimension

Training in life-skills should be imparted to children of all age groups. School-based programmes and policies should be supported at primary school level by the community, and be consistent with other interventions such as parenting programmes and policy initiatives. Adults should be guided on how to handle stress without the use of drugs. The media could play an important role in conveying a clear message about a healthy life style.

8.1.4.3 Spiritual and Social Dimension

Religious leaders and church organizations could become active in prevention and treatment programmes. Counselling by religious leaders play an important role in the prevention of drug abuse. The Reconstruction and Development Programme (RDP) mentions the role of community-based rehabilitation centres and the fact that public accountability must be developed (ANC, 1994). The RDP also suggests that provincial departments must be responsible for social services at preventive and curative levels. Communities should play an active part in combatting the drug problem in their own area through taking responsibility and acting against the exploitation of the youth. Communities should take a stand against irresponsible advertising or oversupplying of alcohol by the presence of too many shebeens and taverns. Positive peer groups should also play an important part in prevention.

8.1.4.4 Economic Dimension

Employee Assistance Programmes should be presented in certain big industrial organizations. Every worker in the country should be access to such programmes, especially in the prevention of alcohol and drug abuse. This could lead to early identification of the problems as well as preventing of accidents in the work place,

saving the country thousands of Rand. Combatting drinking and driving should also be an integral part of prevention, thereby also saving lives.

8.2 Summary

The present study investigated prevalence of substance use and abuse among Black university students. Firstly, it examined the extent to which the university students abuse various substances such as alcohol, tobacco, spirits, amphetamines, barbiturates, sleeping medicine, hallucinogens, heroin, mandrax, dagga whiffers and opium. Secondly, it investigated the variables that are associated with both use and abuse of these substances.

The overall results showed that alcohol was the most widely used (22%), followed by sleeping medicine (18%), spirits (6%) and tobacco (4%) in that order. However only tobacco (9%), alcohol (5%) and dagga (3%) were abused. Out of the seventeen hypotheses that were tested only three, namely, those about the effects, place of origin, amount of confidence, stress and depression, were rejected.

Possible relationships between the levels of substance use and various personal and social variables mentioned in hypotheses in Chapter 1 were tested using chi-square test. The results of the chi-square tests show the significant relationships between the level of use of alcohol and gender, year of study, church attendance, family instability, income of parents or guardians, father's and mother's use and abuse of alcohol, cousin's, uncle's and aunt's and friends use and abuse of alcohol, amount of confidence, stress and depression, ignorance of the use of drugs lead to damage to health, mental illness, the levels of use of tobacco, spirits, sleeping medicine and dagga.

There were significant relationships between the level of use of tobacco and gender, year of study, church attendance, family instability, occupational status of parents or guardians, father's, cousin's, uncle's and aunt's use and abuse of tobacco, friend's use and abuse of tobacco, amount of confidence, stress and depression, attitude towards legalization of illegal drugs, family support, love of television, the levels of use of alcohol, spirits, sleeping medicine and dagga.

There were significant relationships between the level of use of spirits and gender, year of study, occupational status and income of parents or guardians, family instability, brother's, cousin's, uncle's and aunt's use and abuse of spirits, family support, love of television, ignorance on the use of drugs leading to mental illness, friends' use and abuse of spirits, the levels of use of alcohol, tobacco, sleeping medicine and dagga.

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There were significant relationships between the level of use of sleeping medicine and gender, occupational status of parents or guardians, family instability, mother's, sister's, cousin's uncle's and aunt's use and abuse of sleeping medicine, love of television, family support, ignorance of the use of mild drugs leading to use of stronger drugs, damage to health, the levels of use of alcohol, tobacco, spirits, hallucinogens, whiffers and dagga.

There were significant relationships between the level of use of dagga and gender, church attendance, family instability, brother's, cousin's and friends' use and abuse of dagga, ignorance of the use of mild drugs leading to use of damage to health, attitude towards legalization of illegal drugs, family support, love of television, the levels of use of alcohol, tobacco, spirits, whiffers, sleeping medicine, heroin, mandrax and opium.

There were significant relationships between the level of use of amphetamines and religiosity, attitude towards legalization of illegal drugs, the levels of use of barbiturates and hallucinogens.

There were significant relationships between the level of use of barbiturates and church attendance, family instability, occupational status of parents or guardians, sister's and friends' use and abuse of barbiturates, levels of use of amphetamines and hallucinogens.

There were significant relationships between the levels of use of heroin and occupational status of parents or guardians, attitude towards legalization of illegal drugs and the levels of use of dagga, mandrax and opium.

There were significant relationships between the level of use of mandrax and occupational status of parents or guardians, ignorance of the use of drugs leading to damage to health, attitude towards legalization of illegal drugs, the levels of use of dagga, heroin and opium.

There were significant relationships between the level of use of opium and father's use and abuse of opium, family support, the levels of use of dagga, heroin and mandrax.

There were significant relationships between the level of use of hallucinogens and progress at university, brother's, cousin's, uncle's and aunt's use and abuse of hallucinogens, ignorance of the use of drugs leading to mental illness, the levels of use of amphetamines, barbiturates, whiffers, sleeping medicine and dagga.

Finally, there were significant relationships between the level of use of whiffers and church attendance, friends' use and abuse of whiffers, the levels of use of dagga, heroin and mandrax.

8.2.1 Implications of the results for substance abuse prevention

Having presented the results of the present study, it is therefore proper to provide some advices as to what to be done to fight against the problem of drug use and abuse that faces the society. The present study discovered that females take more alcohol and other drugs than males. This is probably because of the stressful conditions they find themselves in and because they are fighting for equality to males. The female should be educated that engaging in drugs won't prove anything instead they are destroying themselves. There are so many avenues that they can prove themselves to be equal to males, for example, educational wise. Also the work load should be divided equally between males and females at home, so that is it manageable to both parities, maybe drinking rate will drop. This is a process that should be started during the period of socialization. The parents should refrain from dividing household work among males and females, the kitchen for both males and females, maybe this can provide some form of help.

The present study discovered that the year of study is associated with the use and abuse of drugs. The first year students at university take more drugs as compared to third years. The problem is that the first years are abusing the freedom they find themselves in, there are no parents around them to say no. Secondly, the peer pressure is the problem, they are not quite sure of what they want and they problems with time management. The parents therefore should teach their children to be responsible for their own lives, they should prepare them for the cruel world, and they should acknowledge that fact that there is no way that they will always be there for them. Maybe that can help a bit.

The youth should also choose good friends that they can learn from them. The peer pressure tend to overpower the parental teachings, choosing good friends may therefore counteract bad influence from bad friends. Drug education should also start as early as high school because this is mostly where drug initiation takes place. Also the vocational guidance should be practised in schools because most of the student pass Standard 10 without knowing exactly which career to follow. They find themselves in universities because they are sent by their parents. They don't make any progress, and out of frustrations they end up taking drugs. Some do not even attend the orientation programme at university where they can be guided about things like time management, what career they can follow. Maybe if these flaws are corrected drug rate will drop.



Church attendance has been discovered to discourage drug initiation. It is a shame that most of the youth is not attending any church services because they claim services are boring. It is therefore the duty of the church to develop programmes that can attract the youth to the church. It is when they have won them to their side that they can learn things like the dangers of drugs, and the values and norms of the society. This can offer some contribution as far as drug use and abuse is concerned.

The present study also discovered that family instability is one of the variables that lead to drug use and abuse. Youth who come from broken homes tend to use drugs more as compared to those who come from stable families. Psychologists could be of some help to these children. They should be made aware that this is not the end of the world, they can educate themselves and make a brighter future for themselves instead of destroying themselves with drugs. They can instead learn from the mistakes that were made by their parents that might have led them to divorce.

They should pick up any pieces that are left and move on with their lives.

Occupational status and income of parents or guardians were also discovered to be associated with drug use and abuse. Youth who come from poor families tend to be drug users as compared to those from rich families, because they see life as hopeless to them. These children should be educated that education can be the answer to their problems, their situation is not hopeless and the fact that they are born poor does not mean that they will stay and die poor. Life is a challenge that they must be ready to face, and drugs are not the way to their future but instead they are retarding their progress. Maybe by making the youth see the light that can contribute to reducing the drug use and abuse among them.

Family history of use and abuse of drugs was found to be associated with the adolescents' use and abuse of drugs. The parents should be good role models to their children, because they are seen to be examples by their children. The parents must not drink in front of their children because some of the children drink because they have seen their fathers drink and they want to be like their fathers. The parents should instead educate their children about the dangers of drug use and abuse. If the parents can work together with other structures of the communities on anti-drug campaigns, that can help because the children believe more in their parents than in strangers.

The present study did not discover that adolescents who lack confidence in themselves tend to use and abuse drugs as compared to those who are confident. However, the children should be taught at an early age to believe in themselves. The parents have the key roles in helping the children develop positive attitudes about themselves. By the time the child is in a school going age he or she is positive about

himself or herself. The problem is that the parents themselves do not know how to help their children develop positive attitude towards themselves. This is the challenge to the psychologist to prepare the mother for their kids. They should work together with the medical staff that prepare the mothers physically, they should prepare them psychologically. The psychologists should make their services available to the people. The present researcher strongly believes that their services can be successful in fighting against drug use and abuse in this way.

Stress and depression were not found to be associated with both drug use and abuse. However, youth and adolescents ordinarily take drugs because they want to relieve stress and depression. They do not know that drugs can only offer a temporal relief. Thus, this also becomes the duty of the psychologist to help the youth to develop coping skills and that can reduce drug use and abuse.

The present study also discovered that the adolescents are not aware of the damage that can be caused by drugs to their bodies. Drug education should be offered in schools and by the community organizations, and the anti-drug campaigns should be organized in all languages. If the community can work together as a system, positive results can be expected.

The present study also discovered that the use of one drug can lead to the use of others. The adolescent may start by taking alcohol or tobacco and the progresses to stronger drugs. The youth should be discouraged from drug initiation. Abstinence should be emphasized as the solution to the problem. Although this is a very difficult task for the community, it is worth giving it a try.

Love of television and movie were also found to be associated with drug use and abuse. The television adverts should also emphasize the negative side of drug

use and abuse. These should be done in such a way that the message is carried through to the people, and this should be done in all languages so that no one is left out in the process of education. Radios should also offer the same education for those who do not have television sets.

Finally, the present researcher strongly feels that the present study will make some contribution to the well-being of the community, and more research should be done to correct some of its flaws.



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APPENDIX A

QUESTIONNAIRE ON SUBSTANCE USE AND ABUSE

Supervisor: Prof. L. C. Simbayi

Researcher : N. Hewana

BACKGROUND INFORMATION CONCERNING THE STUDY



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The Department of Psychology at the University of Fort Hare is currently conducting a number of research projects on a variety of topical issues affecting today's society.

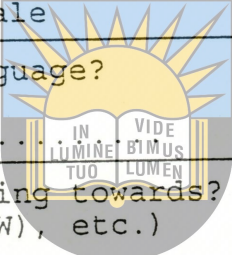
One of the issues being looked into is that of substance use and abuse which affects everyone in one way or another.

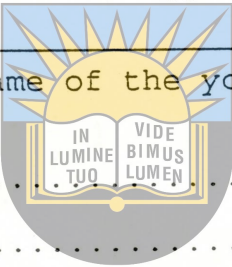
Despite its obvious significance, very few studies have been conducted on this issue in South Africa especially in the Black communities and hence the present study.

This questionnaire asks pertinent questions about substance use and abuse. You are asked to complete it as honestly as possible : Apart from signing a separate informed consent - form which explains to you about your rights as a participant in this survey, you will not be required to disclose your name anywhere on the questionnaire.

In this way, the information that you provide will be completely anonymous. Also remember there are no right or wrong answers.

QUESTIONNAIRE ON SUBSTANCE USE AND ABUSE ON CAMPUS

		OFFICIAL USE ONLY
<p>SECTION A</p> <p>PLEASE PROVIDE THE FOLLOWING INFORMATION ABOUT YOURSELF BY EITHER FILLING IN THE EMPTY SPACE OR MARKING WITH A CROSS (X) IN THE APPROPRIATE BOX</p>		
<p>1. How old are you?</p>		
<p>2. Are you male or female? Female Male</p>		
<p>3. What is your home language?</p>		
<p>4. What degree are studying towards? (e.g. BA, B.Sc, BA (SW), etc.) </p>		
 <p>University of Fort Hare <i>Together in Excellence</i></p>		
<p>5. When did you commence your studies?</p>		
<p>6. What year of study are you in? (e.g. 1st, 2nd, 3rd etc)</p>		
<p>7. What test mark did you get in your psychology course this (last) semester ?</p>		
<p>8. When do you hope to complete your studies?</p>		
<p>9. Did you grow up in urban (town) or rural (country) area ? Urban ① Rural ②</p>		
<p>10. What church do you belong to?</p>		

		OFFICIAL USE ONLY
<p>11. How often do you attend worship services on the average?</p> <p style="text-align: center;">Every week</p> <p style="text-align: center;">Once or twice a month</p> <p style="text-align: center;">On religious holy days only</p> <p style="text-align: center;">Not at all</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<p>12. Do you belong to any youth club or society?</p> <p style="text-align: center;">Yes</p> <p style="text-align: center;">No</p>	<input type="checkbox"/> <input type="checkbox"/>	
<p>13. If yes, specify the name of the youth club or society.</p> <p>.....</p> <p>.....</p> <p>.....</p> <p style="text-align: center;"></p> <p style="text-align: center;">University of Fort Hare <i>Together in Excellence</i></p>		
<p>14. a) Have you ever received any health education in any of the organizations specified above?</p> <p style="text-align: center;">Yes</p> <p style="text-align: center;">No</p> <p>b) If yes, on what health issue(s)?</p> <p>.....</p> <p>.....</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<p>15. a) Are you currently using any prescribed medical drug(s)?</p> <p style="text-align: right;">Yes</p> <p style="text-align: right;">No</p> <p>b) If yes, specify which drug(s)</p> <p>.....</p> <p>.....</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

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16. How frequently do you use these prescribed medical drugs on average each month ?

.....

17. Using a scale from 1 - 5 rate your own personality on following dimensions by circling the appropriate rating. In order to assist you, a glossary of the terms as provided below.

- with (1) Strongly disagree
(2) Disagree moderately
(3) Neither agree nor disagree
(4) Agree moderately
and (5) Strongly agree



Extraversion or Surgency 1 2 3 4 5

Agreeableness or Pleasantness 1 2 3 4 5

Conscientiousness 1 2 3 4 5

Emotional Stability 1 2 3 4 5

Culture or Intelligent 1 2 3 4 5

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Definition of Terms

Extraversion or Surgency - talkative, bold, active, outgoing etc.

Agreeableness or Pleasantness - warm, kind, cooperative, flexible etc.

Conscientiousness - organized, responsible, hardworking, efficient, etc.

Emotional Stability - relaxed, secure, steady, peaceful. etc.

Cultured or intelligent - artistic, wise, creative, imaginative. etc.

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SECTION B

PLEASE INDICATE YOUR RESPONSE TO THE FOLLOWING QUESTIONS BY MARKING WITH A CROSS (X) IN THE APPROPRIATE BOX OR FILLING IN THE EMPTY SPACE PROVIDED

18. For most of your life, you were brought up by your:

father and mother, both living at home

father (separated or divorced from mother)

mother (separated or divorced from mother)

father (mother deceased)

mother (father deceased)

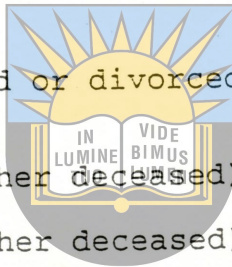
father and step mother

mother and step father

some other relative (Please specify nature of relationship)

.....

a non-relative



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19. How would you describe your relationship with your parents, or guardian, WHILE YOU WERE GROWING UP?

very good (we were very close)

all right (we got along but were not close)

indifferent (we didn't communicate very much)

not good (we disagreed and argued frequently)

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20. How would you describe your relationship with your parents, or guardian AT THE PRESENT TIME?

very good (we are very close)

all right (we get along but we are not close)

indifferent (we do not communicate very much)

not good (we disagree and argue frequently)

21. Please describe as precisely as possible the occupation of your father or the main provider in your family.



.....
.....

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22. Please estimate the total monthly income of your parents or guardians.

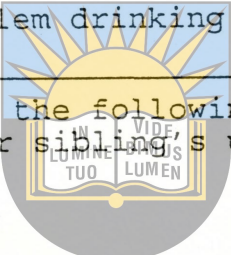
- 1. Under R1000
- 2. 2000 - R3999
- 3. 3000 - R4999
- 4. R4000 - R5999
- 5. R6000 and above

<p>23. Please indicate which of the following most nearly describes your parent's or guardian's use of alcohol.</p>	<p>OFFICIAL USE ONLY</p>																											
<table border="0"> <tr> <td style="width: 150px;">Mother</td> <td style="width: 150px;">Father</td> <td></td> </tr> <tr> <td>.....</td> <td>.....</td> <td>does not use it at all</td> </tr> <tr> <td>.....</td> <td>.....</td> <td>occasional social drinking</td> </tr> <tr> <td>.....</td> <td>.....</td> <td>considerable social drinking</td> </tr> <tr> <td>.....</td> <td>.....</td> <td>regular use, not only socially</td> </tr> <tr> <td>.....</td> <td>.....</td> <td>problem drinking</td> </tr> <tr> <td>.....</td> <td>.....</td> <td>considerable social drinking</td> </tr> <tr> <td>.....</td> <td>.....</td> <td>regular use, not only socially</td> </tr> <tr> <td>.....</td> <td>.....</td> <td>problem drinking</td> </tr> </table>	Mother	Father		does not use it at all	occasional social drinking	considerable social drinking	regular use, not only socially	problem drinking	considerable social drinking	regular use, not only socially	problem drinking	
Mother	Father																											
.....	does not use it at all																										
.....	occasional social drinking																										
.....	considerable social drinking																										
.....	regular use, not only socially																										
.....	problem drinking																										
.....	considerable social drinking																										
.....	regular use, not only socially																										
.....	problem drinking																										
<p>24. Please indicate which of the following most nearly describes your parent's or guardian's use of cigarettes.</p>																												
<table border="0"> <tr> <td style="width: 150px;">Mother</td> <td style="width: 150px;">Father</td> <td></td> </tr> <tr> <td>.....</td> <td>.....</td> <td>does not smoke at all</td> </tr> <tr> <td>.....</td> <td>.....</td> <td>1-10 cigarettes daily</td> </tr> <tr> <td>.....</td> <td>.....</td> <td>11 - 20 cigarettes daily</td> </tr> <tr> <td>.....</td> <td>.....</td> <td>more than 20 cigarettes daily.</td> </tr> </table>	Mother	Father		does not smoke at all	1-10 cigarettes daily	11 - 20 cigarettes daily	more than 20 cigarettes daily.													
Mother	Father																											
.....	does not smoke at all																										
.....	1-10 cigarettes daily																										
.....	11 - 20 cigarettes daily																										
.....	more than 20 cigarettes daily.																										
<p>25. Please indicate which of the following most nearly describes your parent's or guardian's use of illegal drugs</p>																												
<table border="0"> <tr> <td style="width: 150px;">Mother</td> <td style="width: 150px;">Father</td> <td></td> </tr> <tr> <td>.....</td> <td>.....</td> <td>does not use them at all</td> </tr> <tr> <td>.....</td> <td>.....</td> <td>occasional use only</td> </tr> <tr> <td>.....</td> <td>.....</td> <td>regular use</td> </tr> <tr> <td>.....</td> <td>.....</td> <td>problem usage/dependent</td> </tr> </table>	Mother	Father		does not use them at all	occasional use only	regular use	problem usage/dependent													
Mother	Father																											
.....	does not use them at all																										
.....	occasional use only																										
.....	regular use																										
.....	problem usage/dependent																										



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<p>26. Please indicate which of the following most nearly describe your sibling's use of alcohol</p> <p>Sister Brother</p> <p>..... does not use it at all</p> <p>..... occasional social drinking</p> <p>..... considerable social drinking</p> <p>..... regular use, not in social situations</p> <p>..... problem drinking</p>		<p>OFFICIAL USE ONLY</p>
<p>27. Please indicate which of the following most nearly describe your sibling's use of cigarettes</p> <p>Sister Brother</p> <p>..... does not smoke at all</p> <p>..... 1 - 10 cigarettes daily</p> <p>..... 11 - 20 cigarettes daily</p> <p>..... more than 20 cigarettes daily</p>		
<p>28. Please indicate which of the following most nearly describes your sibling's use of illegal drugs</p> <p>Sister Brother</p> <p>..... does not use them at all</p> <p>..... occasional use only</p> <p>..... regular use</p> <p>..... problem usage / dependent</p>		



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<p>29. Please indicate which of the following most nearly describes your close relatives use of alcohol</p> <p>Uncles & cousins Aunts</p> <p>..... do not use it at all</p> <p>..... occasional social drinking</p> <p>..... considerable social drinking</p> <p>..... regular use, not in social situations</p> <p>..... problem drinking</p>		
<p>30. Please indicate which of the following most nearly describe your close relatives use of cigarettes</p> <p>Uncles & Cousins Aunts</p> <p>..... do not smoke at all</p> <p>..... 1 - 10 cigarettes daily</p> <p>..... 11 - 20 cigarettes daily</p> <p>..... more than 20 cigarettes daily</p>		
<p>31. Please indicate which of the following most nearly describes your close relatives' use of illegal drugs</p> <p>Uncles & Cousins Aunts</p> <p>..... do not use them at all</p> <p>..... occasional use only</p> <p>..... regular use</p> <p>..... problem usage / dependent</p>		



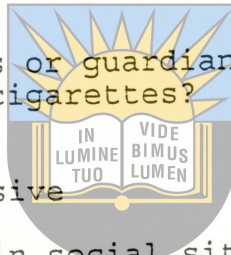
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32. How would your parents or guardians react to your use of alcohol?

- 1) extremely permissive
- 2) tolerant of use in social situation only
- 3) indifferent
- 4) disapproving

33. How would your parents or guardians react to your use of cigarettes?



- extremely permissive
- tolerant of use in social situation only
- indifferent
- disapproving

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34. How would your parents or guardians react to your use of illegal drugs?

- permissive
- indifferent
- disapproving

35. USING THE FOLLOWING KEY
 INDICATE HOW OFTEN YOU HAVE USED
 THE FOLLOWING SUBSTANCES EACH MONTH
 OVER THE PAST YEAR.

	Never	A few times (once a week)	Frequently (2-3 times per week)	Very frequently (almost every day)	OFFICIAL USE ONLY
alcohol, e.g., beer and wine					
tobacco					
spirits, e.g., whisky, gin					
amphetamines, e.g., uppers					
barbiturates, e.g., downers					
hallucinogens, e.g., LSD, nutmeg, banana skin					
whiffers e.g., glue/petrol sniffing					
sleeping medicine					
dagga					
heroin					
mandrax					
opium					
Others, specify <i>hcl</i>					



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<p>36. Do you see the level of your usage of any of these substances as a problem?</p> <p style="text-align: center;">No</p> <p style="text-align: center;">Yes</p> <p>If yes, specify the substance(s) concerned and explain your answer</p> <p>.....</p> <p>.....</p> <p>.....</p>	<table border="1"><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr></table>								
<p>37. Who introduced you to drugs?</p> <p>never used drugs</p> <p>a friend from my neighbourhood</p> <p>a friend from another city</p> <p>a friend from a rural area</p> <p>a friend from school</p> <p>other (please specify)</p> <p>.....</p>	<table border="1"><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr></table>								
<p>38. Of the three people you consider your best friends at home or university, how many have used illegal before or them now?</p> <p style="text-align: center;">none</p> <p style="text-align: center;">one</p> <p style="text-align: center;">two</p> <p style="text-align: center;">three</p> <p style="text-align: center;">don't know</p>	<table border="1"><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr></table>								



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39 (a) Do you currently or have you
previously used alcohol?

Yes

No

(b) If yes, when did you start?

(Choose one correct choice only).

At high school. Please indicate in what Std

.....

At university. Please indicate which year of
study

.....

Elsewhere. Please indicate where and when

.....

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40. (a) Do you currently or have you
previously used tobacco?

Yes

No

(b) If yes, when did you start?

(Choose one correct choice only).

At high school. Please indicate in what Std

.....

At university. Please indicate which year of
study

.....

Elsewhere. Please indicate where and when

.....

41. (a) Do you currently or have you previously used illegal drugs?

Yes

No

(b) If yes, when did you start?

(Choose one correct choice only).

At high school. Please indicate in what Std

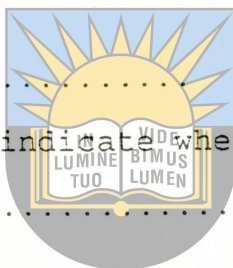
.....

At university. Please indicate which year of study

.....

Elsewhere. Please indicate where and when

.....



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42. When was the last time you used alcohol?

never used it

within the last week

within the last month

one or two months ago

six months to a year ago

more than a year ago

43. When was the last time you used tobacco?

never used it


within the last week


within the last month

one or two months ago

six months to a year ago

more than a year ago

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<p>44. When was the last time you used illegal drugs?</p> <p>never used them</p> <p>within the last week</p> <p>within the last month</p> <p>one or two months ago</p> <p>six months to a year ago</p> <p>more than a year ago</p>		
<p>45. On average, how frequently do you use alcohol?</p> <p>never use it</p> <p>daily or more</p> <p>once a week (not everyday)</p> <p>once to three times a week</p> <p>two to three times a week</p> <p>two to three times a year</p> <p>once a year or less</p>		
<p>46. On average, how frequently do you use tobacco?</p> <p>never use it</p> <p>daily or more</p> <p>once a week (not everyday)</p> <p>once to three times a week</p> <p>two to three times a week</p> <p>two to three times a year</p> <p>once a year or less</p>		

<p>47. On average, how frequently do you use illegal drugs?</p> <p>never use them</p> <p>daily or more</p> <p>once a week (not everyday)</p> <p>once to three times a week</p> <p>two to three times a week</p> <p>two to three times a year</p> <p>once a year or less</p>	<table border="1"> <tr><td></td></tr> <tr><td></td></tr> <tr><td></td></tr> <tr><td></td></tr> <tr><td></td></tr> <tr><td></td></tr> <tr><td></td></tr> </table>								<p>OFFICIAL USE ONLY</p>
<p>48. If you have previously used alcohol in the past, but you are no longer using it any more, indicate the reasons for discontinuing its use</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p style="text-align: center;">  University of Fort Hare <i>Together in Excellence</i> </p>									
<p>49. If you have previously used tobacco in the past, but you are no longer using it any more, indicate the reasons for discontinuing its use</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>									
<p>50. If you have previously used illegal drugs in the past, but you are no longer using them any more, indicate the reasons for discontinuing their use</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p style="text-align: center;">le 1</p>									

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51. If you have used dagga before, please indicate your main reason for doing so, (Please tick as many responses that are applicable).

Have never used it, question does not apply.

Curiosity, just to find out what it is like

'Kicks', an enjoyable experience, to feel good

Escape from problems or depression

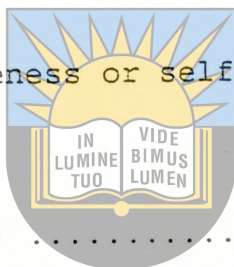
Boredom, for something to do

Social pressure, to go along with friends, to be 'in'

To increase self awareness or self understanding

Relaxation

Other (Please specify)



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52. If you have used mandrax before, please indicate your main reason for doing so, (Please tick as many responses that are applicable).

Have never used it, question does not apply.

Curiosity, just to find out what it is like

'Kicks', an enjoyable experience, to feel good

Escape from problems or depression

Boredom, for something to do

Social pressure, to go along with friends, to be 'in'

To increase self awareness or self understanding

Relaxation

Other (Please specify)

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53. If you have never used dagga before, please indicate the main reasons why you have not done so. (Please tick as many responses that are applicable).

- Have used it, question does not apply
- Not interested or curious
- No access to drugs
- Influence of friends
- Influence of parents
- Risk of being caught for legal violation
- Contrary to moral or religious values
- Risk of physical or mental damage

Other (Please specify)

.....

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54. If you have never used mandrax before, please indicate the main reasons why you have not done so. (Please tick as many responses that are applicable).

- Have used it, question does not apply
- Not interested or curious
- No access to drugs
- Influence of friends
- Influence of parents
- Risk of being caught for legal violation
- Contrary to moral or religious values
- Risk of physical or mental damage

Other (Please specify)

.....

.....

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55. Indicate which of the following risks you feel is taken by anyone who uses drugs (Please tick as many responses that are applicable).

damage to health

psychological dependence on drugs

addiction

may lead to use of stronger drugs such as opium and Heroin

Other (Please specify)

.....
.....



56. What are your (hobbies) *extra-mural activities*
List as many as possible.

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.....
.....
.....
.....

57. What do you think are the specific reasons why people begin to use illegal drugs?

<p>58. (a) Do you believe that some of the illegal drugs should be legalised?</p> <p style="text-align: center;">Yes</p> <p style="text-align: center;">No</p> <p>(b) If yes, specify which drugs?</p> <p>.....</p> <p>.....</p> <p>(c) Explain why the drugs you have identified in b) above should be legalized.</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>		<p>OFFICIAL USE ONLY</p>
<p>59. Do you have any additional comments you wish to make concerning "Substance use and abuse"</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>		



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Thank you very much for participating in this survey. Please make sure that you have answered all the questions adequately before handing in the completed questionnaire to the researcher.

