

ABSTRACT

Substance abuse has become a source of major concern from the public health perspective not just for the individual but also for the wider society. Drug abuse extends far beyond the substance abuser, contributing to damaged relationships with family, community, health workers and volunteers. However, the major impact is upon the children of the abuser (Fox, Oliver & Ellis, 2013). The purpose of this study is to capture the subjective experiences of diagnosed substance abusers from an under-resourced suburb in the Eastern Cape. A phenomenological investigation is conducted at a local rehabilitation centre, focusing on the target population, to make sense of their major life experiences as members in a marginalized community focussing on mental health and poverty. This gives them a voice in their own health care, allowing them to suggest ways in which their needs could be sufficiently met by social services. Taking cognizance of their unmet needs creates awareness of any scarcities that may be bridged by new evaluations. This could bring added value to existing interventions. In doing so, improvements to the quality of life experienced by this community may evolve from a legacy of mental ill-health and poverty. In addition, it may create a positive platform for the future generation by breaking the negative evolution to which they are confined. The results of this study concluded that addiction starts of as a coping mechanism which then leads to dependency and tolerance becoming an addictive habit. Responses from participants indicated the risk of enabling, environmental influences such as peer pressure, their work place and the accessibility of drugs as threat to their possible relapse after recovery. Due to heredity and exposure other members of the family also become addicted resulting in marginalised societies remaining in a cycle of poverty for generations. Children of substance abusers are at risk of becoming substance abusers themselves through modelling and neglect. The cost of recovery revealed a lack of social support and rehabilitation centres in East London.

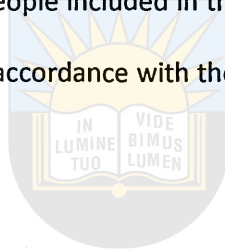
Keywords: *substance abuse, community, children, poverty, psychology, treatment, social service.*

DECLARATION

I, Sivamoney Sharma, am the sole author of this mini-dissertation.

No part of this mini-dissertation has been published or submitted for publication.

I hereby declare that to the best of my knowledge my mini-dissertation does not infringe upon anyone's copyright nor violate any proprietary rights. Quotations, ideas, techniques, images or any other material from the work of other people included in this mini-dissertation, that were published or otherwise, are fully acknowledged in accordance with the American Psychology Association (APA) guidelines.



This is a precise copy of my mini-dissertation, including my final revision, as approved by my supervisor.

This mini-dissertation has not been submitted for a higher degree to any other university.

A handwritten signature in black ink, appearing to read 'Sivamoney Sharma'.

SIVAMONEY SHARMA

ACKNOWLEDGEMENTS

I thank my family, my husband, Prakash Sharma, and my children, Usash and Nitesh Sharma, who contributed to my emotional well-being throughout my endeavour with their continuous encouragement and support. I thank my friends who have made time to assist me with guidance and knowledge.

My sincere gratitude is extended to my supervisor, Professor Dirk Odendaal, for guiding and assisting me with his proficient knowledge during the process of writing this mini-dissertation. I thank Tracy King for giving me hope and inspiration when I started writing up the mini-dissertation, and GMRDC for the supervisory linked bursaries.

I thank the Director and staff of SANCA for allowing me to conduct my study at their centre. Their kindness and assistance contributed to the successful completion of my research. A special thanks to the participants for sharing their experiences with me openly and honestly.

I thank Brian Carlson the editor who was kind and patient with me during the crucial time of completion of this thesis.

DEDICATION

In loving memory of my late nephew Hariendren Nadasen.

Whose untimely death inspired me

to embark on this enriching journey of erudition.

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LIST OF ACRONYMS

AA	Alcoholics Anonymous
ACMD	Advisory Council on the Misuse of Drugs
ACPC	.....	Area Child Protection Committee
CATOR	.....	Comprehensive Assessment and Treatment Outcome Research
COA/COSAs	.....	Children of Addicts and Substance Abusers
DSM	.....	Diagnostic and Statistical Manual of Mental Disorders
IPA	.....	Interpretative Phenomenological Analysis
MRC	.....	Medical Research Council

NGO	.....	Non-Government Organisation
NIDA	.....	National Institute of Drug Abuse
SAPS	.....	South African Police Service
SAMJ	.....	South African Medical Journal
SANCA	.....	South African National Council on Alcoholism and Drug Dependence
SUDs	.....	Substance Use Disorders
Tik	.....	Crystal Methamphetamine
UREC	University Research Ethics Committee
USA	United States of America



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CHAPTER 1

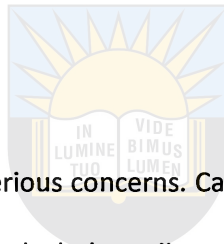
INTRODUCTION

INTRODUCTION

Substance abuse has become a source of major concern from the public health perspective, not just for the individual but for the wider society as well. Drug abuse extends far beyond the substance abuser, contributing to damaged relationships with family, community, health workers and volunteers. However, the major impact is upon the children of the abuser (Fox, Oliver & Ellis, 2013). Substance abuse is a pervasive, devastating problem in present society that affects all sectors of the population. Substance abuse is one of the most serious issues facing children and families. Family dynamics and socio-economic factors interact with parental substance abuse to increase the possibility of child maltreatment both within and outside of the family system (Choi & Tittle, 2002).

Taking a closer look at substance abuse in South Africa reveals that the Police Service (SAPS) crime statistics (2009/10) in the Western Cape has the highest number of drug-related crimes reported in the past ten years. Mitchells Plain Police Station on the Cape Flats was reported as having the highest drug-related crime figures of all the police stations in South Africa. A case study in Mitchells Plain and a literature review reveals that low economic status, a mixture of different ethnic groups, disrupted families and broken homes are all elements found present in the communities of Mitchells Plain, contributing to 'social disorganisation'. These factors should be viewed within the broader context of a number of external socio-economic factors that impact on the prevention of substance abuse (Haefele, 2011). The community chosen for this study is one of the communities in East London that is known for its high levels of poverty which raises the question whether the influence of substance abuse on families can also be discovered here and what the effect of the dependency is. Does substance abuse generate poverty or does poverty instigate substance abuse in these communities that deepens poverty?

Substance abuse not only has a biological and psychological impact but also a negative impact on the economic status of the abuser and his/her family. The abuse contributes enormously to ill-health and poverty. The low socio-economic status that encourages substance abuse also deepens poverty through unemployment and escalating medical bills due to ill-health resulting from the addiction. Children who are growing up with substance abusing parents tend to model their behaviour and become substance abusers themselves. In this way substance abuse is transmitted to the next generation causing these communities to remain in a negative cycle of ill-health and poverty for generations. The problem is determining how this cycle can be broken and thereby freeing these marginalised community members from remaining in poverty and ill-health for generations.



REASON FOR THIS STUDY

The poverty in South Africa has raised serious concerns. Causes are the high unemployment figures and also the abuse of substances such as alcohol, marijuana, cannabis, methamphetamines, cocaine and benzodiazepines, the most commonly abused drugs in South Africa, has raised serious concerns and are devastating society (Akeso, 2015) .

RESEARCH PROBLEM

Substance abuse is an enormous social problem in South Africa, aggravating poverty and crime and contributing to child abuse and gender violence. An exploration of the causes and the reasons surrounding the abuse of substance is necessary in order to develop strategies to prevent more people from becoming substance abusers.

The prevalence of substance abuse amongst high school students in the community of Mitchells Plain in Cape Town was investigated. Factors such as crime, gangsterism, unemployment, overcrowding and poverty were associated with substance abuse (Mash & Hamdulay, 2011). The drug 'nyaope' has been widely used among young ethnic people in various townships suggesting poverty as a contributory factor in impoverished communities. The combination of easy access to

both cannabis and nyaope, and the high unemployment rates seem to be contributing to nyaope use (Morojele & Mokwena, 2014). Statistics reflected that in the East London area ethnic substance abusers by far outnumber any other race group (Van Heerden, Grimsrud, Seedat, Myer, Williams & Stein, 2009).

On the 8th of July 2015 the police simultaneously raided five East London suburbs, namely Vergenoeg, Parkside, Bramley, Buffalo Flats and a farm in Kei Road. The recoveries were estimated at a street value of R3,5 million and R4 million in cash. In another raid in Buffalo Flats on the 7th of July 2015, the police seized R1.3 million in cash, as well as at least 2 800 Mandrax tablets worth more than R1.6 million (Smal, 2015). The estimates of the recoveries are just an illustration of the drugs made accessible to the community members, but what about the drugs that are not recovered and distributed?

An article focusing on how poverty has contributed to the unfortunate situation of abuse of children in Zimbabwe found that the prevalent abuse includes sexual, emotional, neglect and child labour. The abuse of these children violated their fundamental rights (Masuka, 2013). The risk factors contributing to sexual abuse of toddlers in a specific settlement in Buffalo City (East London, King William's Town and Bhisho) identified the danger of alcohol and drug abuse and its consequences for the toddlers in respect of sexual abuse (Nel, 2013). South African Police statistics on drug related crimes and maltreatment of children in the precinct of Buffalo Flats alone revealed a 22.6% increase in drug related crimes and 33.33% increase in neglect and ill-treatment of children since 2014 to date (Crime Stats SA, 2015). Researchers suggested that criminalising drugs may be justified by the public harm principle, but it does not effectively achieve the purpose of preventing and decreasing drug use in South Africa (Fellingham, Guidozi, Gardner & Dhai, 2012). According to Van Niekerk (2011) "to make people criminals for taking psychoactive substances is in itself criminal, for one is dealing with, at worst, a vice but not a crime".

THE AIM AND OBJECTIVE OF THE STUDY

The aim of this study is to understand the personal, psychological and physical, experiences of substance abusers in a typical community in which there are high levels of unemployment and poverty. The researcher's interest was alerted to this community by the high number of people who have been diagnosed with substance abuse disorders after being referred for treatment. The objective of this study is to capture thick descriptions of how participants make sense of their major life experiences and the everyday flow of lived experience that take on a particular significance for them as members in their community.

RESEARCH QUESTIONS

This study focuses on the effects of substance abuse on the lives of the participants in terms of their physical and mental health, relationships with family, friends and community, economic impact and their views on social assistance.



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RESEARCH SETTING

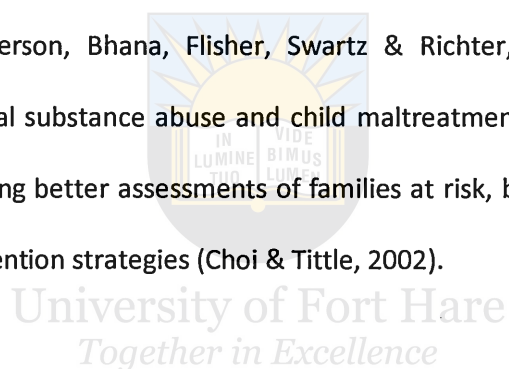
The participants came from a suburb in East London where it appeared that substance abuse has become a dominant problem. Almost 50% of patients treated every six months at a local treatment centre are members of this community. Because of the limited availability of rehabilitation centres in East London, people recovering from addictions are forced to go to the South African National Council on Alcoholism and Drug Dependence (SANCA) in spite of their financial difficulties and lack of medical aid, which places the centre in a well-informed position. According to statistics from SANCA, these statistics exclude those who do not come for treatment. Although SANCA has put interventions in place that currently provide mental health care to the members of this community, approximately 10% of the patients who attend annually have had prior treatment.

This study was therefore conducted at the South African National Council for Alcoholism and Drug Dependence Centre in the Eastern Cape (SANCA). The participants were in-patients at SANCA who

followed a recovery programme at the time of the study. The participants who came from the community described in depth their experiences in semi-structured interviews about their journeys to recovery. The Interpretative Phenomenological Analysis (IPA) informing this study permitted the researcher ample latitude to explore with the participants the unique notions and perspectives they had to contribute.

THE RELATIONSHIP BETWEEN THE REHAB CENTRE AND THE COMMUNITY

The treatments at rehab centres become crucial when focusing on not just recovery but prevention and relapses. Therefore identifying interventions that would be most appropriate to effect change in a context is essential (Patterson, Bhana, Flisher, Swartz & Richter, 2010). Understanding the relationship between parental substance abuse and child maltreatment is imperative because it is not only necessary in providing better assessments of families at risk, but is also helpful in creating better intervention and prevention strategies (Choi & Tittle, 2002).



This study focuses on individuals who have been diagnosed with a substance abuse disorder. In exploring the interrelatedness of these individuals in their families can pour new light on their experiences. When a treatment plan is decided for the recovering substance abuser, it is important to view the individual within his or her family system. A pattern of transmitted addiction can be caused by co-dependence or enabling behaviours of the family members (Flanzer & Delany, 1992). When inhibitions decrease it contributes to generational boundaries blurring, and generally interferes with many functional areas of family life (Mayer, 1985). Families need an array of treatment and prevention services in order to eliminate this dysfunctional cycle and the negative impact on future generations (Freeman, 1993). A number of theoretical approaches that clarify the addiction and recovery process in families are combined to form the family systems approach (Chaudron & Wilkinson, 1988).

ORGANISATION OF THE STUDY

The layout of the study covers six chapters. The first chapter is the introduction which guides the reader to the process the study takes. It addresses the sequence of the chapters and the relevance of each chapter to the research findings and conclusion.

Chapter two is the literature review which discusses and explores different views of addictions and the understandings of other researchers. Relevant publications in this field produced by other researchers are discussed in respect of their pertinence to this study. Literature by researchers suggests that the reasons for the use of a substance is either instrumental or for recreational purposes. In the literature review attention is given to the descriptions in texts and articles of: the influence of the chronic use of alcohol which can result in psychological or physical dependence, the factors that influence the prevalence of substance abuse, substance abuse by children and adolescents, neglected children of substance abusing parents, enabling and co-dependency, social responsibility and assistance, and substance abuse treatment planning and effectiveness.

Chapter three covers the theoretical framework that informs this study. An in-depth discussion offers the reader an understanding of the underlying principles of the Interpretative Phenomenological Analysis (IPA) approach. An explanation is offered for the suitability and application of the theory. This study is of a qualitative nature and therefore entails subjective experiences of the participants and the above approach elicits the appropriate data for analysis. The fourth chapter explores the research design and methodology. The context of the research describes the location and surrounding of the rehabilitation centre and the suitability of the venue chosen for the research. The study population was recruited within the institution during their rehabilitation. A description is given of how the participants were selected through purposive sampling and the individual participants were chosen as the most likely to contribute appropriate data, both in terms of relevance and depth (Oliver, 2006).

Chapter five is a discussion on the presentation of the findings of the study. The data was discussed as follows: Attention was firstly given to the relevant history of dependency and the recovery process of the participants and then attention was given to the various themes that surfaced during the interviews. These themes were discussed separately with reference to the literature reviews and the findings from the study. The final chapter draws together the conclusions derived from the data analysis and makes recommendations based on the findings. The conclusion encapsulates the discussion on the findings of the study.



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CHAPTER 2

LITERATURE REVIEW

INTRODUCTION

The focus of this study is to investigate how substance abusers experience their addiction and how it affects their relationship with significant others and the community they live in. The research explores the in-depth understanding of the participants' life experience during their addiction and treatment programme. This chapter seeks to find out how other researchers view and understand substance abuse. Attention will be given to definitions of substance abuse, the different uses of substance, the effects of abuse, factors influencing the prevalence of abuse, the effect of abuse on families and, finally, to how the treatment of abuse is viewed.



DEFINITION OF SUBSTANCE ABUSE

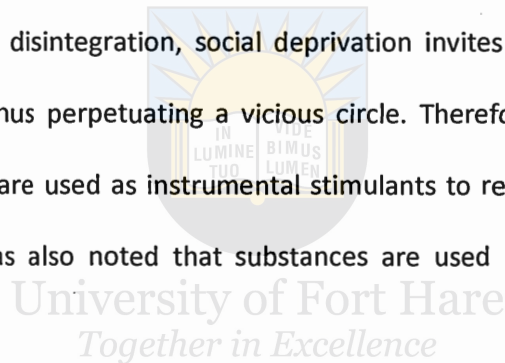
The 'social use' of a substance is defined by traditional social standards. The term 'social use' refers to the rare or infrequent use of a substance in a social setting. The intention is not to cause unemployment, physical, family, marital or legal problems (Doweiko, 1996). Substance abuse is the description used for an individual, who is using a drug or substance without legitimate medical need to do so or who is drinking in excess of accepted social standards and is said to be abusing that chemical (Schuckit, 1989). Fayombo (1998) defined substance abuse as the use of a mood modifying substance illegally, excessively and in a socially unacceptable manner.

INSTRUMENTAL ABUSE OF DRUGS AS A COPING STRATEGY

Drugs and alcohol have are known to be used as instrumental to achieve a specific behavioural goal either to overcome emotional discomforts or to acquire pleasurable feelings in a social setting for recreational purposes (Levinthal, 1999). A study conducted to examine the reasons for young people using psychoactive substances found that the most popular functions for use are to: relax (96.7%), become intoxicated (96.4%), keep awake at night while socializing (95.9%), enhance an activity (88.5%) and alleviate depressed mood (86.8%). According to the responses from the

participants, they used amphetamines to 'keep going on a night out with friends', 'to enhance an activity to help feel elated or euphoric or to help stay awake'. The results also showed that 60% of cocaine users used cocaine to 'help to feel more confident in social situations and to feel better when down and depressed' (Boys, Marsden & Strang, 2001).

A study funded by the National Institute of Drug Abuse (NIDA) suggested that addiction educators view substance abuse as a coping mechanism rather than a moral failure, and are ambivalent about referring to substance abuse or addiction as a disease (Broadus, Hartje, Roget, Cahoon & Clinkinbeard, 2010). It has been deliberated by the World Health Organisation that while substance misuse contributes to social disintegration, social deprivation invites the abuse of substances to alleviate emotional stress, thus perpetuating a vicious circle. Therefore there have been reports from Africa that substances are used as instrumental stimulants to relieve stress from depression, anxiety and boredom. It was also noted that substances are used as a kind of self-medication (Uchtenhagen, 2004).



The instrumental use of drugs as discussed above indicates the abuse of a substance as a coping strategy to relieve the person from emotional discomforts or for recreational purposes. The use of a substance gradually progresses to substance abuse with the theme of coping playing a spherical role as represented by the diagram below, presented by the researcher. The diagram below depicts and explains the circular process and stages of coping, a strategy used by the participants in this study. The persons start off using drugs to cope with life stresses or in social settings and then they gradually become tolerant and start using more until they become dependent when they cannot overcome the cravings. What started off as using for instrumental purposes becomes an addiction. During addiction drugs or alcohol are then abused to cope from day to day.

FIGURE1: DIAGRAM OF THE CYCLE OF COPING WITH ADDICTION



THE PSYCHOLOGICAL THEORIES OF SUBSTANCE ABUSE

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), no longer uses the terms substance abuse and substance dependence, rather it refers to substance use disorders, which are defined as mild, moderate, or severe to indicate the level of severity, which is determined by the number of diagnostic criteria met by an individual. Substance use disorders occurs when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria (American Psychiatric Association, 2013).

According to the DSM 5, activation of the brain's reward system is central to problems arising from drug use. The rewarding feeling that people experience as a result of taking drugs may be so profound that they neglect other normal activities in favour of taking the drug. While the pharmacological mechanisms for each class of drug are different, the activation of the reward

system is similar across substances in producing feelings of pleasure or euphoria, which is often referred to as a 'high' (Hartney, 2014).

THE PSYCHOLOGICAL AND PHYSICAL EFFECTS OF SUBSTANCE ABUSE

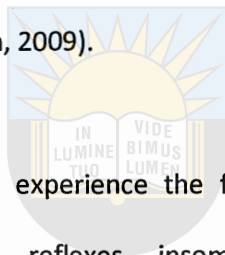
Drug abuse has many damaging consequences not only for the individual but also for the society as a whole (Fox, Oliver & Ellis, 2013). The overall adverse effects of drug abuse can be understood from the three different perspectives: (1) the direct physical harm of the substance to the individual user, (2) the physical and psychological tendency of the drug to induce dependence, and (3) the psychological effect of substance-abuse on families, communities, and society (Gable, 2004, 1993).

The impairment in judgement and thinking (the classic features of being drunk) stems from a loosening of social inhibitions that allow us to be relatively civil and well behaved. On a behavioural level, serious adverse effects include blackouts, significant impairment in sensorimotor skills such as driving an automobile and an increased potential for aggressive acts. As with other depressant drugs, acute alcoholic poisoning produces death by asphyxiation (Pinel, 1997; Levinthal, 1999; Steinhagen & Friedman, 2008).

Depressive disorders often cause acutely uncomfortable feelings such as overwhelming sadness, hopelessness, numbness, isolation, sleep disorders, digestive and food-related disorders. If medications aren't being prescribed or used properly, people suffering from depression may be tempted to self-medicate. They may use substances for instant relief. This can compound the depression and make it far worse. Using substances such as alcohol or drugs might temporarily relieve some symptoms, but the after effect of the chemical when it leaves the body brings the depression to new lows (Grohol, 2013).

The results of a review conducted by Bushman and Cooper (May 1990) on the effects of alcohol on human aggression revealed that alcohol does cause aggression. This conclusion was confirmed by a study conducted at the Kent State University on the effects of alcohol and drinking experience on human physical aggression (Laplace, Chermack & Taylor, 1994). Bushman (1997) added that,

although alcohol is not the only factor that contributes to violent crimes, it does however make a significant contribution. Numerous correlated studies have found a strong relation between alcohol intoxication and violent crimes. These studies found that in general over 50% of the assailants were intoxicated at the time of the crime. A significant number of untimely deaths and accidents have been attributed to the activities of persons under the influence of drugs (Amosun, Ige & Ajala, 2010). South Africa went through major social and political transformation during the 1990s and early 2000s. During this period links and trade with the rest of the world opened, increasing substance-related problems dramatically over the past 10 years. These include road traffic accidents, mental illness, violence and severe crime committed under the influence of substances (Van Heerden, Grimsrud, Seedat, Myer, Williams & Stein, 2009).



During intoxication the individual may experience the following symptoms: agitation, anxiety, diarrhoea, hyperactivity, exaggerated reflexes, insomnia, nausea, restlessness, sweating, tachycardia, vomiting and vertigo (Lehman, Pilich & Andrews, 1994; Lieveld & Aruna, 1991). These symptoms may give rise to both physical and psychological reactions. A study conducted by Edwards and Gross (1976) concluded that dependence should perhaps be seen as being in the same group of disorders as phobic and obsessional states, with a potent, complicating, biological factor. The individual may find it impossible to remember events that took place while intoxicated which is a condition that is commonly known as blackout. These periods of alcohol-induced amnesia may last several days, although for the most part they involve shorter periods of time (Segal & Sisson, 1985; Willoughby, 1984). It is not uncommon for an intoxicated individual to fall and strike his or her head on whatever happens to be in the way resulting in head injury (Anderson, 1991; Sparadeo & Gill, 1989).

Estimates indicate that between 10 and 28% of patients who report anxiety symptoms also have alcohol use disorders (Decker & Ries, 1993; Stockwell & Town, 1989). Kushner, Sher, and Beitman (1990) conclude that alcohol withdrawal symptoms may be “indistinguishable” from the symptoms

of panic attacks and generalized anxiety disorder. They also conclude that agoraphobia and social phobias usually predate alcohol use.

The exact cause of alcohol dependence is not known. One may become dependent on alcohol after physical or emotional stress, such as the loss of a loved one. Some may also drink alcohol to try to relieve anxiety, depression (deep sadness), loneliness, or tension (Doweiko, 1996; Lehman, Pilich, & Andrews, 1994; Weiss & Mirin, 1988). Suggestions from other researchers indicated that adolescents who used drugs had significantly lower levels of psychological well-being and life satisfaction (Visser & Routledge, 2007). A study conducted on the causative factors of substance abuse revealed numerous reasons and therefore one cannot state for certain specific causes of substance abuse (Amosun, Ige & Ajala, 2010).



Numerous studies have demonstrated a strong connection between the experience of stigma and the well-being of the substance abuser. A study conducted testing the above hypothesis revealed that stigma has enduring effects on the well-being of the stigmatized. Therefore the findings of this study indicate that stigma continues to complicate the lives of the substance abusers even as treatment improves their symptoms and functioning (Link, Struening, Rahav, Phelan & Nuttbrock, 1997). A study conducted by the Alcohol and Drug Abuse Research Unit found that stigma towards individuals with substance abuse disorders was present in historically disadvantaged communities and as a result remained hidden. Respondents in that study thought that historically disadvantaged communities held negative perceptions of 'addicts' that included notions that 'addicts' are weak, lack self-control and are mad. Therefore substance abusers and their family were reluctant to seek treatment due to the stigma attached to the label 'addict'. The shame was related to ostracism should the problem become known in the community (Myers, Fakier, Louw, 2009). A study on exploring the harmful potential of drug abuse concluded that drugs sabotage the pathway that is intended for natural 'rein forcers' causing harm acutely and chronically to both the individual and society (Fox, Oliver & Ellis, 2013).

THE FACTORS THAT INFLUENCE THE PREVALENCE OF SUBSTANCE ABUSE

The factors that influence the prevalence of alcoholism are associated with a number of other psychiatric disorders, notably depression and sociopathic behaviour. These associations have been widely observed, both in clinical settings (Weissman & Meyers, 1988; Schuckit, 1973) and in community surveys (Boyd, Burke, Gruenberg, Holzer, Rae, George, Karno, Stoltzman, McEvoy & Nestadt, 1984). This is known as dual-diagnosis. Dual-diagnosis clients are those clients who suffer from mental illness and also substance abuse disorders or are addicted to chemicals. Although each disorder has an independent course, each is able to influence the progression of the other (Kivlahan, Heiman, Wright, Mundt & Shupe, 1991; Carey, 1989). This would tend to be associated with higher than expected rates of substance abuse in their off-spring based on their primary psychiatric diagnosis alone. Similarly a secondary psychiatric diagnosis could have a higher influence on alcoholism rates in children whose parents were alcoholic with a concomitant disorder (Kivlahan, Heiman, Wright, Mundt & Shupe, 1991).

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Genetic Influence

It has been long recognised that the prevalence of alcoholism and drug addiction among children of substance abusers is higher than in other children who have non-substance abusing parents. Such familial aggregation has been attributed to heredity, to environmental factors such as exposure and accessibility to alcohol, and more recently to an interaction between the two (Russell, Henderson & Blume, 1985). As Schukit (1987) pointed out, the family members become addicted as well due to a projection process caused by behaviour that results from a co-dependent and co-enabling system. Individuals who are genetically predisposed to drug abuse may also live in social environments that are conducive to drug abuse which makes it difficult to differentiate between the two contributing factors (Hawkins, Catano & Miller, 1992).

According to Searles (1988) when considering the role of genetics in the pathogenesis of substance abuse it is important to distinguish between the risk for dependence as a result of genetic transmission and physical and psychological consequences of being exposed to substance abusing parents. While they are clearly not mutually exclusive, they can be independent. Individuals who are physically assaulted and/or psychologically exploited as a result of parental substance abuse may develop psychiatric problems, including addiction, independent of any genetic liability. Despite the uncertainties, there is a general consensus that children of substance abusers are a population at risk (Russell, Henderson & Blume, 1985).

Research supports the suggestions of the above investigators that concluded that approximately 50% of the risk of substance abuse or dependence in adolescence is genetically influenced. The transition between stages of use, from regular use to abuse and dependence, is also genetically influenced, although the relative genetic contribution compared with environmental influences varies by substance. Their findings showed evidence that supported the principles of social learning theory and social control theory (Yule & Wilens, 2011).

Although research suggests that genetic heritability may be a possible explanation for intergenerational familial alcoholism or other drug problems, it is difficult to disentangle genetic-environmental interactions (Sher, 1991). According to Reich (2000) researchers have not yet identified one gene or an inherited quality that is solely responsible for alcoholism or drug abuse.

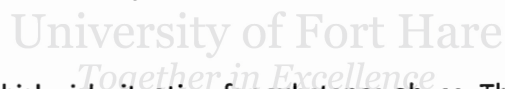
Intrapersonal Predictors

However neurobiological processes are also an intrapersonal predictor of drug use. Variations in neurochemical systems may influence individual differences in reinforcing the effects of drugs (Olson, Olson & Kastin, 1992; Cloninger, Svrakic & Przybeck, 1993).

Personality Predisposition Theories of Addiction

Personality traits are yet another intrapersonal predictor since there is some agreement that sensation seeking is a personality trait and manifested in individuals who are likely to be susceptible to the reinforcing effects of pleasurable stimuli and drug effects (Zuckerman, 1994). Sensation seeking as a construct has been found to be positively related to and predictive of alcohol use (Stacy, Newcomb & Bentler, 1993; Jessor & Jessor, 1977; Earleywine & Finn, 1991).

Another trait is lack of regulation, such as 'behavioural under-control' (Sher, 1991). The third trait is the inability to bond, relate or connect with significant others (Newcomb & Earleywine, 1996). They may lack a sense of coherence about their lives. Drug use may provide a superficial means of bonding with others. Dispositional attitudes such as unconventionality, rebelliousness and tolerance of deviance are obvious correlates of counter-normative behaviours such as drug use (Antonovsky, 1984; Hoffman, Loper & Kammeier, 1974).

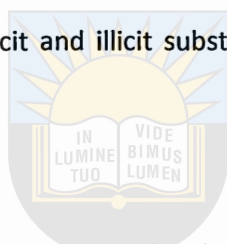


The workplace can become a high-risk situation for substance abuse. The 2007 treatment profile for SANCA shows that around 40% of persons who seek treatment for addiction are employed full time and that two thirds of addicts are adults (HR Future, 2010). Although national statistics on substance-abuse prevalence in the workplace are limited, it is estimated that approximately 6% to 16% of the average labour force are likely to suffer an alcohol-dependence problem and that 20% are likely to experience drug problems (Pick, Naidoo, Ajani, Onwukwe, Hansia & Bielu, 2003).

According to Galanter (1988) the stresses of work impact on all job levels causing the workplace to become a high-risk situation. The Canadian Centre for Occupational Health & Safety (2014) suggests that various and numerous personal and social factors can play a major role as possible elements that may contribute to abuse of substances at work. But some work-related factors can be a cause for substance abuse, such as: high stress, low job satisfaction, long hours or irregular shifts, fatigue, repetitious duties, periods of inactivity or boredom, isolation, remote or irregular supervision and easy access to substances.

From an Organisational Cultural Perspective culture could mean a community, the workplace or the organisation and it is one of the most powerful influences to impact on an individual and a work group (Milton, 1990). The way in which a community or work group consumes alcohol or uses drugs has a direct influence on the number of people with alcohol or drug problems, irrespective of genetic or personality susceptibility (Roberts, 1988).

Advertising contributes to environmental pressures and its impact can be seen in the way advertisements present alcohol as an easy way to attain an attractive lifestyle. It is not the taste or effect of alcohol that is promoted, but an escape into an unattainable world of pleasure. The access to availability has also increased both licit and illicit substances (McCann, Burnhams, Albertyn, & Bhoola, 2011).



However it was found that substance abuse increased with age and that nearly twice as many males as females abused substances. Language group was found to be a determining factor with regard to current and excessive use of alcohol but did not seem to influence drug use (Visser & Routledge, 2007).

SUBSTANCE ABUSE BY CHILDREN AND ADOLESCENTS

To understand why adolescents use chemicals, Joshi and Scott (1988) explored the initial factor such as curiosity which influences adolescent experimentation with recreational chemical use. Some adolescents use chemicals in response to peer pressure and some get relief from internal discomfort, such as feelings of depression. Chemically dependent adolescents are three times as likely to be depressed (Deykin, Buka & Zeena, 1992). Evidence supports the hypothesis that adolescents use chemicals to self-medicate painful feelings and to deal with conflict and stress (Evans & Sullivan, 1990). The evolution of child and adolescent substance-use patterns and values takes place in a mixture of forces that vary in intensity at different points in the individual's early years. During childhood, parental influence on drug use behaviour is the strongest. Children may

accept parental guidance on behaviour but they are very aware of modelling behaviours (Cohen, Richardson & La Bree, 1994; Rogers, Harris & Jarmuskewicz, 1987).

Research update reviews on adolescent substance abuse for the past ten years show that there has been a sharp resurgence in adolescent drug use recently. Biological factors, including genetic and temperament characteristics, as well as family environment factors, are emerging as important etiological variables. Comorbidity with other psychiatric disorders, particularly with conduct disorder, is frequent and complicates treatment (Weinberg, Rahdert, Colliver & Glantz, 1998).

Research findings on the influence of family and peers on adolescent substance abuse suggested the impact of their relationships. Generally, positive family influences, such as family bonding and consistent rules, appear to reduce the risk of tobacco, marijuana, and other drug abuse among teens, while negative family influences tend to increase risk (Mann, 2003). Mann (2003) suggested that family bonding was particularly influential before the age of 18 years. Youths with low family bonding at age 15 were three times more likely (9% vs. 3%) to initiate illicit drugs than those with high family bonding. Higher levels of family conflict were associated with a higher risk of initiation. High family conflicts at age of 18 were over twice as likely to initiate illicit drugs as those with low family conflict. He also found that youths over the age of 15 years were four times as likely (19% vs. 5%) to initiate illicit drugs with low antisocial peer influence. Studies conducted by Guo & Hill, (2002) confirmed the above suggestions of Mann.

Yule & Wilens, (2011) explained that behavioural modelling of substance use through exposure to parental substance use early in life also accounts for part of the familial association in substance use disorders (SUDs). The association between exposure to parental SUDs and the development of an SUD in offspring is consistent with social learning theory. A review by Petraitis, Flay and Miller (1995) promoted a description of social learning theory as the “hypothesis that children model their behaviour on people who are important to them and those they frequently interact with, such as their parents”. The above hypothesis is also supported by Yule & Wilens (2011) and Bahr, Hoffmann and Yang (2005).

From a family systems perspective, during childhood parental influence on drug use is the strongest because the children are very aware of modelling behaviours (Cohen, Richardson & La Bree, 1994; Rogers, Harris & Jarmuskewicz, 1987). Therefore children of substance abusers are more prone to becoming addicted to substance themselves. Children raised by substance abusers have to deal with conflict, stress and poverty which are contributing factors to depression and other related illnesses so they become vulnerable targets to substance abuse.

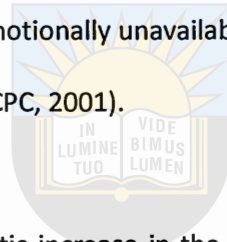
The above findings point in a consistent direction towards a combination of biological, genetic and family environmental factors as contributing factors to adolescent substance abuse. There also seems to be evidence of social learning theory and social control theory as contributing factors. This emphasises the role of parental influence and relationship with adolescent substance abuse.

NEGLECTED CHILDREN OF SUBSTANCE ABUSING PARENTS

The extent and gravity of the problem which drug-abusing parents pose has been fully recognised and documented. In 2004 the Advisory Council on the misuse of drugs reported to the government on “the needs of children of problem drug users”. The report covered the whole of the UK but there were important differences regionally. The report focussed on the particular importance of those parents whose drug abuse posed as a high risk for the care of their children. However it does not assume that all such substance abusing parents pose a high risk to their children. The report estimates that there are between 200 000 and 300 000 children of problem drug users in England and Wales, i.e. about 2-3% of the ten million children under the age of 16 years. In Scotland, they conclude that between 40 880 and 58 700 children are in this position, i.e. about 4-6% of the one million children (ACMD, 2004).

Reported cases in the Western Cape involved 9, 1% child sexual offences committed by offenders under the influence of substances. Substance abuse poses a major risk of increased child neglect and abuse in this province (Modernisation Programme, 2010). The policy statement adopted by the

Newcastle Area Child Protection Committee (ACPC) was produced in response to the increasing problem of substance misuse and particularly the rising number of children who are referred into the child protection arena due to parental substance misuse. The death of three children in separate families in Newcastle where substance abuse was a factor prompted the ACPC to recognise that the link between substance abuse and a person's ability to act as a responsible parent is not always clear. Children's physical, emotional, social, intellectual and developmental needs can be adversely affected by their parents' abuse of substances. Substance abuse may have an impact on a child's emotional well-being as a result of their emotional needs not being met; however, there are other factors which can also affect a child's emotional well-being, for example, it may be that parents under the influence of substances are emotionally unavailable to their child or there may be a lack of boundaries and routines for the child (ACPC, 2001).

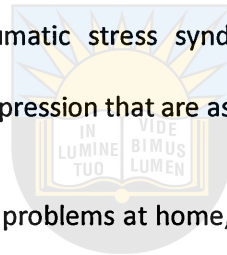


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During 1996 – 2000 there was a dramatic increase in the number of parents with such problems, both those whose children were living with them and those with children living away. There was an increase from about 7000 in 1996 to about 22 000 in 2000. In 1996 – 2000 about half of these children were living away from their parents but only a small proportion of them - about 5% - were in their care (ACDM, 2004 p. 23). Behind these bald figures lies a social problem of some magnitude. A holistic understanding of the concept of neglect means that these 'omissions' of care may affect all aspects of children's development and well-being. Therefore the deficits are not simply in physical or health matters but in lack of emotional responsiveness in the sense that 'you were not there for me' and in their failure to protect their children from the dangerous outside world of the drug dealers and those that accompany them. The report notes that it is much more common for these children to lose parents through separation or death than other children (ACDM, 2004 p. 23, Dubowitz, 1999).

According to Cleaver, Unell and Aldgate (1999) the ways in which mental illness, problem drug use or domestic violence may affect parenting is likely to affect the children's development. Most

importantly there is a possibility that neglectful parents may tip the scales towards substance abuse in their children, young people or adults. Dunn, Tarta, Mezzick, Vanukov, Kirisci and Kirilova (2002) conducted studies that discovered available evidence that indicates children who experience parental neglect, with or without alcohol or drug abuse, are at high risk of substance use disorder. According to the American Academy of Experts in Traumatic Stress (2014) in families where alcohol or other drugs are being abused, behaviour is frequently unpredictable and communication is unclear. Family life is characterized by chaos and unpredictability. They love their parents and worry about them, and yet feel angry and hurt that their parents do not love them enough to stop using alcohol or drugs. These children are frightened for their own well-being. As a result, these youngsters may suffer from post-traumatic stress syndrome, with the same kinds of sleep disturbances, flashbacks, anxiety, and depression that are associated with victims of war crimes.



Although friends can be a buffer for the problems at home, some children of addicts and substance abusers (COA/COSAs) have a limited social life. They may avoid bringing home friends, or going out in public with their parents. They may also find it difficult to make friends because other parents have warned their children to stay away from these youngsters from troubled families. There is a higher prevalence of depression, anxiety, eating disorders and suicide attempts among COAs than among their peers. Children who live in high conflict homes are more likely to have lower self-esteem and less internal locus of control. This puts COAs/COSAs at higher risk of being re-victimized in the future. As a result of these stressors, COAs/COSAs often have difficulty in school. They are also more likely than their peers to have learning disabilities, play truant, repeat more grades, transfer schools and be expelled. Parental substance abuse can have other effects on children besides parent-child interactions. For example, if a parent loses a job because of drinking or drug use, the child suffers the economic consequences, especially if this is the household's only income. The child might develop stress-related health problems like gastrointestinal disorders, headaches, migraines, or asthma, causing them to miss school (The American Experts in Traumatic Stress, 2014).

However, on a more positive note, only one in four COAs will become alcoholics themselves, three in four will not because most children and teens are able to draw upon their inner strengths to cope with their circumstances and succeed in life. COAs and COSAs can be helped in many ways, both formal and informal, by calling on their own resiliency (The American Experts in Traumatic Stress, 2014).

ENABLING AND CO-DEPENDENCY

Co-dependency and enabling have become themes for the current generation; substance abuse professionals have explored the substance abuser's interpersonal relationships and found that some people, although sickened by the addict's behaviour, actually behave in ways that enable the individual to continue to abuse drugs. Researchers have found that some family members seem to be co-dependent with the addicted member of the family. The enabler may have the intention to protect the addict but is actually part of the problem and not the solution. An enabler may be a family member; he or she could also be a co-worker, supervisor, neighbour, friend, advisor, teacher, therapist or even a drug rehabilitation worker (Doweiko, 1996; Thailand, 2008-2015).

Results from a study on enabling behaviour in a clinical sample of alcohol-dependent clients and their partners indicated that the partner took over chores or duties from the alcoholic client at some point during the relationship, drank or used other drugs with the client, and lied or made excuses to others to cover for the drinker (Rotunda, West & O'Farrell, 2004). A co-dependent believes that they are not worthy of being happy. This unhealthy attitude sets them up to fail at having meaningful and caring relationships (Thailand, 2008-2015, Wegscheider-Cruse 1985). Therefore in an enabling relationship there is an abuse of power, the substance abuser takes advantage of the other person's low self-esteem and degrades or belittles them into giving in (Thailand, 2008-2015).

Substance use disorders affect not only the identified client but significant others as well; therefore, family dysfunction is typically associated with a family member's alcohol or drug abuse. Research

notions of these families are that of partner support or coping in response to the addiction. Often female partners of male alcoholics have been labeled as co-dependents, co-alcoholics, or enablers (Rotunda & Doman, 2001).

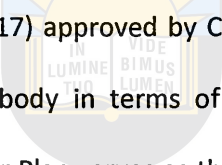
The benefits of enabling are twofold: the individual who is **using substances** can continue the behaviour they want and, secondly, the enabler does not have to acknowledge that anything is wrong. This action, however, is a short term solution to a long term problem. Long term, enabling drug abuse behaviour leads to unhappiness for the enabler and the further deterioration of the individual using drugs. Another reason enabling occurs is because of the idea of co-dependency (Codependency Resources, August 2007). The discussion insinuates a complementary connection between enabling and co-dependency.

SOCIAL RESPONSIBILITY AND ASSISTANCE

Substance abuse places a large burden on the health, social development, criminal justice and economic sectors (McCann, Burnhams, Albertyn & Bhoola, 2011). According to the South African Stress and Health Survey, the country has the second highest prevalence of substance-use disorders when compared with 14 other countries surveyed (Stein, Seedat, Herman, Heeringa, Moomal & Mayer, 2007). At a Cosatu-sponsored safety and health conference it was revealed that every day in South African industry on average five people die from injuries received, 430 people are injured and 52 people are permanently disabled due to substance abuse (Meneses, 2010). Therefore drug abuse costs South Africa millions of rands a year due to productivity losses as a result of drug-related illnesses and deaths (HR Future, 2010; Rose-Inness, 2008; Kew, 1994).

According to the MRC report South Africa proclaims one liquor outlet (23 000 licensed and 200 000 unlicensed) for every 190 persons in South Africa offering easy access and encouraging the prevalence of alcoholism. The new democracy saw increased trafficking and availability of drugs such as cocaine and heroin in South Africa. The country has become a drug transit point which may be due to factors such as the decrease in local controls following the collapse of apartheid, an

increase in tourism as well as increased economic and political migration to South Africa (McCann, Burnhams, Albertyn & Bhoola, 2011). The legacy of the 'dop system' is considered a contributing factor to alcohol abuse in South Africa. The term 'dop system' refers to the provision of alcohol to farm workers as partial payment for their labour (Parry, Pluddemann, Steyn, Bradshaw, Norman, & Laubscher, 1998). Although the system is now illegal in South Africa, alcohol dependence among farm workers continues to play a major role, entangling them in a cycle of poverty and dependence, and is likely to be a contributing factor to alcohol abuse (London, 1999). The reviews above point out the role and contribution of the Government in the drug and alcohol problems in the country and therefore prompt the question, what are social services doing about the crises of substance abuse?



The National Drug Master Plan (2013-2017) approved by Cabinet on 26 June 2013 established the Central Drug Authority as an advisory body in terms of the Prevention of and Treatment for Substance Abuse (Act No. 70). The Master Plan serves as the country's blueprint for preventing and reducing alcohol and substance abuse in South African Society (Central Drug Authority, 2013). An article in the HeraldLIVE dated 25 January 2014 six months after the above publication stated 'No state rehab for drug addicts'. The article read as follows "Eastern Cape families of addicts are being drained financially as there is no state-funded rehabilitation centre in the region, and funding one currently in the pipeline remains a challenge". The article points out further that the Garden Route has several private rehabilitation centres but the vast majority of the substance abusers rely on one free outpatient facility at SANCA in George. Eastern Cape Department spokesman Govani Maswana confirmed that there was no state rehabilitation centre as yet but the Department is in the process of establishing one. The challenge the Department is facing is non-availability of funds (Heraldive, 2014).

An investigation into the availability of rehab facilities in East London revealed that SANCA, AA (Alcoholics Anonymous) and Eastern Cape Home Detox were the only options as an alternative to residential treatment. Dr Tobela Nogela, the Director of Special Service Department of Health,

Eastern Cape, suggested Fort England Hospital in Grahamstown for in-patients. But the access to that service meant being on a long waiting list and prior to being admitted the patient has to go to a district hospital or non-government organisation (NGO) for detox. The above publications indicate measures that are considered to address the problem but due to lack of funds nothing has been done as yet. According to the provincial community safety budgets the total figure attributed to alcohol abuse was estimated at R43, 9m (de Jager, Oelofse & Hollands, 2014). The argument labours around the issue of fair distribution, because it appears as though the marginalised communities still seem to suffer the consequences.

SUBSTANCE ABUSE TREATMENT AND EFFECTIVENESS

Treatment planning involves individual care, treatment and rehabilitation goals specific settings, services or programmes. The plan is based on identified needs and specific goals and objectives (Brown, O'Farrel, Maisto, Hickman & Suchinsky, 1997). According to Riley (1994) dual-diagnosis clients represent a special challenge to treatment professionals because it is so difficult to make an accurate diagnosis because of the client's emotional stability (Carey, 1989; Rado, 1988; Wallen & Weiner, 1989; Evans & Sullivan, 1990). Therefore it may be necessary for the patient to be drug-free for up to four to six weeks before an accurate diagnosis can be made (Nathan, 1991). Several treatment processes have been developed by different organisations over the years. In this study focus is given to the AA Twelve Step approach because SANCA has developed an in-patient treatment model that follows the principles of this approach. Since the study was conducted at SANCA and the participants were in-patients at the time, it would be beneficial to the reader to understand the underlying principles of this approach.

The AA Twelve Step Approach

The path to sobriety, according to the AA model, is a journey of many small steps and in the fellowship of recovering alcoholics (Van Wormer, 1995). According to Jellinek, (1960) the first step is for the client to admit that they were powerless over alcohol. The client decides to turn their will and lives to the care of God as they understand him (Jellinek, 1960). A narrative inquiry in a study

confirmed that the process of surrender is a crucial element in long term recovery. Although triggers for relapse still exist, embracing a surrender identity allows addicts to gain control by giving up control, leading potentially to long term recovery through individualized support (Brooks, Arminio & Gaballero-Dennis, 2013).

Vaillant (1983) conducted an extensive longitudinal study, covering a low socio-economic status population of males for over a forty year period. He concluded that factors associated with recovery in middle age were attributed to recovery of willpower, active church membership, other group membership such as AA, stable relationships and hobbies. However, Hester and Miller (1989) conducted two hundred controlled studies on the effectiveness of treatment and only four involved controlled trials of AA strategies and none of these demonstrated a beneficial treatment effect. Miller's explanation for poor results concerns the confrontational style typical of traditional alcoholism counselling. He concludes that the uncontrolled evaluation studies done by individual Twelve Step treatment programmes based on follow up telephone calls cannot be regarded as creditable reports of treatment effectiveness (Miller, 1990).

The best evidence in support of the Twelve Step programme is provided by the independent evaluation service for the chemical dependency field, CATOR (Comprehensive Assessment and Treatment Outcome Research). According to Hoffman, Belile and Harrison (1987) approximately 53% of 1,975 adult patients (male and female) were followed for two years after discharge. Of those interviewed, only 28% relapsed significantly. Statistically correcting for the patients who could not be contacted, the study concluded that at least half of the men and women treated at the inpatient treatment centre maintained sobriety for at least two years.

THE IN-PATIENT TREATMENT MODEL

SANCA in Eastern Cape was awarded the tender by the National Department of Social Development to develop an in-patient treatment model for substance abuse to guide service providers who render

treatment services to consumers in both public and private treatment centres. The National Department of Social Development Health observed during official visits to SANCA that a balanced approach between prevention and treatment is needed to establish an effective treatment model. The goal of treatment is not only to stop drug abuse, but to return the person to productive functioning with the family, community and workplace (National Institute of Drug Abuse, 2011).

CONCLUSION

Literature discussed above suggested that the instrumental use of drugs has a specific behavioural goal or is used for recreational purposes. Studies on alcoholism found that heredity and environmental factors contributed largely to alcoholism among children and adolescents. Some adolescents may use substance to self-medicate due to painful feelings of depression or peer pressure. It can contribute or escalate children and adolescent substance abuse because most of these children are more prone to violence, poverty, abuse and depression. Studies revealed that substance use disorders can affect other members within families over different generations when jobs and other valuables are lost and thus contributing to extreme poverty. When abusers resort to crime to maintain their addiction, the criminal behaviour poses a threat to the members of the community.

Substance abuse is a prevailing problem in the under-resourced suburb in East London in which the research was done. In the next chapter attention will be given to the methodology used to explore the experiences of the participants with the hope of adding value to existing treatment plans.

CHAPTER 3

THEORETICAL FRAMEWORK

INTRODUCTION

An Interpretative Phenomenological Analysis (IPA) approach is committed to the examination of how people make sense of their major life experiences. (Smith, Flowers & Larkin, 2009). The proposed study is of a qualitative nature aimed at eliciting subjective experiences of the individuals participating in the research. The interest is on how the participants understand their diagnosis of being a dependent and the understanding they have of what the impact substance abuse has on their relationships, finances and their roles in the communities. The advantage of IPA as a research approach is the emphasis it places on the reported experience of the participants.

In the discussion below the core principles of IPA are explained, and how they are used to elicit the reports of participants' experiences. Attention will be given to the core principles, then the relevance of IPA for psychological research and how it was applied to this research.

INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS (IPA)

At the core of interpretative phenomenological analysis (IPA) is the notion of people as "self-interpreting beings" (Taylor, 1985). This means that individuals are actively engaged in interpreting the events, objects, and people in their lives. This interpretative activity is captured by the phrase 'sense making'. The central concern for IPA is the analysis of how individuals make sense of their lived experiences. This theoretical approach aims to provide a detailed exploration of these personal lived experiences as well as a close examination of how participants make sense of them. The main idea that supports IPA study is the meanings particular experiences, states, events and objects have for participants (Breakwell, Hammond, Fife-Schaw & Smith, 2006).

PHENOMENOLOGY AND HERMENEUTIC

Phenomenology and hermeneutic inquiry form the dual epistemological underpinnings of IPA. Phenomenology is concerned with attending to the way things appear to us in experience; as individuals, how we perceive and talk about objects and events. This is in contrast with an attempt either to produce an objective statement of the object or event in itself or to examine the object or event in terms of pre-existing conceptual and scientific criteria. The contemporary hermeneutic inquiry draws attention to how individuals make sense and interpret events. The IPA's aim is achieved through interpretative activity on the part of the researcher. This is a familiar and human activity carried out empirically and systemically. IPA emphasises that research is a dynamic process with an active role for the researcher in that process (Breakwell, Hammond, Fife-Schaw & Smith, 2006).

According to Conrad (1987) the researcher attempts to assume an insider's perspective, trying to understand what it is like to stand in the shoes of the participant whilst recognising this as never completely possible.



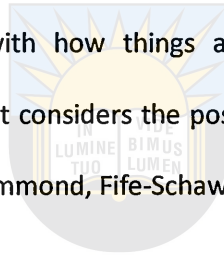
DOUBLE HERMENEUTIC

The process of participants trying to make sense of their world and the researcher trying to make sense of the participants trying to make sense of their world is a process described as 'double hermeneutic' or 'dual interpretation' (Smith & Osborn, 2003). 'Reality' as it appears to and is made meaningful for the individual is what is of interest to the IPA researcher. The researcher recognizes his or her dynamic role in making sense of that reality. Another way of thinking of double hermeneutic is as one which combines both an empathic and critical hermeneutics (Ricoeur, 1970). Consistent with its phenomenological origins, IPA aims to understand what an experience, an event and an object is like from the point of view of the person. Yet at the same time IPA can assume distance from the participant, allowing the researcher to ask interesting and critical questions of the accounts.

The typical examples of questions asked are:

- What is the person trying to achieve here?
- Is something leaking out here that wasn't intended?
- Do I have a sense of something going on here that maybe the person is less aware of?

Both of these modes of interpretation can be part of a sustained qualitative inquiry and IPA studies will often contain elements of each. To permit both aspects of inquiry is likely to lead to a richer analysis and can do greater justice to the totality of the person's life world. Therefore, in summary, IPA synthesizes ideas from phenomenology and hermeneutics, resulting in a method which is descriptive because it is concerned with how things appear and allows them to speak for themselves, and interpretative because it considers the possibility there is no such thing as the uninterpreted phenomenon (Breakwell, Hammond, Fife-Schaw & Smith, 2006).

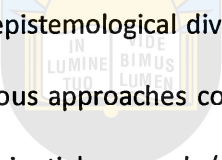


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IPA AND PSYCHOLOGY

Interpretative phenomenological analysis is firmly located within the discipline of psychology, seeking opportunities for a useful dialogue between the various traditions, which can contribute to the debate as to what constitutes a possible mode of enquiry for psychology. The emphasis is on 'sense making' by both participant and researcher so that cognition can be usefully seen as a central analytic concern. It suggests a compelling theoretical alliance with the dominant cognitive paradigm in contemporary psychology. IPA shares a common concern with cognitive psychology and social cognition with unravelling the relationship between what people think (cognition), say (account) and do (behaviour). However, this shared concern differs when it comes to deciding the appropriate methodology for such questions. Cognitive psychology continues to be committed to quantitative and experimental methodology, whereas IPA employs in-depth qualitative analysis. IPA therefore shares with Bruner (1990) a vision of cognitive psychology as a science of meaning and meaning-making rather than a science of information processing.

According to Smith (2004) IPA is one of several closely related approaches described as 'phenomenological psychology'. These approaches share a commitment to the exploration of personal lived experience but have different emphasis or suggested techniques to engage in this project. An example by Giorgi and Giorgi (2003) describes a method for conducting empirical phenomenological inquiry which aims to ascertain the underlying essential structure of psychological experience. Ashworth (2003a) is particularly interested in identifying the elements of the 'life world' in participants' accounts of selfhood, sociality, embodiment, temporality, spatiality, project and discourse.



Qualitative research is characterized by epistemological diversity. Recently researchers have begun to reflect on the ways in which the various approaches converge and diverge. Elliott, Fischer and Rennie (1999) distinguish between experiential research (a focus on understanding, representing and making sense of people's ways of thinking, motivations, actions, etc.) and discursive research (a focus on the ways in which language constructs people's worlds). IPA undoubtedly fits in the former category. Although IPA recognizes the importance of language in influencing how individuals make sense of lived experiences and then, in turn, researchers make sense of participants' sense making, but it disagrees with a claim that language is the sole or primary constructor of reality (Reicher, 2000).

In this study the researcher focussed on understanding the participants' making sense of their way of thinking, what motivates them and how they will act it out. Although the participants described and expressed their understanding in their own language, the themes were derived from the participants' own way of thinking, their motivation and action. This means that although each participant used language differently to express themselves the overall understanding and sense making gave rise to shared themes.

THE DATA COLLECTION METHODS

Most IPA studies have been conducted on data obtained from face-to-face semi-structured interviews. This method of data collection might be considered the typical one. The IPA studies require a flexible method of data collection, one that gives experience a central place whilst recognizing the multiple influences on any experience (Smith, 1991). The data collected in this study followed the above approach so semi-structured face to face interviews were conducted with the participants. The duration of the interviews was 60 minutes for each participant. The tool used to collect data included semi-structured interviews and audio recordings to ensure greater flexibility in the responses of the participants and to encourage participants to enter unique areas and offer in-depth accounts of their experiences, so that richer data could be produced. The context of the target group was multicultural and therefore the questionnaires were designed to be culture sensitive by taking into consideration the participants' world views, their beliefs, behaviour, practices and norms.

Semi-structured interviews conducted by the investigator have a set of questions on an interview schedule. The interview is guided by it rather than dictated by it. The interview follows the respondent's interest or concerns and the order of questions will become less important. An attempt to establish rapport with the respondent will allow the interviewer to feel free to probe interesting areas that may arise during the interview allowing the respondent to be the expert (Smith, 1991). The interviews conducted for this study did not follow the specific order of the questions; participants were allowed to lead the interview by the way they structured their discussions. Some participants required prompting so the questions on the interview schedule were very useful but, once the relationship and rapport between the researcher and participant was built and the interviewee became comfortable to discuss more sensitive issues, the direction of the interview was then dictated by the interviewee. In this way subjective in-depth experiences were described in great detail.

Meaning is central to a study of this nature and the aim is to try and understand the content and complexity of those meanings. The investigator tries to engage in an interpretive relationship with the transcript rather than using it as a measuring tool, observing the frequency of experiences that have occurred in the participants' lives. An idiographic approach to analysis begins with particulars and slowly works up to generalization. One key value of phenomenological philosophy is that it provides us with a rich source of ideas about how to examine and comprehend lived experience. The sample size will focus on the issue of quality and not quantity so that the studies may benefit from a concentrated focus on a small number of cases (Smith, 1991). Therefore only seven participants were chosen from the clinic so that focus could be on the depth of experiences and not the rate of recurrences of these experiences.



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The interpretative focus of IPA means that the researcher adopts a probing stance towards the meaningful worlds offered by the participants. Interviewing is one of the most powerful and widely used tools of the qualitative researcher. The advantage of the semi-structured format for IPA is that the researcher is in the position to follow up interesting, important and even unexpected issues that emerge during the interview. However there are other means of collecting rich verbal accounts, for example participants can write autobiographical or other personal accounts (Smith, 1991).

The semi-structured interview lies on a continuum from unstructured to structured, but what researchers mean by these terms can vary considerably. A set of questions is developed by the IPA researcher that will address the topic of interest, but the questions will guide rather than dictate the course of the interview. If the participant opens up a novel and interesting area of inquiry then this should be pursued. The researcher treats people as experiential experts on the topic under investigation (Smith & Osborn, 2003). The aim is to facilitate the giving and making of an account in a sensitive and empathic manner, recognizing that the interview constitutes a human-to-human relationship (Fontana & Fry, 2000). The researcher chose face to face semi-structured interviews with the participants for this study because the responses from the participants' were spontaneous

and was described in their own words with expressions and emotions that portrayed a very graphic description. This enhanced the accounts of their experiences and also provided the researcher with a better understanding of it.

However it is quite possible that the interview may move away from the questions on the schedule and enter an area that had not been anticipated by the researcher but is extremely pertinent to and enlightening of the study's overall question. These unique avenues are often the most valuable because they have come unprompted from the participant and, therefore, are likely to be of special importance to the researcher. However the researcher needs to ensure that the interview does not move too far away from the agreed topic. In essence, the researcher is aiming for a conversational and participant-led style of interviewing that allows the participant's perceptions of and stories about the topic to come to the fore. Therefore the interviewer was cautioned by the possibility that the interview may stray from the purpose or aim of the study. At this point of the interview the interviewer used the questions on the interview schedule to redirect the focus to the topic of the study.

It is usually necessary to record and transcribe the whole interview. When making field notes and transcriptions the researcher needs to leave wide enough margins on both sides of the page to make analytic comments. Transcriptions of the tapes can be a lengthy process, depending on the recording and one's typing proficiency. A rough estimate as a guide, the researcher should allow seven hours of transcription time per hour of interview for the type of transcription required for IPA (Breakwell, Hammond, Fife-Schaw & Smith, 2006). The interviews in this study were recorded and some notes were made because it became necessary to make eye contact with the participants giving full attention to their conversations. This made it difficult at times to cover most of the material from the interview in the notes. Therefore the data collection relied profoundly on the transcripts from the recordings and much of the focus was given to the recording of the sessions.

STAGES OF ANALYSIS

The most important step is for the qualitative researcher to feel positive about dealing with data because it is sometimes difficult to imagine that one will be able to make sense of the many pages of interview material. However, if the researcher is careful, systematic and takes time with each analytic stage, he or she will begin to develop confidence. It could be useful to think in terms of totally immersing oneself in the data - as far as possible stepping into the participant's shoes.

The researcher must remember that the aim is to give evidence of the participant's sense-making with respect to the topic under investigation, and at the same time document their own sense-making as researcher. The other aim is to look at the data through the psychological lens, making sense of it by applying psychological concepts and theories. The IPA approach is not a prescriptive approach but rather it provides a set of flexible guidelines which can be adapted by individual researchers in light of their research aims and this is particularly true when it comes to its analysis (Breakwell, Hammond, Fife-Schaw & Smith, 2006).

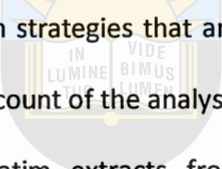
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WRITING UP AN IPA STUDY

Narrative and interpretation

The analysis continues into the formal process of writing up a narrative account of the interplay between the interpretative activity of the researcher and the participants' accounts of their experiences in their own words. The aim is to provide a close contextual reading of each participant's account, moving between description and different levels of interpretation, and at all times clearly differentiating the participant's words from the researcher's analysis. According to Smith (2004) the quality of moving between levels reflects the multifaceted nature of psychological process and gives qualitative psychology its imaginative force. When writing up the study enough data should be presented for the reader to assess the usefulness of the interpretations. IPA's iterative process means that the interpretative levels acquire more depth as the researcher moves beyond a description of the phenomenon to interrogating the participant's sense-making.

The researcher can demonstrate a hermeneutical position in empathy and meaning recollection and in more or less accepting what the participant says at face value. However the researcher can also engage more critically and ask questions of the accounts which the participant might be unwilling or unable to do. At this stage, the empathic reading is likely to come first and may then be qualified by a more critical and speculative reflection. Interpreting the data at a more subtle and conceptual level involves the researcher building an alternative coherent narrative from the messy sense-making of the participant. The messiness is usually only revealed when the researcher examines closely what the participant is saying (Smith, 2004).



Finally, there are two broad presentation strategies that are possible. In the first presentation the 'results' section contains the narrative account of the analysis with the researcher's descriptions and interpretations interspersed with verbatim extracts from the transcripts, and the separate 'discussion' examines that analysis in light of the extant literature. The second strategy is to discuss the links to the literature as one presents each superordinate theme in a single 'results and discussion' presentation (Breakwell, Hammond, Fife-Schaw & Smith, 2006).

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CONCLUSION

In this study attention was given to the theoretical framework within which the research was conducted, i.e. IPA. Attention will now be given in the following chapter to the practicalities of the research, i.e. on the application of the theory within life circumstances, i.e. where and how it was conducted and how it maintained ethical validity.

CHAPTER 4

METHODOLOGY

INTRODUCTION

In this chapter attention will now be given to the context within which the research was conducted, which study design was followed and amongst which population it was conducted. Attention will also be given to the ethical considerations.

RESEARCH CONTEXT

The study was conducted at SANCA that is a rehabilitation centre located within the surrounding target area. Almost all of the recovering addicts from the target area are admitted in this particular institution. SANCA in the Eastern Cape was awarded the tender by the National Department of Social Development to develop an in-patient treatment model for substance abuse to guide service providers who render treatment services to consumers in both public and private treatment centres. The goal of treatment is not only to stop drug abuse, but also to return the person to productive functioning within the family, community and workplace (National Institute of Drug Abuse, 2011). A study within this local treatment centre provided an appropriate starting point for my research.

STUDY DESIGN

A qualitative research approach was followed that was committed to the examination of how people make sense of their life experiences. The theoretical stance is phenomenological, in which participants' experiences are explored, explained and interpreted according to their own terms. The researcher was especially interested in what happens when the everyday flow of lived experience takes on a particular significance for the participants (Smith, 2009). Phenomenology is concerned with attending to the way things appear to us in experience and how individuals perceive and talk about objects and events (Breakwell, Hammond, Fife-Schaw & Smith, 2006). The fundamental concept of the life world and people's lived experience of their situation was analysed. (Smith,

2008). Detailed descriptions of the participants' views and experiences were recorded as field notes and became the data for analysis.

STUDY POPULATION

Seven participants were selected from the target population from three suburbs of East London. The participants were currently in the process of recovery and were in-patients at SANCA. The sample size addressed issues of quality and not quantity.

PARTICIPANT RECRUITMENT

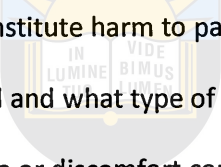
Sampling was theoretically consistent with the qualitative paradigm in general and with IPA's orientation in particular. A homogenous sample was selected through purposive sampling because it offered the research project insight into the particular experience of the participant and for whom the research questions were significant. (Smith & Eatough, 2007). Purposive sampling starts with a purpose in mind and the sample is thus selected to include people of interest (Jupp, 2006). The participants had to be over the age of 18 years and from the target population exposed to the realities of that community. Recruited participants had to be willing to share their experiences as substance abusers who were in recovery at the time of the study.

ETHICAL CONSIDERATIONS

This study followed the ethical codes set out by the University Research Ethics Committee (UREC) of Fort Hare University. The research was conducted according to the International Declaration of Helsinki and other applicable international ethical codes for research on human subjects as stipulated in the Ethical Clearance application forms by the UREC of the University Of Fort Hare.

A letter was addressed to the Director of SANCA obtaining his consent to conduct the study at this institution. Informed consent was a required pre-requisite and participants were required to sign a consent form. The identities of the participants were kept anonymous and they were identified

through numbers instead. The letter to the participants described the aims and objectives of the research and it informed them of the nature of questions to expect. It was explained to participants that should they have reservations about answering any question they may refrain from responding to the line of questioning. They may also withdraw from participating at any time if they wished to do so. Participants over the age of 18 years were selected so that they could be competent to give consent to participate. During the interviews issues of consent were revisited to reassure participants. All participants were assured of confidentiality and their identities remained anonymous. All data collected was handled and controlled by the researcher alone and was stored in a safe place.



Sensitive issues during interviews may constitute harm to participants; therefore, it was explained to participants what topic was being covered and what type of questions to expect. In the event of any participant experiencing emotional trauma or discomfort counsellors within the institution of SANCA were available to offer assistance. The participants were respected at all times because the questionnaires were culture sensitive and cultural views and perceptions were always acknowledged.

DATA COLLECTION METHODS

The tool used to collect data included semi-structured interviews and audio recordings to ensure greater flexibility in the responses of the participants and to encourage participants to enter unique areas and offer in-depth accounts of their experiences, so that richer data could be collected. The context of the target group was multicultural and therefore the questionnaires were designed to be culture sensitive by taking into consideration the participants' world views, their beliefs, behaviour, practices and norms.

Semi-structured interviews were conducted by the investigator assisted by a set of questions on an interview schedule. The interview was guided by it rather than dictated by it. The interview followed

the respondents' interests or concerns and the order of questions became less important. Rapport with the respondent was established allowing the interviewer to feel free to probe interesting areas that were raised during the interview allowing the respondent to be the expert. As a result of flexibility and open-endedness, qualitative research methods provide a space for validity issues to be addressed. According to Willig (2001), the validity of the instrument is determined by the extent to which the data collected addressed the question that needed to be answered.

The unit for analysis was the data collected from semi-structured interviews. The content and complexity of the participants' interpretations of how they make sense of their addiction and how they understood the experience of their addiction was elicited by the focus of the questions in the interview schedule. The questions on the interview schedule were considered to stimulate reflection on their addiction, how the participants experienced their recovery process and how it affected their lives as community members. All necessary efforts were made to ensure that the research methodology and data analysis were justifiable and feasible so that valid results were produced.

The data that was collected through recorded conversations and semi-structured interviews elicited in depth accounts of participants' personal experiences. The data was then transcribed and analysed in detail of how participants made sense of their addiction and how they understood the causes of their addiction. Field notes were taken during the interview to keep an accurate record of the accounts of the participants during the interviews. Audio recordings assisted in the transcription of the data which needed to be ordered when transferred to a line-numbered transcript. Copies of the interview schedule and notes were made for safe keeping and locked away. The interview material was handled and accessed only by the interviewer.

DATA ANALYSIS

In order to explore the reported views and experiences of participants, the transcripts were read a number of times until the interviewer became familiar with the accounts. Each reading had potential

to bring new insights. Each text was divided into meaningful units and each unit was assigned a comment. The similarities and differences, echoes, amplifications and contradictions in what a person was saying were commented on.

The next step involved using the right hand margin to transform initial notes and ideas into more specific themes or phrases which refer to psychological concepts and abstractions. At this point caution was exercised about the connection between the participants' own words and the researcher's own words so that the researcher's interpretations are not lost (Breakwell, Hammond, Fife-Schaw & Smith, 2006). Themes were listed in chronological order and were based on the sequence with which they came up in the transcript.

Further refining of data was followed by establishing connections between the preliminary themes and then by clustering them appropriately. A more analytical or theoretical ordering was done to make sense of the connections between the themes that emerged. Some themes were in turn clustered together and this led to the discovery of some superordinate concepts. The clusters were then given a label which conveyed the conceptual nature of the themes therein. This form of analysis is iterative and involves a close interaction between reader and text.

A table of the themes was created and the themes ordered so that the clusters that most strongly captured the respondents' concerns on the topic could be identified. Each participant's transcripts were then written up so that they could be translated into narrative accounts. The coding's of the notes were arranged in a systemic organisation of data so that the occurrence of experiences could be tabulated. Illness was considered in terms of participants' perception, experience, expression and pattern of coping with symptoms. The experience of illness was understood as a culturally shaped phenomenon. Finally an extract from the final write-up of the research study on substance dependency was drawn up.

This study offered the participants a platform to voice their experiences of their diagnosis and recovery with regards to their mental and physical health. The secondary aim was to explore mental health care services offered by social services to these under-resourced communities. The result of the research presented themes that are discussed with reference to literature and the voice of the investigator without losing the essence of the participants' personal views. The section discussed in this chapter will address the effects of addiction on the mental and physical health of the participants' coping strategies, relapses, parental substance abuses, family support and economic impact. Conclusions will then be drawn from the findings of the discussion.

STRENGTHS AND LIMITATIONS

The strength was that participants' had a voice in describing their own experience of health care. They were able to express how they felt and were heard in a sensitive manner. They were able to describe their life experiences from their own perspectives. They also suggested ways in which their needs could best be met. Participants felt empowered to make their own choices about their realities.

The limitation was that sensitive issues during interview could have constituted harm to participants; therefore, they were told the topic to be covered and what type of questions to expect. The necessary steps were taken to ensure that in the event of any participant experiencing emotional trauma or discomforts counsellors within the institution of SANCA were available to offer assistance.

CONCLUSION

In this chapter the process of collecting, storing and interpreting the data was considered. The research context, study design, study population and the participant recruitment were discussed in detail. During data collection the researcher was cognisant of ethical considerations at all times. The strengths and limitations of the study were noted. The research findings, however, may be to the

benefit of the community as a whole as it may bring added value to existing interventions. In the following chapter attention will be given to how this data was interpreted.



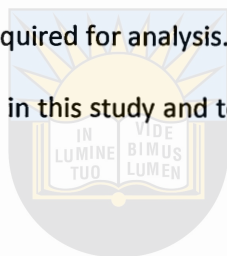
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CHAPTER 5

FINDINGS AND DISCUSSION

INTRODUCTION

According to the literature reviewed the themes resulting from substance abuse are poverty, peer pressure, the influence of environmental factors and family hereditary. All of these factors play a role in a vicious cycle in which members of communities find themselves entangled for generations. In the previous chapters the theoretical stance and how it will be practically applied in the research was described. An interpretative phenomenological analysis of the participants' views and experiences elicited the pertinent data required for analysis. The intention of the investigator was to find data relevant to the topic of interest in this study and to add richness and depth to the existing body.



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The researcher sought to understand the reasons the participants gave for their dependence and abuse of substance. The explanations of how they relapsed or how they viewed the possibility of a relapse when they return to their environment were also important. Diverse viewpoints offer other ways of understanding an already existing problem which may influence the findings of this study. The data that came from the interviews is now discussed according to how participants described the history of the dependency, the choice of substance, fear of relapse, the role of alcohol on the dependency, the role of family support, views on parental substance abuse, the community's understanding of the addiction, the influence of treatment on the participant's life experience, future plans to maintain a life of sobriety, experienced economic and social impact and the importance of personal hygiene.

THE HISTORY OF THE PARTICIPANTS' DEPENDENCY AND CHOICE OF SUBSTANCE

The four male participants were all diagnosed for drug abuse; three of them used cocaine and two used tick but all of them used more than one type of drug concomitantly. Together with the two

drugs mentioned above, they used crack, dagga (weed), crystal methamphetamine, mandrax, cat and ghb. The three female participants were all diagnosed with alcohol abuse only and were diagnosed with depression concurrently or some time before their addiction.

Participant 1 is a 36 year old male, single with two children. He was diagnosed with the addiction of crack, cocaine and dagga. He completed matric but is currently unemployed. Participant 1 indicated that he started smoking dagga in 2010 because of financial stress. Although he did find work afterwards, he relapsed because of relationship problems with his girlfriend and used his salary to maintain his drug addiction. He said that he was influenced by friends but was not on any drugs from June 2011 to January 2013. He then found out that his girlfriend was not faithful to him and this caused him to become disillusioned and vulnerable. She wanted him to marry her or else she would move on with the other man. He felt pressured because he was not ready for commitment. He then met an old friend and decided to have one glass of wine. This brought up all of his cravings for drugs. He went back to where he got drugs from in the past and started using drugs again. He confessed that he “smoked hard” continuously, finally coming to a point of overdosing.

He lost his job and then had no money to maintain his addiction. He had no time to take care of his children because most of his time was spent on preoccupations for his next ‘fix’. His mother and sisters advised him to get help from SANCA. He said, “I admitted to my family that I have an addiction problem and they supported me with this treatment”.

Participant 2 is a 20 year old male who discontinued school in grade 11. He was diagnosed with dependency on ‘tik’ (crystal methamphetamine) and cocaine. He is single and was introduced to drugs by his ex-girlfriend who was seven years older than him. As soon as he became addicted he had to maintain his addiction through committing crimes such as breaking into houses and theft.

Participant 2: “I started abusing substance when an older girl that I was dating used to call me in class when I was maybe in the accounting class. I was attracted by girls who were older than me”.

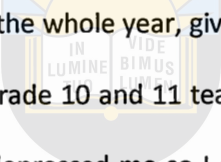
“Everybody is like shoo, I get a call, please come to my flat – she had a flat. I go there, she gives me money, go buy some beers, go buy some weed, she has cocaine, but she is a nurse. I thought she is a nurse, she knows what she is doing, sniffed cocaine, drag, drink. When I am about to go home she would say no, don’t go home, go back to school then come back to me. I ended up living with her now, but I was still a high school student”.

“What happened is, she got transferred to Durban to work there and she had – she didn’t treat me as her boyfriend. She was treating me like a toy boy, but I didn’t understand. I was still young. She had a boyfriend that [inaudible], that was actually well off, they had a baby together, but he didn’t live in East London. Whenever he used to come she used to say I am her cousin because I am young, I am way younger than her, she was like how many years, and she was seven years older than me. I would say yes, I am just the younger cousin. Then they would give me like 20 bucks to go buy alcohol, whatever. They would spend time together. I was like that is fine, I am not panicking, at least I am getting cash, I am chilled. When he goes I stay with her and stuff like that. Until she left, she left me with that cocaine addiction. I am a student. I couldn’t afford it”.

“She had a girl friend who was dating the drug dealer. So they were stealing the drugs from the drug dealer and would smoke with me. It was a lot of it. She would sell some of it because she would steal it from her boyfriend. It was just large supply. I quickly recovered from cocaine. It wasn’t that bad to me because I couldn’t use it every day anyway. It was too expensive. What was really hard for me was tik. It is nice. I am not going to lie to you. It is nice. The feeling is yo, it is very nice”.

He then became addicted to the drugs and in order to afford it on his own he resorted to crime and became a trouble maker. These factors resulted in him going to rehab at the age of 17. He went into rehab in Durban at the Lulama Treatment Centre. He did not finish his treatment there and ran away from rehab after only three weeks of treatment. He is presently at SANCA and finds the group sessions helpful in his recovery process.

Participant 3 is a 48 year old female that is a teacher and mother of three children who was diagnosed with alcoholism and major depression. Her alcoholism was triggered by her depression. She consumed alcohol to cope with her depression. She started consuming alcohol two years ago when she became stressed and depressed due to workload at school and finding out that her son was abusing drugs. The principal of the school became aware of her problem and suggested she get some help. She was then diagnosed by a psychologist with major depression and was on antidepressants. She continued drinking and then the Department of Wellness decided that she take leave of absence and admit herself into SANCA.



Participant 3: "I was given life science for the whole year, given the same school Grade 10, 11 and 12 and I also have been a physical science Grade 10 and 11 teachers. I had a boy which started giving trouble, so I think this made me – they depressed me so I drank a lot, would drink a lot, I became sick and I went to the hospital, Cecilia Makiwane... Yes, I was going to the doctors there. So they were complaining of stress. So my principal decided to go to the department and acknowledged my situation. In our department there is a department of wellness, yes. Yes, they referred me here. They started by sending me to a psychologist, [inaudible], you know? No, he also said that I've got major depression, but the wellness department took me – referred me here. They took me straight here".

She used alcohol to cope every day and her tolerance level increased. She could not stay sober for any period of time so she drank during school hours.

Participant 4 is a 42 year old female who is a single mother and is a teacher by profession. She was diagnosed with alcoholism but was depressed in the past and was on antidepressants. She started drinking alcohol in her first year at college because of social reasons and being away from home. She experimented with different types of alcohol. She felt that it was the freedom and her father dying

the same year that contributed to her alcoholism. She is currently unemployed because of her dependency.

Participant 4: “Yes, I was doing my first year. I started enjoying life of being free, do whatever I want to do because my dad was a very strict person, very strict”.

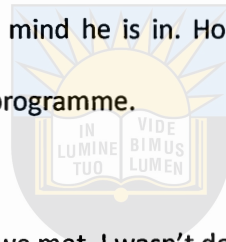
Her previous boyfriend was emotionally abusive and caused her to drink so that she could cope day to day. Her new boyfriend encouraged her in 2006 to go to SANCA for help. She managed to stay sober for two years but relapsed in 2008 because she then got involved in another abusive relationship that was compounded by her unemployment and financial difficulties so she started to drink again. She has now decided to go into rehabilitation for the second time but fears that she may relapse like the last time. However she hopes to change and be a better mother.

Participant 5 is a 41 year old divorced female who is a single mother and was diagnosed with alcoholism and depression. Her depression was diagnosed first and then she started to drink to cope every day with her depression until she became dependent on alcohol. She discontinued school in Grade 11 and worked as a financial manager but is currently unemployed because of her alcoholism. Two and a half years ago her ex-husband took her two children away from her without her consent or knowledge. She did not know their whereabouts and was estranged from her children. Although she contacted the police and social workers, she could not find them. She has been drinking alcohol ever since to cope with the loss of her children whom she did not see for two and half years.

During the time of her alcohol abuse she got arrested for disorderly conduct, driving under the influence of alcohol, disturbing the peace in the neighbourhood and eventually she lost her job. She was evicted from her cottage and rejected by her family because they did not want to have anything to do with her. “But last week Monday I got my children back and they now seven and nine”. Now that her children have been returned to her she still has a problem with alcohol and has to get help

so she can take care of her children. Her family helped her financially to come to SANCA to recover and her sister helped to take care of her children during her stay at SANCA.

Participant 6 is a 24 year old male who has completed grade 12 and was diagnosed with drug addiction. The drugs he consumed were mandrax and tik. He is in a relationship and has two daughters from a previous relationship. According to participant 6 he was addicted to mandrax and tik which were readily available in the neighbourhood where he lives. He also added that his addiction was maintained by the influence of the company he kept. He is unemployed and has suffered financial losses because of his addiction. He becomes impatient with his daughters and shouts at them because of the state of mind he is in. However, he indicated that his family and girlfriend support him with his recovery programme.



Participant 6: "Well, my girlfriend when we met, I wasn't doing drugs, but as time passed I became a different person towards her. That is when I actually was doing the drugs and that is where everything started".

He started using tik and then found that he could not sleep well and lost weight so he started taking mandrax which he indicated made him feel high and low. This is his first time in rehab but he did try once before to stop on his own and was not successful.

Participant 7 is 27 year old male who is single and unemployed. He was diagnosed with drug addiction and has a long history with his dependency. He used dagga, crystal methamphetamine, cocaine, mandrax, cat and ghb. He has a tertiary qualification, a diploma in electrical engineering and used to be self-employed until he could not function effectively in his daily life. He was abusing substances for 12 years and on three occasions he went into rehabilitation but relapsed each time and continued his addiction. He started at a very young age when he got influenced and pressured by his peers at parties to fit in.

Participant 7: "It started off at college with weed. Ja! Then I went overseas. The first time I used was in 2001/2002 when I went overseas, that was the first time I used hard core drugs, like cocaine. From there it was 'CAT'. I started taking 'CAT'. That is also like coke in a liquid form and 'CAT' is very similar to crystal meth, but not as dangerous if I could say it that way. But 'CAT' is also a very highly addictive drug and also it keeps you awake". The second time he went to rehab was when his best friend past away because of crystal meth.

"A very, very close friend of mine, ja. He died because of crystal meth. That is when I went to rehab the second time. After that I was clean for maybe three or four months and then I was looking out for jobs because a matter of still trying to qualify and all of that". He agreed that the area he lives in influenced him as well.



The third time he went to rehab was for two months. He indicated that it gave him time to reflect and find himself. "I went to Heart Haven for two months, basically two months, ja. When I realised.... when I actually opened my eyes and I saw what I was doing". Although he relapsed after three months because of influence from his peers who were also using drugs he was clean for two months but he started using drugs again when he bumped into one of his drug dealers. The fourth time he came to SANCA for detox and the rehabilitation programme on his own volition because he realized that he had enough and that it would kill him if he carried on abusing substances.

The history of the participants' dependency revealed themes of stress, social pressures, peer influences, relationship problems and financial difficulties. The three younger male participants indicated that their history of drug addiction started when they were influenced by their peers and had social pressures. They indicated the need to fit in socially with their peers. Their environment, accessibility and peer influence played a major role in their addiction. They enjoyed the experience of it the first few times that they used drugs and then it became an addiction. The older male participant experienced stress caused by relationship problems and financial problems which

resulted in him using drugs to cope. This older participant became addicted because of a stressful lifestyle and using drugs was his way of coping.

One of the female participants had a long history of alcoholism that started in her first year at college. Her reasons for abusing alcohol were for social reasons and the freedom she experienced being away from home. Her alcoholism was not continuous because she would stop abusing alcohol and then whenever she felt any form of stress she would resort to alcohol to cope. She became depressed and was on antidepressants for a period of time in the past. The three female participants indicated that their stressful lives caused them to drink to cope every day and then gradually they became dependent.



The reasons participants give for the substance of choice:

Five participants used substance as a coping strategy with life stresses but found that the substance then became an addiction and it soon caused them to battle to cope in their daily functioning. Participant 1 used drugs to cope with his financial and relationship difficulties and then found that he could not keep his job because of his dependency.

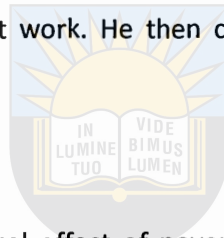
Participant 3: "Okay. I started drinking when I was 46 years. This started when I had an overload of work". What started off as a coping strategy became an addiction. She could not stay without a drink for too long so she then started to drink during school hours.

Participant 4 started drinking due to peer influence but later used alcohol to cope with relationship problems and unemployment.

Participant 5: "Basically my ex-husband kidnapped my children at the age of four and six. I haven't seen them for two and a half years and the only way I coped was drinking. Initially I was able to cope without drinking as the pain got stronger and stronger, so I started to drink to ease the pain. I'm

normally good and fast at what I do so it slowed me down and there were days I would not go to work at all and make excuses and lie why I couldn't make it each time I am babalast and can't get out of bed".

Participant 7: "It started there. But from there, it is obviously from a young age, we used to go to parties. You can't sleep so basically if you are going to work the next day you forget about sleeping that night, so you are going to use it the next day to keep you going through. That is how.... it has a snowball effect and then you start using it every day". He admitted using drugs for recreational purposes with friends at parties and then found that he could not cope the next day to go to work so he used drugs the next day to cope at work. He then could not cope at work because of the dependence on drugs.



This theme 'coping' brings up a spherical effect of poverty in the marginalized community. The members of the community remain in a 'cycle of poverty', a description commonly used in most literature on substance abuse. The common use of this phrase could be owed to the appropriateness of the description of the process of addiction starting with the reason for the addiction which is usually 'to cope' with unemployment, workload, depression and relationship problems. What starts off as a coping strategy slowly becomes an addictive habit that leads to dependency and tolerance. The substance abuser gradually consumes more and more to get the same results. If the substance abuser resorts to addiction because of unemployment, he or she becomes desperate for the 'next fix' so desperation forces him/her to resort to crime or selling household stuff. If the substance abuser has employment and uses a substance as a coping strategy for any other reasons, then he or she gradually battles to cope to function day to day and eventually loses his/her job (Uchtenhagen, 2004).

When substance abusers resort to crime then they become a danger hazard to their community. They add to the poverty of their community because they steal money and break into homes causing

them financial losses. If they are the only income earner in the family, their loss of jobs causes financial difficulties in the home environment. Those who steal from the family and sell stuff from their home also add to the poverty of the family. Substance abusers who are working cause the economy of the country losses in terms of production time lost due to absenteeism from work.

The colossal sum of money used every year by the social development to combat drug abuse and its effects on the community run into billions of rands. The argument raised is how the billions are spent on the community and why the community members are still requiring more assistance. According to this study all of the participants required financial assistance for their recovery but only two participants enjoyed the benefit of social assistance. The argument rests on the issue of fair distribution. Are the marginalised community still targets of unfair distribution?

Some participants found that drug used the night before resulted in lack of sleep urging them to use drugs yet again in the mornings to cope during the day at work. This pattern of abuse continues until their bodies failed to respond to the drugs as they did when they first started using them for recreational purposes or self-medicating. In this study the researcher found that all of the participants have used substances to cope one way or another. As a result of their addiction they battled to cope to keep their jobs. Their job losses resulted in them doing crime, whether it was petty theft or serious crimes like house breaking and car theft. The findings in this study were consistent with the discussion above on coping and its negative economic impact on the substance abusers, their families and the economy of the country.

Literature posted by Teaminspiremalibu (2013) indicated that drug addiction is most commonly found in marginalized communities although there were no reliable studies to prove this. In this study participants were chosen from a marginalized community as indicated by the topic of the study. The investigator was especially interested in the experiences of members of a marginalized community with the prime intention of understanding the reasons for them remaining in a

marginalized community. Data from the interviews supported issues of poverty as pointed out above due to various reasons already discussed. The members of marginalized communities do not enjoy the comforts that privileged communities have; as a result they resort to substance abuse as an escape from unpleasant feelings.

The findings of this study emphasize the reality of these community members. All of them indicated the reason for their addiction which centred on the issue of social economic status. As pointed out above, an addiction can be very costly to maintain and recover from. Their children are exposed to substance and negative modelling behaviour making them more vulnerable and susceptible to becoming substance abusers themselves. In this way it is passed on to the future generations. The members of this community become stuck in a rut for generations because the addiction gets passed on to the future generations. The participants indicated that most of them have other family members or partners who are substance abusers as well. Their susceptibility to the addiction is compounded by environmental factors that encourage accessibility to drugs and alcohol and how the community they live in pose as a risk factor.

THE NEGATIVE EFFECTS OF ADDICTION ON MENTAL AND PHYSICAL HEALTH

The participants described in detail their experience of the symptoms of substance abuse on their mental and physical health.

The participants' personal experiences of the addiction:

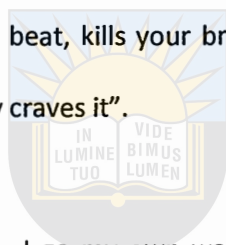
Participant 1: "It was enjoyable for a while but not anymore. I feel wasted and its killing me. I cannot think right and cannot function normally".

Participant 2: "I later discovered that my excessive use of drugs impaired my abilities, specifically my mental and physical abilities (loss of weight, unable to hold a conversation). I feel that drug addiction is a disease and it is not simple to stop it".

Participant 3: “They talked about stress. The last doctor I met there, she said I’ve got major depression. And then even at school I couldn’t attend properly, I couldn’t attend school...I used to go to the doctors to get sick leave. No it is just that headache now, that pressure, that anxiety”.

Participant 4: “No, I don’t feel powerless. I am powerless to the addiction. So for me I must know that alcohol is a monster; I need to run away from it. I need to know that”.

Participant 5: “Alcohol made me laugh, it made me feel happy. And then obviously you pass out, you sleep; you don’t stay awake whole night and think. Alcohol makes you have blurred vision, it gives you a loss of appetite, raises your heart beat, kills your brain cells so on and so on.... It’s far too difficult to fight it on your own; your body craves it”.



Participant 6: “After smoking and then ... I go my own way doing my own thing, you start losing respect, you start breaking your rules, the house rules, and you actually start losing respect for your own body. You start becoming careless and irresponsible and eventually the people don’t trust you anymore. You are like heartless, you know. I don’t still want to talk about it, about you know – how can I say – I’ve been almost dead how many times.....but you know”.

Participant 7: “My body is not agreeing with it anymore. I was in hospital. Two years ago I was in hospital for heart failure because of drugs. Yes.... I mean a person can only do so much drugs before they die. I am getting to the end and I don’t want to die”.

According to Khantzian (1985) individuals are known to use drugs and alcohol to self-medicate to avoid unpleasant feelings. As explained above by the participants in their own words, it was enjoyable for a while which helped them to overcome their depression, loss and stress. According to Doweiko’s (1996) discussion on the process of metabolic tolerance, an individual who initially starts off by using a substance as an escape slowly becomes tolerant and dependent and begins increasing

the intake. This then leads to the process of 'craving' which maintains the disease. However, it is known that chronic alcohol use will have an impact on virtually every body's system. Exactly which ones will be affected in any one person will vary from individual to individual (Browning, Hoffer, & Dunwiddie, 1993). According to Beasley, (1987) chronic alcohol use often results in a range of symptoms similar to those seen in neurotic and psychotic conditions. The symptoms may include depressive reactions such as generalized anxiety disorders and panic attacks (Schuckit, 1989, Beasley, 1987, Toneatto, Sobell, Sobell, & Leo, 1991).

The participants expressed fear of death and acknowledged it as a 'disease'. One participant felt powerless and described the dependence as a 'monster'. All of the participants started off using substances for instant relief and recreational purposes. They soon became addicted to the drugs and alcohol which resulted in them feeling close to death. Most of the participants were also diagnosed with depression at some point of their addiction or before. They also described feelings of anxiety and panic attacks. The personal experiences described by the participants confirm the above suggestions offered by Khantzian and Doweiko. What started off as an escape or recreation resulted in dependence. The relief and pleasure they derived from the use of substances eventually became an insufferable outcome. They also confirmed Beasley's understanding of depressive and neurotic episodes due chronic alcohol use.

Participants' emotional experiences of the influence of the dependency:

The responses of the participants' unveiled feelings of sadness, regret, sense of relief and clarity on their diagnosis of their dependency. Expressions of feelings that surfaced during the interviews from the participants, in their own words, were as follows:

Participant 1: "I feel sad because I could not be a good parent and am a bad role model".

Participant 2: "I still think that taking drugs makes me feel good although I understand that it has harmful side effect." "I also feel that the group sessions make me feel stronger and make me want to help people around me who have similar problems".

Participant 3: "Because I am a responsible teacher, so I am very worried. They are very worried about me. I am learning here that when I go back to work the stress is going to come back again because the learners, they do not want to do their work properly. They do not want to study, so I am going to be ... keep pushing and pushing and you find that they are not doing their work and I must cover up for these three weeks. They are just staying there. They have no support there and they are waiting for me to come back. That load of work again is going to stress me. This could lead to a relapse. The problem is just that very hard because of stress".

Participant 4: "I feel that the diagnosis will help me with my addiction and that I will be a good example for my son." She also felt that her father was an alcoholic and she took after him. "One of the things I am scared of is I don't want to relapse again. I am scared of that and I am scared of the environment I am going to".

Participant 5: "Initially it was embarrassing, you are in denial but after coming here I knew, here I was going to get help. But prior to that, I was embarrassed, in denial and ashamed. My family decided I come here for help but I was in agreement". She realized that now her children are back she cannot take care of them because she still has a problem with alcohol dependency that she needs to address and that's what motivated her to come to SANCA.

Participant 6: "Yes and I went through a lot as well and you tend to manipulate people and things like that. Ja, you tend to manipulate other people and it becomes a habit by manipulating. You are lying, ja. That is how drugs manipulate your ways...Just for the next fix. I was going so backwards in my life". He indicated that it feels like things have started to fall back into place and he has started to

become himself. He also felt that it was hard to do this on his own. He realised that opportunities were passing him by whilst dealing with his dependency. He was thankful that he is in rehabilitation.

Participant 7: "Yes, I feel good. I am seeking help because I understand I cannot do it by myself. I needed this help. They take ... It is like they bring you to the water, but I am the only one that can make myself drink, you know. Like when you take a horse to the water you can't make him drink it, but I mean they are giving me the footsteps, the first footsteps to start afresh. I went through painful withdrawals, some physical withdrawals and I've never had that before. I don't want that again. I mean even now my nervous system is a wreck. The thing is it has changed me, you won't even believe the difference now the way I looked when I came in here".

There appeared to be an overall sense of relief and acknowledgement that they had a problem with substance abuse that had to be addressed, with a sense of determination to get better. Both male and female participants expressed similar feelings. However, three shared concerns about relapsing when they leave the safety of the rehab and return to their environment.

The participants' understanding of the influence of dependency:

Participant 1's response was that it was enjoyable for a while but he started to feel wasted and felt that he was going to die.

Participant 2 understands that his addiction is having a bad effect on his health and that the addiction is difficult to get rid of because he thinks that it controls his life. The recovery process made him stronger because it made him realise that "I am not going to lie, the feeling is still nice, but the effects it has and have after you do it are bad. It is like taking too much sugar. Sugar is sweet and nice, but the effect is you get diabetes, like that".

Participant 3 responded as follows "I would like to get better. I want to get better, full recovery. I am not yet right emotionally because at night I couldn't sleep". She understands that the

dependency is due to depression and a stressful lifestyle but cannot say if the recovery has been helpful this far.

Participant 4 understands that her dependency has a bad effect in her life and the people around her, especially her relationship with her son and in the community. "I mean, appointments that I wouldn't go to which would have been helpful to me. I feel that the recovery will help me have a better relationship with my son and to help me get a job and be more responsible in life".

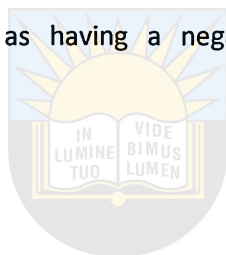
Participant 5 feels that, "I'm allergic to alcohol because I'm not like other people who can have a drink and they can relax and say I had enough, I'm not like that, I continue to drink and drink, drink and drink. While my children were not with me I was in the company of other alcoholics. It made me forget about my children, about not being with them. After a while, "It made my problems worse, I bumped my car, lost my job, had no money and it put me into danger. I've been in dangerous places because sometimes I would go to bars and go home with a man. I wouldn't sleep with him but they would offer to drive me home, now that I realize that it could've been a murderer. Fortunately they were people that were good they just took me home, drove me home, put me into bed and left. It made a big difference not being in denial, it is actually an illness, and people don't realize that".

According to participant 6, "Ja, it starts becoming a habit. Also, sometimes you would – like I say, I would like to stop for two weeks, but eventually you – how can I say – after the first week you can actually feel that you are becoming yourself now, you know, and you are normal now again, but the craving comes. Once the craving comes, triggers, then you are like okay I want to go smoke now again. Then you will smoke now again then that is the time you are not yourself anymore. That is what addiction does because it makes you be like this person, can't tell you what to do, you know; you know better than that person. You couldn't care. It is like you are being ... It is like you don't have a heart in your body basically. But eventually all these things I had thought through, because you – say for instance you are frustrated and here your child comes, she has to do this or she has to

play. Now, I am happy with myself. I am proud of myself". He indicated that he has a need to forgive himself and accept his past in order to move forward. He also realised it is not easy to do "... but I'm going to take it one day at a time. The recovery has helped me by giving me a support structure and made me stronger. I realised that it is my decision to start over".

Participant 7 acknowledged that drugs were bad for him and that his body was now becoming sensitive to the substance abuse and was not able to cope.

On some level all the participants' acknowledged the harmful effects of the drugs and the implication of their substance abuse as having a negative impact financially and in their relationships.



FAMILY SUPPORT STRUCTURES

Exploring the role of support from the participants' family:

All the participants received support from family, partners and the community one way or another. Most of them stressed that recovery was not possible without the support and help from significant others.

Participant 1: "They suspected and confronted me and I admitted. They found out about SANCA and my mother and sister helped me to get help from SANCA". He indicated that he was not able to do this on his own and that recovery was only possible through the help of his family.

Participant 2: The second time around his parents brought him to SANCA and they also attended group sessions. He felt supported and encouraged by his parents' involvement to continue his process of recovery.

Participant 3: "The father of my 10-year old stays with me. It is a good relationship. He is feeling very bad". However, he also assisted and enabled her alcoholism because he bought her the alcohol and

drank with her. "My sister, she is very supportive to me". The principal of her school referred her to the Wellness Department and they decided to send her to SANCA.

Participant 4: "The thing is I never talked to my son about this. We never discussed it. That is the thing. He knows I am here, but he doesn't know the deep, deep, deep ... reason".

Participant 5: "Time after time, they told me to stop but never really gave me a solution. They cared about me and wanted to help but did not want me near them when I was under the influence of alcohol. I have my family and their support eventually".

Participants 6: "My dad is a person that gets very frustrated and he was very frustrated over me. The things I had done made him actually to a level where he beat me up and things like that, but as from my mother's side she was trying to find out ways to help me and things like that and she always has been so supportive towards me and she never gave up on me until my dad was actually there by the giving up stage already on me. I was never going to do this on my own. I don't know how I was going to do this on my own", but "yes, we have a family support group as well" and his parents attend with him. "My girlfriend loves me, without her support, I don't think I was going to be able to do it. She is very supportive towards me, even my mother, but while you do the drugs that you do you tend to not care about the people around you".

Participant 7: "I am upset with myself because I have lost now so much trust and my dad is so disappointed in me now it actually is unbearable, but life goes on. My mom is, yoh she is in a state because she knows now there is nothing she can do because now she is in Jo'burg. No, they are very supportive because they understand. Very, very supportive. Yes, my uncle. He is coming tonight, him and my pastor. They want to come and share a little bit of insight".

The participants expressed their need for family support; some of them indicated that they could not do this on their own. However, some became addicted to substances because of their relationship problems with partners, parents or children. Participants 2, 4, 5, 6 & 7 had bad relationships with their family members because of the addiction. However, they all got support from their family during their recovery and most of them wanted their family's respect.

PARENTAL SUBSTANCE ABUSE

The participants' views of their children and consequences they endure due to their addiction:

The role their children played in their lives during their difficulty as substance abusers was very fundamental to them as parents. The five participants who were parents expressed similar concerns with regards to their children. The expressions were mostly regret and guilt. All of the parents made commitments to making up to their children. Their inspiration to get well was mostly motivated by the love for their children.



Participant 1: "I feel sad because I cannot be a good father. I'm setting a bad example to my children. I would like to make up to my children. Start working so I can support them and be a better father".

Participant 3: "I want to change and be that person I used to be. Yes, that (her name) was a responsible person to the kids, to my school." She hoped that her children will understand her illness so that they can help her to get better.

Participant 4: "What am I teaching him? I plan to have a better relationship with my son and show him the affection that I did not get as a child. I also want to set an example for him and other children at school".

Participant 5: "I cannot be a good mother and take care of them while I have this disease. I have to get well and be a good mother to them".

Participant 6: “Ja, the part of the children; you also start losing interest in them, in your children. For me what I can say is that spending more time with my children that is one thing” (he is committed to).

ACMD (2004) reported on the needs of children of substance abusers, focussing on the risk for the care of their children, assumed that not all such parents posed such problems. However, according to Dubowitz (1999) in the USA substantial evidence of harm caused by parental substance abuse and neglect were revealed by studies. Research findings supported the hypothesis that parental substance abuse has a negative impact on family functioning and as a predictor of child maltreatment (Teaminspiremalibu, 2013). The results of this research supported the above statement. The introduction of this study addresses the risk and danger the children of substance abusers are faced with. They are not provided for, loved and given attention, can possibly be abused physically, emotionally and sexually, they encounter educational difficulties, delinquent behaviour that could put their lives in danger, suffer mental and physical health problems and could themselves become substance abusers.

However the data on the thoughts and feelings of the participants who are parents revealed a deep sense of guilt, regret and remorse. These feelings were especially directed towards their children and acknowledged the consequences their family and children endured during their illness. All of them found their children to be the inspiration and motivation to recover so that they could resume their roles as responsible parents. Their future plans included “making up” to their children. The participants voiced these views during the interviews about their children:

Participant 4: “I want him to stay away from alcohol. I always wanted him to come here during group sessions. I also wished for him and me to have an appointment with the social workers so that we can sit down so that he can talk to voice out his feelings and after that we can be put together so that I can say sorry to him for ignoring him”.

Participant 5: “My children have been living with no food. They’ve not been living up to standard. With what they had been learning they have to redo their grades and they need my help otherwise they gonna end up being drug addicts, alcoholics”.

Participant 6: “You are not giving them attention, but they want attention and things like that you find it irritating and frustrating. When you are frustrated you shout them just like that because you are in your own world but the child doesn’t know in what world you are in”.

The crucial fact is that they are the future generation and they are at risk of contributing to the cycle of poverty in the community. The voices of the participants resonated with concern and regret for the maltreatment of their children during their addiction. The question to be asked is this: how do under-resourced communities remain and become targets of substance abuse and poverty? The American Academy of Experts in Traumatic Stress concluded in their article titled *Effects of Parental Substance Abuse on Children and Families*, that parental substance abuse affects their children on many levels, namely:-

Economical level

According to literature reviews the substance abusers have difficulty coping and as a result lose their jobs. According to the data collected this is evidenced to be true. As a result the children of the participants suffered consequences because their homes, cars and other valuables were lost due to their parents’ illness. All of their children were not in their care but with family members. Their children’s living conditions, nutrition and day to day living were disrupted as indicated by the participants. These children require stability, nourishment and favourable living conditions but from the feedback from the participants it was clear that their children’s basic needs were not met. This could put them at risk emotionally and physically.

Health

Children are known to suffer from gastrointestinal disorders, headaches, migraines and asthma as a result of stress developed due to economic difficulties. The participants, however, did not indicate any such illnesses that may be affecting their children. This could be due to the fact that the children were removed from their care in time and taken care of by other responsible family members.

Educational consequences

Parental substance abuse also has a negative impact on their children's education. COSA's usually encounter learning difficulties; they tend to repeat more grades, become delinquents, play truant and drop out of school because of teenage pregnancies, expulsion or institutionalization. Participant 5 expressed her concern for her children's education. She indicated that, because of their neglect, lack of nourishment and living conditions, they will not cope with school work. Children need constant supervision and attention to cope with school work but if the parents are under the influence of substances they will not be able to give the child that care.

Social

Literature reviewed suggested that COSAs become withdrawn, avoid bringing home friends and avoid being seen with their parents in public. Participant 3 blamed her son's friends for his addiction and indicated that she started abusing alcohol because of the stress his addiction caused. Participant 4 raised the issue of modelling behaviour which could lead to her son becoming a substance abuser himself. She also felt guilty because her son constantly protected her from the scrutiny of the community. She indicated that at times she would ask him to buy her alcohol from the local taverns. Children under these circumstances can become potential enablers or substance abusers themselves because of the exposure and accessibility of the substance.

Family influences such as being role models play an important part in whether an individual will develop substance dependence or not. Parents who display drinking or smoking habits can be

modelled by their offspring. The stability of family life at the age of onset of drinking is an important family or social risk factor because existing family values, norms behaviours and perceptions encourage responsible use of alcohol and zero tolerance toward illicit drugs (Pidd, 2006). The reasons for chemical use are often influenced by the adolescent's emotional maturity, available intrapersonal and interpersonal resources and available social support system (Cohen, Richardson & La Bree, 1994; Rogers, Harris & Jarmuskewicz, 1987). Clinicians and researchers have long observed that substance use disorders (SUDs) frequently affect multiple members within families over different generations (Weinberg, Rahdert, Colliver & Glantz, 1998).

However, on a more optimistic note, not all children of COSAs end up in horrible circumstances. According to statistics, one out of every four children suffers from the above consequences; the rest draw from their inner strength to cope with resilience (American Academy of Experts in Traumatic Stress, 2014). The researcher found this to be true because some of the participants were receiving support from their children, especially the older ones. The data disclosed the thoughts and feelings of these parents which inspire the possibility that their diagnosis and recovery programme may have a positive effect on their future responsibilities as parents.

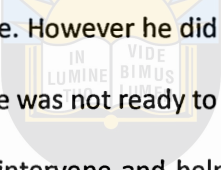
THE COMMUNITYS' UNDERSTANDING OF THE ADDICTION

The participants' interpretation of the perceived views of the community and significant others in their lives brought up issues of stigma involved in having a label attached to addiction.

Participant 1 was confronted by his mother and sisters about his addiction. According to participant 1 his family took the initiative to learn about drug addiction and the effects thereof. He was then willing to follow the programme so that he could be helped with his addiction.

Participant 2 was 17 years old and became very disorderly in school and the students were afraid of him. "My school found out. One student went to the principal's office and said he was scared of me

because I said I am going to shoot him and ... but he knowing me and my partners and my friend, he thought I was actually serious because we were getting out of the door then he pushed me and I was like why are you pushing my bro, I am going to shoot you. Wow, he got really scared and raced to the principal's office saying I am going to shoot him because he knows me; he knows my friends and he thought I was actually talking the truth. I am like no, no, you know me, I don't like nonsense. I was like being the boss or want to be bossy, even in class. Where most troublemakers sit at the back, I was sitting in front. I was not that kind of troublemaker. I was sitting in front of the teacher. They saw me that I had changed in behaviour. The students were scared of me now". This made him realize that he was being judged according to his behaviour and the company he kept.



The school sent him to rehab the first time. However he did not finish his treatment because he ran away from the centre. He indicated that he was not ready to stop but was pressured by the school to go in for treatment. His parents tried to intervene and help him to change but even they got to a point that they gave up on him. They now managed to convince him to get help from SANCA and they also come in for counselling.

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Participant 3 got to a point that she was drinking during work hours and being a school teacher realized that it was not good for the pupils. The principal's reaction was to refer her to The Wellness Department and they attempted to help her by sending her to Ceclia Makiwane Hospital where she was diagnosed with depression. Her boyfriend used to help her when he worked. By this she meant financially to maintain her alcoholism. She also indicated that he drank with her so it was difficult to control herself when she got home because they shared a drink together and her fear was that when she went back home she could relapse because of this.

"The community they do not know anything because I hide it. I don't drink publicly". They will just ... Oh, you know people, they will judge me". She expressed fear at being judged by the community so she was discreet about her dependency.

Participant 4 indicated that her son partially understands her dependency on alcohol but not completely; therefore, she would like a social worker to explain it to him. She indicated that he knew she was drinking but he would not expose her to her friends and family. He sometimes bought alcohol for her and she started to feel guilty that she was using him in that way. She wished that her son would join her in the group sessions and get some counselling as well because of his exposure to her illness. Her current boyfriend understands and encourages her to get well but she feels that he is responsible for her alcoholism. She found out that her father was an alcoholic before he died in a motor accident in her first year of college. She blames her father's attitude, as being very strict, for her dependency on alcoholism.



She found that she got encouragement from people who drink. Her mother found out about her problem when the social workers from SANCA phoned her house because her phone was off. Her sister and her mother gave her two options that she can either go to SANCA or go back to her house. Although she agreed she was tempted to go back and drink with her friends, "but there was something that said you know what it is about time, you are relapsing; because you are relapsing it doesn't mean that you have to be embarrassed to ask for help". She then went to SANCA for help. "When they look at me, what do they see? What do people see when they look at me? I hated what they saw". Even though no one expressed their judgements she assumed that they saw and thought the worst of her.

Participant 5 didn't think that her family understood that alcoholism was an addiction but they understood it as her way of coping with the loss of her children. They then encouraged her to go to SANCA but she could not afford the programme so her family contributed small amounts of money and managed to raise enough to pay for her stay at SANCA. She realized that she cannot take care of her children who were just returned to her because she was still consuming alcohol and could not stop by herself. She was concerned about being a good mother and taking care of her children. She

also felt that she would not be able to have a good relationship with her children if she was still drinking alcohol. "The previous jobs I missed lots of times, err few weeks at a time ... then you feel bad and embarrassed and you don't want to go back to face the world, you rather stay home and drink more. Hmmm there was only one neighbour that knew then I will cause trouble and eventually they asked me to move".

Participant 6 was influenced by his family to come to SANCA as an in-patient. They attended group sessions with him before he was admitted. When he met his girlfriend he was not using drugs and when his parents found out, they did not tell his girlfriend about the addiction for a long time. His relationship was deteriorating during the time of his addiction so he realised that she would find out anyway so he told her about his addiction. He was surprised that she was supportive and her family also supported him. They thought that he was brave to admit it and get help so they were proud of him. He said, "The drugs is one type of thing that you basically can't stop doing on your own unless you are so, how can I say, I would say you are very lucky to be able to stand up for yourself and say okay no, I am finished with this now and done". He iterated how important it was to be supported by people who cared for him because he needed that support.

"That is why – how can I say – forgiveness doesn't also come by just asking for forgiveness, but forgiveness comes by proving, you know". He believes that his family judges him by the way he conducted himself during the addiction. In the past they would forgive him and he would do the same thing again. Now he does not want to be judged as that unreliable person.

Participant 7 indicated, "You see, normally my mom was the one that is always behind me. My uncle said he has been there; in his younger days he was also an addict. He also obviously had the willpower. He never had to go to rehab. Oh yes, people judge you, but I mean I don't judge".

The emotional response of participants about inferred community and family viewpoints about their dependency: almost all of the participants felt judged by the community and family and expressed how it impacted negatively on their self-esteem.

TREATMENT AND EFFECTIVENESS

The influence of the treatment on the participants' life experience:

Participant 1 indicated, "I started being positive again".

Participant 2 changed from doing crime and drugs to wanting to help people with their addiction. He had a need to educate himself and counsel his friends who were doing crime. "I found a small amount of what I had and the instruments I used to use, like Jesus, I [inaudible]; that I don't want this in my life anymore and I gave it to her" (counsellor at SANCA) "and she was actually prouder than me". She said, "Wow, you actually opened up this; I want you to beat that thing".

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Participant 3 wished to change to be the person she was. She described herself before the addiction as responsible to the pupils in the school, to her community and church.

Participant 4 indicated, "I am scared of that. I am scared if I am going to be able to face the world out there. I am in a protected environment inside here than the world out there, but I am getting stronger. When we had a session yesterday with, one of the recovering addicts who has been clean for years, there is something that he said that made me realise I did fear; I can go out there and do this. I did it, I stayed clean for two years, why not add another two years on top of that. My fear is now with my relationship with my boyfriend. He is so supportive. He phones. He phones me every day. When I need money for medication he pays the money. Now my question is, what if he is supportive if I am inside here, in my prison. He might call it a prison because he likes to control. He is a control freak".

Participant 5 said, "So I am confident that I want to get out there and take care of my children. My children need counselling considering what they had gone through; I have to be strong for my children. I'm positive about going back; I don't think I'll ever touch another drink again. Before I had my children taken away from me I had a wonderful life with them, 'wonderful life', so she is optimistic that she can have that life back.

Participant 6 indicated, "I am a new born. Responsibility? Yes. I am going to be responsible. I will show them I am independent, things like that. That is one thing because how many times have I asked my girlfriend or my parents forgive me, forgive me, forgive me, you know – forgive, forgive, forgive, but you still are doing the same thing. That is why forgiveness comes now by proving. You know when I leave here I am going to have to be able to prove to them that I have changed. I can't just go here and tell them no I have changed now; no, I have to prove my change towards them and towards myself as well".



"That is why I actually realised that you have to grow up because your parents are not always going to be there for you. That is one thing. You are going to have to face reality one way or another. The person before the addiction; I was like I am now, you know, you are happy; each day that comes you are looking forward to that day you know and you are full of new challenges man. I was a person that wasn't lazy. I do things without someone telling me. I have made my decision now. I don't see myself as where other people can decide for me. I can decide for myself now. So I am going to have to go out here and face reality so that is where the yes and the no comes in and that is where I am going to have to test myself".

Participant 7's response was that, "I feel that my personality and lifestyle is changing and that I am more open minded and I have hope that I can recover. I feel that the recovery made me realise that I wasted 12 years of my life on substance abuse yet I could have been a successful man by now if I did

not do that. I know what it does to you and I know what it has been doing to me, my life. I've wasted 12 years of my life".

Treatment consists of confrontation on various items in the 'self-biography' that is presented in the group. Emphasis is on individual responsibility in restoring control over one's life (Iaberg, 1988). The Alcoholic Anonymous (AA) programme is ingeniously cognitive with a strong thrust toward the eradication of "stinking thinking" (Brown, 1985). According to the A.A. *Twelve Step Approach* the substance abusers make a searching and fearless moral inventory of themselves so that they can admit to God, to themselves and to another human being the exact nature of their wrongs. The attention to the psychological component in addictive behaviour is an essential aspect of successful treatment (Van Wormer, 1995). The participants have all at some stage declared their need to take control of behaviour and acknowledge the consequences of it, endorsing the principles of the AA programme which is implemented at SANCA as part of their rehabilitation programme.



Scientific research consistently shows a high relationship between drinking and depression. So the role that depression plays in the onset of alcoholism is another area of confusion between the cause and the effect. The basic psychodynamic position is that depression is the underlying cause for drinking whereby alcohol is used for self-medication (Forrest, 1985). As discussed above, most of the participants have suffered from depression concurrently, before or after and that makes it difficult to know whether the substance abuse started because of depression or the depression is the cause of the addiction. As pointed out by Riley (1994) those dual-diagnosis clients can create a special challenge to treatment professionals because it is difficult to establish what presented first: the depression or the addiction raising the issue of cause and effect. This did pose as a problem with the participants' diagnosis because the three female participants were depressed as well and were not sure what started first.

The emphasis on the thinking and feeling dimensions of the destructive emotional state of depression is incorporated into relapse prevention efforts; therefore, diagnosing and treating alcohol dependence and withdrawal as soon as possible may improve the quality of the substance abuser's life (Brown, 1985). Treating the concomitant disorders is absolutely necessary to be able to control the addiction.

Treatment effectiveness

According to the study on evidence in support of the Twelve Step programme at least half of the men and women treated at the in-patient treatment centre maintained sobriety for at least two years (Hoffman, Belile and Harrison, 1987). Findings of this study proved that the participants have maintained sobriety for approximately one or two years before relapsing and therefore feared the risk of environmental, peer influence and availability when they complete rehabilitation. Therefore, sobriety depends largely on the emotional stability of the addict and awareness of behavioural consequences. Hence the approach of the Twelve Step programme may prove to be more effective than any other programme because it tends to address the thinking and feeling dimensions of the destructive emotional state of the addict. It is through the will power of the recovering addict that the success of sobriety lies.

However relationships and the family dynamics also play a crucial role in the effectiveness of treatment and the prevention of future relapses. As Thailand (2008-2015) suggests, enabling is the abuse of power that is often developed over time out of an already dysfunctional relationship. A dysfunctional relationship is built upon a long standing guilt-and-reward understanding whereby the substance abuser may be drawing pity and sympathy while the enabler fails to see that he or she is being used and manipulated. Participant 6 indicated that he became very manipulative at times and used his family to maintain his addiction. Many people who are partners, children, parents or close friends of people with substance abuse issues have co-dependent relationships that are damaging and manipulative (Thailand, 2008-2015). Family members may continue their co-dependent

behavioural patterns or become addicted themselves if they are not involved in the treatment plan; therefore, substance abuse can be transmitted to future generations by children being exposed to this dysfunctional behaviour modelled (Bowen, 1974). This process causes the family to maintain its denial about the addiction and other problems that may exist or that they are of consequence. Problems that result from the crises and from the family's ineffective responses tend to be manifested in boundary conflicts within the family (i.e. triangulation of children or the addiction) and in their external relationships (Freeman, 1993).

One of the basic principles of the Twelve Step programme is continued personal inventory and acknowledgement, if they are wrong, to promptly admit it is expected of them through prayer and meditation to improve their conscious contact with God as they understand him. The twelfth step is having had a spiritual awakening as a result of these steps they are expected to carry the message to other alcoholics and to practise these principles in all their affairs (Jellinek, 1960). The gist of the data obtained from the participants suggested acknowledgement and awareness of behavioural consequences, the need to help others with a similar problem and considerations for the loved ones. All of them indicated a need for religious affiliations and needed closeness with the church and God. The responses of the participants appear promising and positive of treatment effectiveness, sobriety and future relapses. None of the participants revealed denial or obliviousness to the cause and effect of their addiction.

THE PROCESS OF RECOVERY

The participants' discussed the changes they plan to make in their lives due to the influence of being a recovering substance abuser.

Participant 1 indicated that he would like to be a better father and start working so he can support his children.

Participant 2 felt that, "I am also not regretful. I told myself that I don't regret anything that has happened in my life right now. I take it as a lesson. I take it as what has happened to me, I would use it to teach other youth about life. Maybe not in the same problems, but I sit down and I am actually like a counsellor to my peers too. Even my friend, the one who got out of jail, I counsel him because he is an orphan".

Participant 3 said, "I want to change and be that person I used to be. Yes! I am an asset in church; I am an asset in the school; I am an asset in the community. I am everything in my house". She indicated that she would like to be responsible, accepted by her community/church and be a good mother.



Participant 4 indicated that, "It was me who wanted to come. Nobody dragged me here (SANCA). I was not dragged here. I told myself you know what it is about time, it is about time now, my child grew already, and he is going to be a man next year; where are the norms and values I am being taught at church. I go to church almost every Sunday when I am not drunk. I conduct a choir there in church and I wondered what they saw".

Participant 5 indicated, "Absolutely – the knowledge I've gained from this ... absolutely there's no doubt about that. Ha! Well I got my own little place for them (her children), I do not want to touch alcohol. My children have been kidnapped for two and a half years they've been living with no food. I have my work to go back to and I have my family and their support eventually. They saw my struggles ... my sister is looking after them at the moment, they are happy, they have routine. My children, they know I'm in hospital but they don't know I'm here".

Participant 6 said, "Now I see myself actually as a person where my friends are down there and I am basically higher than them, so I don't actually see myself with them anymore where I already made my decision. I am not being with those friends again because you can actually relapse, so you also

have to change your company. I don't see that as an influence at all because I have made my decision and the support that I am getting, I am very positive about myself because I don't want to go back to where I was before. I have lost a lot of things. How can I say, reliable stuff, things like that, going for up to basically nothing".

Participant 7 indicated that the recovery helped him to be "more open minded now about it and I can start afresh here because I know nobody here, except my aunt and they are big Christians. They are very religious. They go to church. They do their church calls and I am going to be staying with them, so I am going to be around sober people all the time. Even my friend that is supporting me now, he doesn't do drugs. He drinks, but he is very anti-drugs. Yes, I am changing my lifestyle completely. I am even changing my whole personality completely. I'll give my limbs to get that back. [Laughter]. I would give anything to get that back. Actually I am working on it. I am getting there. To stay clean".



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IMPORTANCE OF PERSONAL HYGIENE

Four participants' commented about their personal hygiene and appearance during their addiction with much repulsion and regret.

Participant 4: "I washed up, I cleaned myself up, I took my bag and took a taxi".

Participant 5: "I was not looking after myself hygienically, sleep for days, not shower".

Participant 6: "... because you basically don't even wash for some days and things like that"

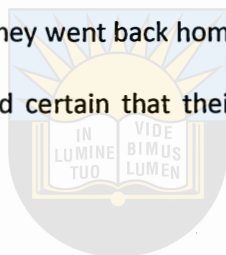
Participant 7: "It made me ... Well, before I came here I was very messy, didn't look after myself, I was skinny, I was more skinny".

This issue appeared to have surfaced as a result of the recovery process. Self-inventory may have triggered self-awareness supporting the effectiveness of the Twelve Step programme. This theme, however, offers a promising prognosis on their recovery.

FACTORS THAT INFLUENCE THE PREVALENCE OF ALCOHOLISM

Peer influence, environmental influence and enabling

All of the participants acknowledged the influence others had on their substance dependency. Six of the participants were influenced by peers and the environment they live in. One was enabled by her boyfriend and feared a relapse when she returned to her home and work environment. Four of the above participants feared relapse when they went back home because of friends, accessibility of the substance and temptations. Two seemed certain that their commitment to their children would motivate their will power not to relapse.



Participant 1: "... when I got influenced by friends"

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Participant 2: "A girl, I was dating her, I was dating a student nurse.... I was young. She was 24..... I was 17" introduced him to drugs that she got from her friend who stole drugs from her boyfriend who is a drug dealer.

Participant 3: "The father of my 10-year old stays with me. He used to help me by the time he was working." Her boyfriend drank with her and this made it difficult for her to stop.

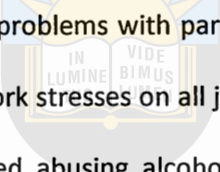
Participant 4: "They welcome you. If you've got a drinking problem they welcome you," she said. "I won't lie to you. It was there; it was saying go back there and drink beers much as you want".

Participant 5: "I was in the company of other alcoholics; we will drink together all of us or three of us or one on one. After that I will go and cause trouble...oh my! The only things I found is that people

that are alcoholics cling to you because you working. I was working and got money so they stole from me as well”.

Participant 6: “My friends that I had before, I pray them away while I am here, so I don’t see myself with them anymore. I don’t want to go back and be with the same friends. I want to change towards them as well so that they can see that I have changed. They are not my friends anymore”.

Participant 7: “... too much pressure and then I started again. Friends, friends are also there, it is around the corner; wherever you go drugs are there”.



Peer pressure, enabling and relationship problems with partners and children pose as high risks to relapse. According to Galanter (1988) work stresses on all job levels can cause the workplace to be a high-risk situation. Participant 3 started abusing alcohol because of workload and eventually started drinking at her workplace. According to participants 2, 3, 4, 6 & 7, they were either influenced or enabled so they feared facing that exposure when they left rehab which could cause them to relapse. Although the enabler intends to protect the addict but he/she is in fact part of the problem and not the solution (Doweiko, 1996). According to Thailand (2008-2015) these relationships can lead to long term dysfunction and other issues which can cause pain, heartache and financial ruin. In many cases, the co-dependent will enable an addict to continue to abuse drugs and alcohol for the sake of maintaining peace and avoiding conflict. As in the case of participant 3 her boyfriend was a joiner and encouraged her drinking problem by drinking with her and provided the alcohol.

Interpersonal conflicts can be a predictor of alcohol or drug abuse (Pidd, 2006). Interpersonal conflicts played an enormous role in this study as the reason for alcoholism and drug abuse. Participant 1 had relationship problems with his girlfriend, participant 3 experienced difficulty with her son who was abusing drugs, participant 4 had many abusive relationships and each time turned

to alcohol for relief and coping, and participant 5 suffered the loss of her two children for two years because of her conflict with her ex-husband.

RELAPSE CAN BE A THREAT TO SOBRIETY

Almost 90% of the participants' feared relapse and almost all of them relapsed at least once before and was in rehab for the second time or more. According to their personal experience they found that the environment they lived in or worked in played a major role in their relapse. The accessibility to drugs and peer influence played an influential role in their relapse.

Participant 3: "That is why I am saying I live in fear because I am going back to those environments and don't want to relapse. That load of work again is going to stress me. This could lead to a relapse".

Participant 4: "Yes, I've been here in 2006. I stayed clear for two years. Then I stayed clean 2006, 2008. Yes, I am scared. I am scared I might relapse".

Participant 5: "We will drink together all of us or three of us or one on one. After that I will go and cause trouble...oh my!"

Participant 6: "Ja, when they took it, I always heard about it, so I wanted to try it and then that was the bad effect".

Participant 7: "Just friends again. Friends are a bad influence, hey. If you don't choose your friends it is bad; then it is one way and it is down. The temptation is too much, yes".

The work place becomes high risk for substance abuse. Plant (1977) points out three main occupational factors that increase the likelihood of alcohol abuse:

- When alcohol is readily available for consumption during work hours.
- When there are strong social pressures to drink (as in a culture of drinking).

- When workers are separated from 'normal' sexual or social relationships.

The influence of culture on alcohol use can be especially problematic in high-risk occupations and for younger workers who may be socialised into an occupation that supports drinking. When safety risks are high, drug or alcohol abuse by employees makes them and their co-workers particularly vulnerable (Bennett, Patterson, Reynolds, Witala & Lehman, 2004). Therefore the reaction to the environment became an area of concern to the participants with regards to relapse. Most of the participants were working and lost their jobs because of their addiction.

Those who were diagnosed with alcoholism indicated that others who abused alcohol would be drawn to them. They enabled each other and made alcohol accessible. Whenever the participants had no money, they stole from the other alcoholics as they stole from them. The participants' acknowledgement of the risk factors that influenced them during their addiction and posed as a threat to relapse confirms that peer pressure and environmental factors contribute largely to a person with an addiction.

Data from the research revealed that drugs and alcohol are more available and accessible in marginalized communities and therefore it is easy to obtain. This encourages substance abuse because the person is already vulnerable to other stresses and easy to tempt. As discussed earlier, the majority of recovering substance abusers who come to SANCA for rehabilitation are from under-resourced areas. The question arises, how can they afford to pay for their recovery and health problems when almost all of them become unemployed due to their addiction? Relapse means that they will spend the same amount of money twice or more for rehabilitation.

Participant 5: "I knew I needed help but I didn't have the money for it".

Participant 6: "I didn't come here like other people paying R12, 000.00 to sort out their problems. I came here and I applied under government and not everybody gets the opportunity to get in here how I got in by not paying R12, 000.00 and that is why I am very thankful for that".

Participant 7: "Asking for money from family, money from friends".

Studies on social pressures in a culture of drinking revealed that 20% of all the relapses were caused by social pressures. Peers can either use verbal persuasion directly or indirectly from a peer group displaying the same target-group behaviour (Marlatt and Gordon, 1985).

Future plans of participants to maintain a lifestyle of sobriety:

Participant 1 plans to, "Control the addiction and not let the addiction control me".

Participant 2 said, "In order to help yourself, to help yourself, I need to help other people too. I think that sort of helps me a lot. I can't do it alone". He wants to remain rehabilitated so that he could complete his matric and get a job to pay for his university studies.

Participant 3 did not have any specific plan but indicated that she intends to occupy herself with work to remain focussed.

Participant 4 said, "There is a lot that I want. I really want to change. I no longer love teaching. I've got so many goals. I've written them down. I want to do the skills development facilitator's course, assessor's course. I plan to get a job and get my own place. I no longer want to work with children and want to get more qualifications. I want to be accepted by the community and my family and want their forgiveness. I want to get my driver's licence".

Participant 5 plans to remain focussed on being a good mother, give her children all that they lacked during the time they were kidnapped. She is committed to making up to her children for lost time.

Participant 6 indicated, "If I complete this test then it means I am basically there, so for me is what I am going to do outside now. I also want to say that there is going to be triggers and things like that that is going to trigger you to go back to that thing; you know you get triggers, you get thoughts and then you start craving then you just want the satisfaction, but in my case I am going to use this thing as my testimony as well, so I want to actually try and influence other people to change their lives, but they can only change their lives if they want to. I can't change their lives for them. I decided to change my own life. I wasn't a person that reads the Bible a lot and so on, but since I've been here I started studying my Bible and reading through my Bible and basically that is where I started also seeing basically the reality. I am going to get those moments where people are going to try and overpower me, but that is where basically I am going to ask God to help me. I don't have to say it out loud. I can speak to Him in my mind. I can pray to Him in my mind and I can pray the things away. Each thought is going to come, each negative thought; I am praying them away.



"My goals, by taking everything a day at a time, like I said. I can't also just focus on my family, but very importantly you have to focus on yourself to know where you were before and where you are going to. That is why it is very important for me, I told her (girlfriend) I am even going to spend more time with her now because I regret all the times I haven't been with her".

Participant 7 had many plans such as, "Yes, definitely. When I go home I am going to study further. I like travelling. I like travelling and seeing places and that, so I don't know if I am maybe going to be working one day on a cruise ship or maybe become a maintenance electrician on a cruise ship. Well, changes I want to make is I want to become more like I say, family orientated. I want to get ... I want to have a wife also, children, settle down you know. I've been too long in this ...".

All seven of the participants had a very positive outlook on their futures. They indicated that they would like to work on significant relationships, get jobs, further their studies and make up for lost

time. All of them expressed the need for faith in God and for His help through their process of recovery. The Twelve Step programme followed by SANCA tends to direct the recovering dependents towards their religious beliefs. Some expressed the need for acceptance in their church and the respect they once had from the members of their religious institution. It was as though they needed it for their empowerment and self-esteem.

ECONOMIC AND SOCIAL IMPACT

The experienced economic and social impact on the participants during and after their addiction:

All seven of the participants experienced financial difficulties because of their addiction. Four of them lost their jobs because of the addiction, whilst the others could not get jobs because of the addiction. When they had no income they resorted to crime, stealing and selling household goods. Their behaviour created a negative social impact on the community. Four of them who are parents failed to support their children.



Participant 1 started abusing substances because, "I had stresses because of money, I was unemployed at that time and could not support my children". However, when he got another job he used the money to maintain his addiction until he could not keep his job any longer because of the addiction and lost his job.

Participant 2: "When I don't have and I still have that energy and I still want some more, it led to crime, so I would go and do some crime and I didn't even think about it". As soon his girlfriend who provided him with the drugs left East London he had no money to maintain his addictions because he was still a student, so he resorted to crime.

Participant 3 indicated that her boyfriend who lives with her used to help her financially to maintain her addiction. "He used to help me by the time he was working, but now he is a pensioner".

Participant 4: "It forced me to take money. It forced me to steal. It forced me to steal from my sister".

Participant 5: "Well basically while I was an alcoholic, I had no money; I spent all my money on alcohol. I lost one job, I was fired from one job, I couldn't concentrate". When she worked and had money she spent it on alcohol and her friends stole from her; when she lost her job she then stole from them.

Participant 6: "You spent so much money on that thing, but yet you are letting it go for so little, so little just because of the disease that you have just to satisfy yourself. So ja, the thing is the problem became where you start not worrying about your things and then you are stealing from yourself, your house and then you steal from other people outside your house". He stole household goods and sold them at a much lower price just to make some money for his next fix.



Participant 7: His parents started to notice "... jewellery started going missing and money. I was always asking my mom for money". Then they suspected that there was something wrong. "Yes, I lost my job now".

Money and financial difficulties were experienced by all of them. They expressed desperation for money just to get their next fix. Their lives gradually spiralled into a cycle of poverty. If they were employed before their addiction then their money got spent on substances. They eventually could not keep their jobs and hence got fired. Then they could not maintain their addiction so they resorted to crime or selling household goods. An article written by Teaminspiremalibu (rehab centre) points out the economic impact addiction creates. It does not just stop with the unemployment and crime; it continues to escalate with medical bills and rehabilitation.

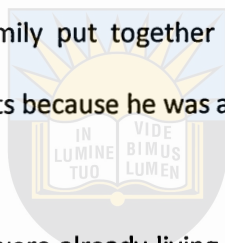
Although the participants' posed as a threat and risk to their community, most of them were also influenced by members of the same community to maintain their addiction. The participants felt judged by their family, neighbours, church and friends. Is this how they felt about themselves because of their low self-esteem? Therefore, the influence of the family and community can play a positive or negative role in the recovery process of the substance abuser. Almost all of the participants included in their interview an affiliation with the church and the need for prayer. However, most of them feared being judged by the church members, yet their need for religion during the time of their illness was crucial to them.

Participants expressed the need for help but could not attain it. Some could not wait for the contribution of social service because life circumstances required for them to get better as soon as possible. The social service in this instance was not adequate or empowering to the patients who required urgent help. Some of them felt threatened by death and waiting was not an option. This burdened the entire family financially because they had to raise funds to help the patient which impoverished them further. The two participants who were fortunate to get social assistance expressed their gratitude for this opportunity. The social assistance benefited the whole family because they were included in the recovery program.

Exploring the participants' views on the lack of social assistance threw up the following responses:

Participant 5 could not wait for a bed at SANCA because her two children relied on her speedy recovery so that she could take care of them. The second participant acknowledges the fact that he was fortunate to enjoy the privileges of social assistance. In the case of this participant he could not get financial help from his parents because they were already taking care of his children during his addiction. The only way he managed his sobriety was to attend group sessions as an out-patient until a bed became available.

SANCA being the closest and accessible rehabilitation centre to this marginalised community has two beds that are subsidized by social services. The substance abusers who apply for this free service are put on a waiting list until a bed is available. Only two of the participants were assisted by social services. Participant 1 received social assistance but was on a waiting list. The participant was an out-patient attending group sessions until a bed became available. Participant 6 also applied for social service and waited till he could get an available bed. Participant 2 is under age and is still supported by his parents so they paid for his programme. Participant 3 was still employed by the Department of Education so she paid for her own treatment. Participant 4 was unemployed and could not afford to pay her own bill so her family assisted her. Participant 5 was also unemployed and had no money for help so her family put together money to pay for her stay at SANCA. Participant 7 was sponsored by his parents because he was also unemployed at the time.



In view of the fact that the participants were already living in an under-resourced area and most of them had already lost their jobs and income due to their dependency, they found it very difficult to rehabilitate due to lack of funds. Raising the sum of R12 000.00 when the substance abuser is already unemployed and possibly the sole income earner in the family is very difficult. This means that even if attempts are made to rehabilitate the resources are not readily available. The aim of this study is to find ways to better or improve already existing interventions so that the battle against substance abuse can be better controlled. Therefore the issue of social assistance offered to this under-privileged community, although an unexpected theme that was raised by the participants, could not be ignored as irrelevant.

CONCLUSION

In this chapter the following themes were raised by the participants for discussion. All of the participants used drugs at some stage to cope one way or another. Their mental and physical health was compromised during their addiction. The role of peer influences, enabling and environmental influences seemed to have played a negative role in the process of their addiction. The children of

the participants played a significant role during their dependency and recovery and with regard to the negative impact it had on them. Although all of them felt judged by their family or the community, they emphasized the importance of family support. All of the participants experienced financial difficulties and brought up the issue of social assistance. Four of the participants became aware of their personal hygiene and neglect of their appearance reflecting a sense of self-awareness sanctioning the essence of treatment effectiveness.



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CHAPTER 6

CONCLUSION

INTRODUCTION

The aim of this research was to establish the personal experiences of diagnosed substance abusers who are members of an under-resourced community and currently in recovery. This study investigated the participants' views of their experience of the addiction and recovery according to a phenomenological examination of their perspectives. The organisation of the study entailed the process of collecting the data through semi-structured interviews. The interviews were conducted in a rehabilitation centre and the study population was selected from within the treatment centre. During data collection the researcher followed ethical principles at all times and acknowledged the strengths and limitations of the study. This study assumed a phenomenological approach. At all times the investigator maintained the true essence of the meanings of the participants' narrations in this study. The data obtained from the study offered the researcher an in-depth understanding of their needs and expectations from their family, their community and social services. The limitation of the study was the possibility of sensitive issues being discussed during interview which could have constituted harm to participants.

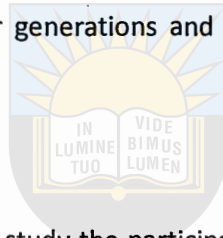
In the literature review the different aspects of substance abuse, starting with the definition of substance abuse, were explored. The discussion on the instrumental use of drugs revealed that it is targeted at specific behavioural goals or recreational purposes. Suggestions offered other reasons for the instrumental use of substance as a coping strategy. According to the data from this study, all of the participants used drugs at some stage to cope one way or another. The addiction starts with the reason 'to cope' with life stresses and eventually results in dependency and tolerance becoming an addictive habit.

Literature on the psychological and physical effects of alcohol revealed that the effect of alcohol on the brain is a depressant drug but the effects are misinterpreted as stimulating. Alcohol causes the loosening of social inhibitions that result in the impairment of judgement and thinking, typical features of being drunk. According to the participants the use of substances provided instant relief and recreation initially but soon became an addiction resulting in them feeling close to death. The younger participants used drugs to stimulate them so that they could keep going the night before and used drugs yet again in the mornings to cope the next day. The older participants used substances to overcome unpleasant feelings of depression due to life stresses.

The use of substance starts off as an escape but slowly increases the tolerance, dependence and intake leading to the process of 'craving' which maintains the disease. Data from the study revealed the participants' fear of death. They referred to it as a 'disease'. The experiences described by the participants confirm the suggestions of literature on the physical and psychological experiences already discussed. The relief and pleasure initially derived from the use of substances eventually resulted in the excruciating outcome of addiction.

The participants feared relapse because all of them relapsed at least once before and were in rehab at least once or more. They indicated the risk enabling, environmental influences such as peer pressure, their work place and the accessibility of drugs posed in their possible relapse after recovery. The participants found family support to be of utmost importance in their recovery because they failed to do this on their own in the past. The participants' perceived views of the community and family members brought up issues of feeling judged and being labelled. With view to dual diagnosis, three of the female participants were diagnosed with depression concurrently with their substance abuse. It was difficult to determine whether the depression was due to the addiction or the cause of their addiction.

Suggestions from studies conducted on the factors that influence the prevalence of alcoholism revealed that heredity and environmental factors contributed largely to alcoholism among children and adolescents. Genetic heritability influenced metabolic processes resulting in intrapersonal predictors of drug abuse through physiological susceptibility. However, there are other factors that influence adolescent substance abuse such as personal dispositions or sensation seeking, self-medicating due to painful feelings of depression or peer pressure. Literature reviewed focussed on neglected children of substance abusers and how neglect can contribute to or escalate children and adolescents' substance abuse. Substance abuse disorders can affect other members within families over different generations causing marginalised societies to become targets to substance abuse which results in a cycle of poverty over generations and therefore creating an enormous social problem.



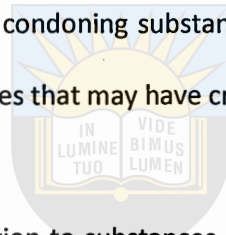
According to the data obtained from this study the participants who are parents acknowledged the neglect and risk they posed to their children. They also pointed out the discomforts their children endured because of their addiction. They feared that their behaviour modelled may be imitated by their children influencing them to become substance abusers themselves in the future. Most of their children were already in the care of other family members. However, they all expressed guilt and remorse. Their future plans were commitment to being better parents. The reactions and responses of the participants were promising for the future of their children which revealed positivity for their children after their recovery.

The results on family support indicated that all of the participants received help and support from family members. Most of them felt that they could not have done this on their own. Only two out of seven of the participants received social assistance from mental health care services; the rest of them were sponsored by their family members. The medical bills are added financial expenses on the family members. The family of the substance abuser is already in financial difficulties and is then

faced with medical bills and bills for recovery programmes. The data from the studies revealed the need for and lack of social support.

CONCLUDING OBSERVATION

The researcher is persuaded to review the political history of this country to evaluate the relevance of this study to the discipline of psychology. South Africa, in spite of its long struggle for equality, carries scars from its political history, which propagated inequality and an unjust system. Therefore, we as community psychologists have to give voice to those who were and still are suffering from the consequences of the past political system. However, we must be cautious about our intention without appearing to be encouraging or condoning substance abuse but clarifying the motives and needs of the under-resourced communities that may have created a breeding ground for addiction.



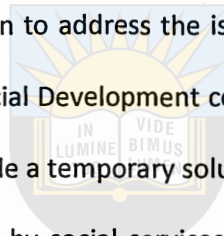
From the research it appears that addiction to substances is the result of complex influences from various spheres of life. When attempting to address the addiction, attention should be given to the macro systems that interact with individuals (e.g. individual, family, community and society). An eco-systemic perspective might offer itself to be most influential. Giving attention to the families of people with addictions could contribute to the prevention of the development of further addictions in other members of the families.

RECOMMENDATIONS

If appropriate interventions are in place at the macro systemic level then it will have a positive ripple effect on the community. From the perspective of the eco-systemic framework the focus is on the concept of prevention. Addressing the safety and care of the children of substance abusers should attain priority so that the future generation is taken care of. Outreach programs and awareness campaigns educating the children on the dangers of substance abuse would be very valuable to children who are already exposed to substance abuse. Bringing awareness of substance abuse may

also prevent other children from being pressured by their peers. Encouraging the adolescents to participate in the program will influence them positively.

The study revealed that the participants hoped for better social assistance so that they could seek rehabilitation sooner, because most of them had to wait for financial assistance before being able to be rehabilitated. Participant 6 expressed his gratitude for the assistance and claimed that he would not have been able to recover from his addiction if he did not receive social assistance. He iterated the fact that he was fortunate to be granted that help. Social assistance became an issue of concern for the participants since all of them experienced financial difficulties and could not afford to pay for their recovery. Although steps were taken to address the issue of free rehabilitation centres being provided, due to financial constraints Social Development could not follow through immediately. In the interim steps could be taken to provide a temporary solution. An increase in the number of beds available at SANCA could be considered by social services as a temporary measure to assist the patients who need help sooner since Fort England Hospital also has a long waiting list.



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Even though the symptoms of substance abuse may be addressed by rehabilitation Centre's, there still remains the need for enormous psychological interventions. The intention is not to cure but prevent and save the future of the members of these communities from living in a legacy determined by the tribulations of the past era. This may not be a simple process because of its historical manifestations and the multidimensional complications but one must understand that to reach the top it takes one step at a time. This enormous task requires planning, dedication, involvement of the many parties, starting from the community members themselves working through the many layers of the eco-systemic framework to bring the community members to a state of homeostasis.

The above discussion threw up many challenges and limitations in the intervention of this case but in spite of the many difficulties one must hold the faith that every little effort towards solutions to

improve or better the interventions already in place is hope for the future. The role of the community psychologist is pivotal in the process of change in these under-resourced communities as so many emotional, financial and political reasons have contributed to the individual's addiction. This means that by addressing the emotional needs of the individual within their family context would be a start to un-do a mammoth pandemic that has manifested itself in these communities for generations keeping them in a 'cycle of poverty and ill-health'. This issue could be open to further investigations by other researchers in the future making it possible for new and richer information and ideas.

According to Gergen (2001) from a postmodernism perspective emphasis is placed on the communal construction of knowledge, objectivity as a relational achievement, and language as a pragmatic medium through which local truths are constituted. This perspective invites a new range of questions about the potential of traditional research. More importantly, this emerging view of psychological science opens new and exciting views of theoretical, methodological, and practical significance. The community psychologist trained from a postmodernism perspective within the new psychology paradigm shift and becoming a member of the patient-centred health care team will be undoubtedly equipped to contribute abundantly to the under-resourced communities.

FIGURE 2: PICTURE OF THE OUTCOME (Dreamstime, www.dreamstime.com)



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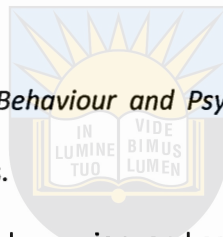
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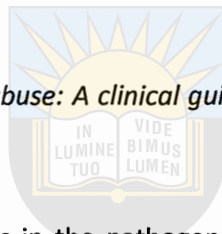
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www.sanca-cec.co.za

NPO: 003-527
Practice No. 0057967

4 June 2013

Dear Sivamoney Sharma

Consent to conduct study at SANCA Central Eastern Cape

I hereby give consent for your study at SANCA Central Eastern Cape to be conducted within our organisation.

We will, however, require you to adhere to our confidentiality conditions, and report back to the organisation regarding the research subjects of the study and activities they will be involved in.

Please set up an appointment to discuss the next steps involved in your study, particularly how you intend identifying the research subjects.

Kind Regards

Roger Weimann

Director

SANCA Central Eastern Cape

SANCA ALCOHOL & DRUG CENTRE
CENTRAL EASTERN CAPE

University of Fort Hare
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ETHICAL CLEARANCE CERTIFICATE
REC-270710-028-RA Level 01

Certificate Reference Number: ODE041SSHA01

Project title: **A Phenomenological study of the experience of substance abusers in an under-resourced Eastern Cape Community**

Nature of Project: Masters

Principal Researcher: Sivamoney Sharma

Supervisor: Prof DH Odendaal

Co-supervisor:

On behalf of the University of Fort Hare's Research Ethics Committee (UREC) I hereby give ethical approval in respect of the undertakings contained in the above-mentioned project and research instrument(s). Should any other instruments be used, these require separate authorization. The Researcher may therefore commence with the research as from the date of this certificate, using the reference number indicated above.

Please note that the UREC must be informed immediately of

- Any material change in the conditions or undertakings mentioned in the document
- Any material breaches of ethical undertakings or events that impact upon the ethical conduct of the research

The Principal Researcher must report to the UREC in the prescribed format, where applicable, annually, and at the end of the project, in respect of ethical compliance.

Special conditions: Research that includes children as per the official regulations of the act must take the following into account:

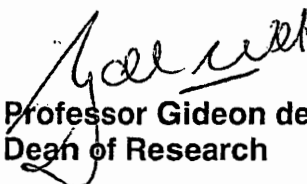
Note: The UREC is aware of the provisions of s71 of the National Health Act 61 of 2003 and that matters pertaining to obtaining the Minister's consent are under discussion and remain unresolved. Nonetheless, as was decided at a meeting between the National Health Research Ethics Committee and stakeholders on 6 June 2013, university ethics committees may continue to grant ethical clearance for research involving children without the Minister's consent, provided that the prescripts of the previous rules have been met. This certificate is granted in terms of this agreement.

The UREC retains the right to

- Withdraw or amend this Ethical Clearance Certificate if
 - Any unethical principal or practices are revealed or suspected
 - Relevant information has been withheld or misrepresented
 - Regulatory changes of whatsoever nature so require
 - The conditions contained in the Certificate have not been adhered to
- Request access to any information or data at any time during the course or after completion of the project.
- In addition to the need to comply with the highest level of ethical conduct principle investigators must report back annually as an evaluation and monitoring mechanism on the progress being made by the research. Such a report must be sent to the Dean of Research's office

The Ethics Committee wished you well in your research.

Yours sincerely


Professor Gideon de Wet
Dean of Research

09 February 2015

Faculty of Social Science and
Humanities:
Psychology Department

Tel: +27 (0) 43 704 7019 /7107
Fax +27 (0) 86 628 2027
Email address: ykoert@ufh.ac.za



Date: 2013-08-20

SANCA Central Eastern Cape
The Director
Mr Roger Weimann
22 St Marks Road
Southernwood
East London
5213



Dear Mr Weimann

LETTER OF APPRECIATION

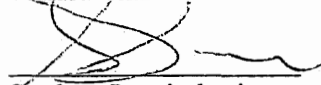
I would like to thank you for allowing me to conduct my study at SANCA EC.

I appreciate your kind support throughout my study. Your staff was always kind, helpful and accommodating. The whole experience was very enriching and the research component of my study was successfully completed with the assistance of your dedicated staff.

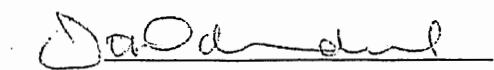
I especially thank Angeliq and Karen for setting up the appointments with the patients and arranging a venue for me to conduct my interview.

Yours Sincerely

Sandra Sharma


Student Psychologist
(University of Fort Hare)

Professor Dirk Odendaal


Supervisor (University of Fort Hare)

APPENDIX

Copy of Consent Form

Title of research: A PHENOMENOLOGICAL STUDY OF THE EXPERIENCES OF SUBSTANCE ABUSERS IN AN UNDER-RESOURCED EASTERN CAPE COMMUNITY

Purpose of the study

For academic purposes as partial fulfilment for a Master's Degree in Counselling Psychology at the University of Fort Hare.

Procedure

Sequence of Interviews will be conducted and will be audio recorded. The notes from the interviews will be used for analysis. Some text from the field notes will be used verbatim in my thesis but your identity will not be revealed.

Sensitive questions may be asked during the interview that may cause you discomfort. In the event of that happening I should be informed immediately so the interview can be discontinued or postponed.

Participation in this study offers you the opportunity to voice your concerns and share your personal experience.

Your participation in this study is voluntary and you are free to withdraw at any point and time. Information provided up to that point will not be included in this study. Participants will be allocated numbers and your identity will be anonymous.

Identification of investigators

Name of Investigator: Sandra Sharma

Ethical approval

This study has been reviewed and approved by the University Research Ethics Committee (UREC) for studies involving human subjects. For research problems or questions regarding this study UREC may be contacted through Prof Gideon De Wet at the Govan Mbeki Research and Development Centre (GMRDC) at the University of Fort Hare.

Consent

I the undersigned understand the procedures described above. My questions have been answered to my satisfaction, and I agree to the above for the purposes of this study. My consent is purely voluntarily, and I knowingly give informed consent to use this data for the purposes of this research.

Participants name: PARTICIPANT . 001

I consent to the above for the purposes of this study

I do not consent to the above for the purposes of this study

Participants signature:

S. Nyikane

Copy of Consent Form

Title of research: A PHENOMENOLOGICAL STUDY OF THE EXPERIENCES OF SUBSTANCE ABUSERS IN AN UNDER-RESOURCED EASTERN CAPE COMMUNITY

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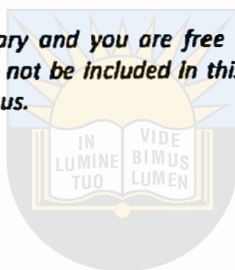
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Consent

I the undersigned understand the procedures described above. My questions have been answered to my satisfaction, and I agree to the above for the purposes of this study. My consent is purely voluntarily, and I knowingly give informed consent to use this data for the purposes of this research.

Participants name: PARTICIPANT 002

I consent to the above for the purposes of this study

I do not consent to the above for the purposes of this study

Participants signature: _____

A handwritten signature in black ink, appearing to be 'S. Sharma', is written over a horizontal line.

Copy of Consent Form

Title of research: A PHENOMENOLOGICAL STUDY OF THE EXPERIENCES OF SUBSTANCE ABUSERS IN AN UNDER-RESOURCED EASTERN CAPE COMMUNITY

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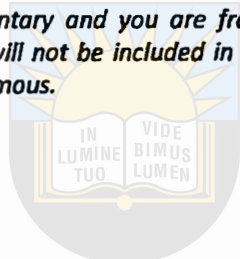
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Identification of investigators

Name of Investigator: Sandra Sharma



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Consent

I the undersigned understand the procedures described above. My questions have been answered to my satisfaction, and I agree to the above for the purposes of this study. My consent is purely voluntarily, and I knowingly give informed consent to use this data for the purposes of this research.

Participants name: Participant 003

- I consent to the above for the purposes of this study
- I do not consent to the above for the purposes of this study

Participants signature: [Handwritten Signature]

Copy of Consent Form

Title of research: A PHENOMENOLOGICAL STUDY OF THE EXPERIENCES OF SUBSTANCE ABUSERS IN AN UNDER-RESOURCED EASTERN CAPE COMMUNITY

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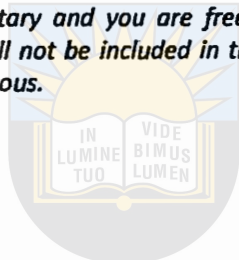
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Identification of investigators

Name of Investigator: Sandra Sharma



Ethical approval

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Consent

I the undersigned understand the procedures described above. My questions have been answered to my satisfaction, and I agree to the above for the purposes of this study. My consent is purely voluntarily, and I knowingly give informed consent to use this data for the purposes of this research.

Participants name: PARTICIPANT 001

I consent to the above for the purposes of this study

I do not consent to the above for the purposes of this study

Participants signature: [Signature]

Copy of Consent Form

Title of research: A PHENOMENOLOGICAL STUDY OF THE EXPERIENCES OF SUBSTANCE ABUSERS IN AN UNDER-RESOURCED EASTERN CAPE COMMUNITY

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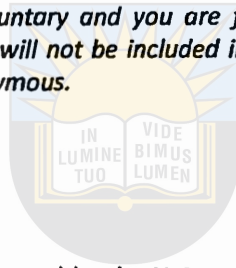
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Identification of investigators

Name of Investigator: Sandra Sharma



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Consent

I the undersigned understand the procedures described above. My questions have been answered to my satisfaction, and I agree to the above for the purposes of this study. My consent is purely voluntarily, and I knowingly give informed consent to use this data for the purposes of this research.

Participants name: PARTICIPANT . 005

I consent to the above for the purposes of this study

I do not consent to the above for the purposes of this study

Participants signature: AMEIEN

Copy of Consent Form

Title of research: A PHENOMENOLOGICAL STUDY OF THE EXPERIENCES OF SUBSTANCE ABUSERS IN AN UNDER-RESOURCED EASTERN CAPE COMMUNITY

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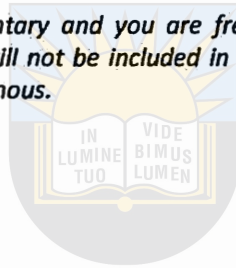
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Identification of investigators

Name of Investigator: Sandra Sharma



Ethical approval

This study has been reviewed and approved by the University Research Ethics Committee (UREC) for studies involving human subjects. For research problems or questions regarding this study UREC may be contacted through Prof Gideon De Wet at the Govan Mbeki Research and Development Centre (GMRDC) at the University of Fort Hare.

Consent

I the undersigned understand the procedures described above. My questions have been answered to my satisfaction, and I agree to the above for the purposes of this study. My consent is purely voluntarily, and I knowingly give informed consent to use this data for the purposes of this research.

Participants name: PARTICIPANT 006

I consent to the above for the purposes of this study

I do not consent to the above for the purposes of this study

Participants signature: 

Copy of Consent Form

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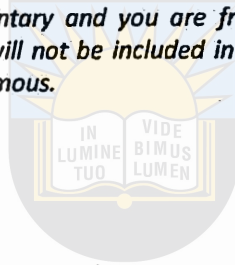
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Identification of investigators

Name of Investigator: Sandra Sharma



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Consent

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Participants name: PARTICIPANT 007

I consent to the above for the purposes of this study

I do not consent to the above for the purposes of this study

Participants signature: _____

A handwritten signature in black ink, appearing to be 'Participant 007', written over a horizontal line.

SANDRA SHARMA – 201309383

DATE: 2013-06-09

INTERVIEW SCHEDULE

INTRODUCTION:

This research is being conducted to get to know the experiences of substance abusers in a particular context. The research is for my Masters course at the University of Fort Hare.

- Everything you tell me will only be used for this research project and will not be shared with anyone outside the research team.
- Your name will not be used so no one can identify you.
- You have already consented to the interview with the consent form.
- Do you have any questions?

BACK GROUND INFORMATION

University of Fort Hare

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DATE OF INTERVIEW	
NUMBER OF INTERVIEW	
PARTICIPANTS NUMBER	
AGE	
MARITAL STATUS	
NUMBER OF CHILDREN	
EDUCATION LEVEL	
SPOUSE'S EDUCATION LEVEL	
OCCUPATION	
SPOUSE'S OCCUPATION	
AREA OF RESIDENCE	

QUESTIONS ABOUT SUBSTANCE ABUSE

1. What were you diagnosed for?

2. What is the history of the diagnosis?

Prompt: when did this happen and did that have an influence on you deciding to come for this treatment?

3. What do you think and feel about the diagnosis?

4. What do you understand about your illness?

Prompt: has the diagnosis been helpful in any way to deal with the challenges of life?

5. Has the diagnosis had any influence on how you started experiencing life?

6. Have you found out how other people understand your diagnosis?

Prompt: How did you find this out?

What do you think about how they understand the diagnosis?

7. Has the diagnosis helped you to make any meaningful changes in your life?

Prompt: If so what are they or why do you think it has not been helpful?

CLOSING QUESTION

8. How do you plan to live with the diagnosis in future?

Thank you for participating in my research study and for sharing your experiences with me. I wish you all the best in your recovery.
