

EXPLORING THE EFFECTS OF SUBSTANCE ABUSE ON THE FAMILY IN A SELECTED ETHEKWINI DISTRICT

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DECLARATION

I, N.G.Radebe, declare that this dissertation titled: EXPLORING THE EFFECTS OF SUBSTANCE ABUSE ON THE FAMILY IN A SELECTED ETHEKWINI DISTRICT is my original work. It has never been submitted before for any other degree or examination in any other University. I also declare that the sources of information used in this work have been acknowledged by means of references.

This research project has been read and approved for submission by my supervisor, Ms A.A.H. Smith

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Date

DEDICATION

I dedicate this study to; late my parents Violet and Jacob Madiya; my husband, Emmanuel Radebe; my sister, Ignatia Madiya; and my son, Andile Radebe.

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Special thanks to God for giving me the wisdom and guidance to complete the study.

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To the community leaders for allowing me to conduct the research project, and the participants for their valuable time, I thank you.

ABSTRACT

Aim

To explore the effects of substance abuse on the family in a selected EThekweni district.

Background

Substance abuse is a socio economic and health problem contributing to the 40% global burden of mental illness that hinders social development and disintegrates communities. The commonly abused substances in South Africa are alcohol, cannabis and heroin. Previous studies conducted focused on various aspects of substance abuse problems ranging from personal to social reasons and implications for substance related HIV infections, but there is limited research on the effects of substance abuse on the family.

Research Methodology

Objectives for the study were twofold; to describe family members' perceived effects of substance abuse on the family, and family members' beliefs about substance abuse contributory factors. It was essential to conduct this study using a qualitative approach to obtain a deeper understanding of the experiences of families living with a substance abuser. A Coloured (mixed race) community living in the north of Durban in KwaZulu-Natal was purposively sampled due to known incidence of substance abuse within the community. Purposive sampling was used to identify key informants from 5 families experiencing substance abuse who were attending a community empowerment workshop. Two families participated, a total of seven individual participants aged between 23 and 67 years of age. Ethical considerations were followed by requesting permission to do the study from the community gatekeepers and by obtaining ethical approval from the Human and Social Science Research Ethics Committee at UKZN. Privacy and voluntary participation were emphasised.

Data collection and Analysis

Data collection was done using face to face and audio recorded interviews using open ended questions that allowed participants to disclose and narrate their everyday experiences with substance abuse. Content analysis was used.

Results

Families reported that the acceptability of illicit drugs in their community lured family members to experiment with these out of curiosity, they learn the cultural behaviour that predispose them to abdication of responsibility resulting in low education and inaccessibility to employment. Family lives are disrupted due to poor cohesion and financial hardships.

Conclusion and recommendation

The greatest concern is the increasing use of these illicit drugs resulting in a global health burden without adequate rehabilitation services due to lack of funds. There is a noticeable uphill battle in reducing both the source of production of these harmful substances especially with the new market developments of the inclusion of licit chemicals in modifying illegal substances. A multi-sectoral policy is needed to eliminate the socio-political factors that predispose families to the substance abuse burden.

Key words: Substance abuse, Families, Psychosocial experience.

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
DSM	Diagnostic and Statistical Manual
HIV	Human Immune Virus
KZN	KwaZulu-Natal
LMIC	Low middle income country
NICRO	National Institute for Crime and Rehabilitation of Offenders
SA	South Africa
SACENDU	South African Community Epidemiology Network on Drug Use
UK	United Kingdom
UNICEF	United Nations Children Fund
UNODC	United Nations Office for Drugs and Crime

USA	United States of America
WDR	World Drug Report
WHO	World Health Organisation
APA	American Psychiatry Association

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Chapter one

Introduction to the study

1.1 Introduction and Background

Globally substance abuse, which includes alcohol, prescription and illicit drugs, is reported as a socio-economic problem by the United Nations Office on Drug and Crime (UNODC 2012; 2014) and supported in current literature (Fischer, Cruz, Bastos, & Tyndall, 2013; Fischer, Keates, Bühringer, Reimer, & Rehm, 2014). The World Drug Reports (WDR 2012; 2014) indicate a global problem that is neither declining nor abating (Burns, 2014; Degenhardt, Singleton, Calabria & McLaren, 2011). Statistics from the WDRs (2010; 2012) indicate a global increase of addiction from 80 million in 2004 to 200 million in 2010, a further increase between 2012 and 2013 to 324 million (WDR, 2014). Briefly, substance abuse, recently grouped under addiction disorders, is defined according to American Psychiatry Association (APA) Diagnostic and Statistical Manual, fifth version, 2015:481, (DSM-V) as “*a maladaptive pattern of substance use manifested by recurrent significant adverse consequences related to the repeated use of substances, occurring within six months.*” Substance abuse is characterised by repeated failure to responsibly fulfil the social roles at home and at work, resulting in job loss and an inability to develop and sustain close relationships, while continuing to expose self to physically threatening situations as tolerance results in a need for increased amounts of the substance to avoid withdrawal (APA, 2013). Most startling is that substance abuse is reported to contribute to 40% of the global burden of mental illness, negatively hindering social development of communities and individual employment opportunities (du Plessis, Corney, & Burnside, 2013). Policymakers face a challenge in formulating effective substance abuse control policies based on the context in which substance use occurs (Merlo, 2011). In addition to their local contexts, policy makers face globalisation and the influence of international markets that enable accessibility of the illicit drugs (Van Tonder, 2013; WDR,2015).

Research also suggests that types of substances used, and or abused, differ between societies. Statistics indicated that globally in 2013 there was a decline of ecstasy use replaced by new psychoactive drugs use rating at 54% in 2014 (Moore, Norman, Sly &

Whitehouse, 2014;WDR, 2015). Furthermore opioid use increased in Asia to 59% while cannabis use remained at 62%, cocaine use in Europe at 59% and cannabis at 52% while 38% in America consume cannabis and 52% in Africa, compared to heroin use that has tripled resulting in high mortality in the United States from 3,036 in 2010 to 8,527 in 2013. Amphetamines are commonly used in Czech Republic and Africa (Degenhardt & Hall, 2012). The WDR, 2014 further indicated that multiple drug use are noticeably linked to recreational purposes, stress relief and leads to unintentional early deaths with mortality rates of up to 40% (WDR, 2014).

Socio-demographic data reveals that within Africa 31.5% of male and female citizens, between the ages of 15 and 64 years, practice ‘weekend binge drinking’, 64% use cannabis and 52% use other illicit drugs (Pasche & Myers, 2012b). It is reported that this substance use costs the region R10 billion annually (Matzopoulos, Truen, Bowman, & Corrigan, 2014; WDR, 2014). Pasche and Myers (2012a & 2012b) reported that South Africans abuse alcohol, cannabis, benzodiazepines, slimming tablets and popular illicit drugs such as heroin and the recently emerging ‘Whoonga’. Indications are that this new illicit drug, Whoonga, shows a 70% use by the South African Coloured community in peri-urban areas with devastating effect on the families and the communities (Grelotti, Closson, Smit & Mabude, 2013; WDR, 2012; 2014). South African researchers Mothiba and Malema (2009) reported that alcohol use by the youth resulted in poor educational achievements due to physical and psychological dependence. KwaZulu-Natal (KZN) substance use behaviour among residents is reported that 55% consume alcohol, 33% smoke cannabis and 17% use heroin (Dada, Plüddermann & Williams, 2012). The KZN District of EThekweni population is reported to contain 23% binge drinkers and 12.8% cannabis users which may account for the unemployment of young adults (Herman, Stein, Seedat & Heeringa, 2009; Du Plessis, 2013). According to van Wijk and Harrison (2013) South Africa, as a lower middle income country (LMIC), is experiencing an escalating problem of illicit and licit drugs that appears to exceed international communities.

Local (Plüddermann & Flisher, 2010) and international (Whiteford, Degenhardt, Rehm & Baxter, 2013 in UNODC) research indicates that substance abuse and poverty contribute to mental illness resulting in unproductive members of society that are incapable of gaining or sustaining employment due to poor performance and or poor symptom control.

Studies indicate that social pathologies such as substance abuse alter the persons' mind and social functioning leading to poor decision making, which further limits future life opportunities resulting in dependence and disrupted social life that maintains poverty and indirectly increases the burden of psychological instability (Keyes, Hatzenbuehler, & Hasin, 2011; Marmorstein, Iacono, & McGue, 2012). These consequences impact on more than just the individual substance abuser who is dependent and addicted to these illicit drugs and alcohol.

Family members and communities also face socio-economic and health related consequences supporting the addict, getting help to eliminate or reduce the detrimental behaviour, or dealing with the psychosocial implications of substance abuse (Short, 2010; Cranford, Hoeksema & Zucker, 2013). Poverty, an economic challenge in developing countries like South Africa, is a recognised precursor of mental illness because it indirectly contributes to psychological disturbance and can result from being poor and maintains mental illness (Lund, De Silva, Plagerson & Cooper, 2011; Nduna & Jewkes, 2012). Despite existing policies aimed at worldwide reduction of substance misuse, the challenge is that substance abuse continues to increase and destabilise the family life, and with this increasing prevalence global attention is focused on environmental interventions that are one of the root and driving force of this behaviour (Cyr, Euser, Bakermans – Kranenburg & Ijzendoorn 2010; Chen, Balan & Price, 2012; Quiñero, 2012; Sheidow, McCart, Zajac & Davis, 2012; Whiteford, et.al, 2013).

Research suggests that environments influencing substance availability, accessibility and use, are embedded within the political, social and cultural systems of societies (Hemovich, Lac, & Crano, 2011; McKay & Deshingkar, 2014). As indicated at the beginning of the introduction, patterns of substance use vary from country to country and among social or ethnic groups from sensation seeking, relaxation, religious and relieving life experiences but the undesirable outcome of the behaviour is altered mental well being (Teshome & Gedif, 2013). This variation affirms that within specific cultural groups substance use is part of social identity and everyday life, while in some cultures it is viewed as unacceptable based on community and or cultural values, specifically religious values (Bennett, Campillo, Chandrashekar & Gureje, 2013). There are noticeable trends of substance abuse across countries that are reported to undermine traditional values which previously regulated alcohol consumption among social groups (Onya, Tessler, Myers, &

Flisher, 2012). In addition, structural environments, wars, tribal conflicts and natural disasters, exacerbate poverty and subsequently susceptibility to mental ill-health and the potential use of substances to 'self-medicate' and or 'escape' these challenges (Mbwambo, McCurdy & Myers, 2012). Within South Africa, the political system and conflicts disempowered the economically disadvantaged and inappropriately moved, and strategically placed them in under-resourced environments (Moscona, Tiwari, Munshi & Srivastav, 2012; Nduna & Jewkes, 2012; Van der Merwe, 2014). In addition, within these poorly developed environments socio-political inequalities, floods and fires exposed individuals to loss of homes, possessions and separation of the cohesive family structure and this contributed to stress, depression, hopelessness and subsequently substance abuse as a mechanism of relieving the psychological pain such as post-traumatic stress disorder and depression (Kim, 2010; Kim, 2012; Stewart, Swartz, & Ward, 2012). The outcome of socio-political circumstances and natural disasters, specifically among the low income social groups, resulted in unemployment and poverty which was the driving force in motivating the desperate to migrate to the cities in search of work (Nduna & Jewkes, 2012; Kim, 2010, 2012). This led to rapid urbanisation and unsuccessful search for work, resulting in unresolved financial hardships which indirectly promoted substance abuse and crime (Atwoli, Stein & McLaughlin, 2013). In addition, financial constraints forced the displaced, unemployed and poverty stricken family members to engage in income generating activities that are at odds with perceptions of self, such as sex work that predispose to HIV and substance use (Xu, Smith, Chu & Ding, 2012; Robertson, Syvertsen, Amaro & Martinez, 2014; Iwamoto, 2015). The stress of living with the chronic infection contracted from sharing contaminated needles leads to emotional stress and depression and is a strong motivator to self-medicate with mood altering substance that eventually reduces the quality of life (Sherbourne, Hays, Fleishman & Vitiello, 2014). Furthermore drinking result in aggression and potential substance induced psychotic episodes, while cannabis impairs coordination and contributes to accidental injuries like drowning, falls, and liver impairment (Degenhardt & Hall, 2012).

Regardless of the conditions influencing and facilitating use of substances, the repeated and continuous consumption lead to addiction and increase stress and discord within families. Nduna & Jewkes (2012) reported that constant misuse of alcohol drives users to commit criminal activities such as stealing to obtain money to buy drugs or commit violent behaviour when intoxicated. Findings from the South African Statistics indicate

that 60-80% of crimes are substance abuse related (Gerber, 2013). Specifically 65% are reported as alcohol related murders, 30% - 40% of driving offenses related to drunken driving resulting in 130 road fatalities per month, The South African Community Epidemiology Network Drug Use (SACENDU, 2011). Indications are family members are subjected to psychological pain as a result of seeing the effects of substance abuse especially when there is harassment, damage to property, sleepless nights before a working day, job loss and time spent giving emotional support is devastating, the physical and psychological abuse of family members increases stress, fear and frustration due to lack of safety in the presence of the user (D'Souza, Karkada, Somayaji, & Venkatesaperumal, 2013). The amount of cost to the family is immeasurable (Copello, Templeton & Powell, 2010). Despite this, there is little local literature related to the effects of substance abuse on the family of the abuser.

1.2 Problem Statement

Several global studies related to substance abuse have produced data related to enabling influences, demographics, economic and health related consequences (WDR 2014; 2015). Despite strategies to curb this social problem disturbing rising levels of substance abuse are reported (WDR, 2012; 2014). Within the South African context of continued disenfranchised and disempowered communities and the threat of communicable disease, specifically HIV, substance abuse is a form of coping and self-medicating for emotional distress and mental ill-health (Kader, Seedat, Koch & Parry, 2012; Mohasoa, 2009; Neuman, Schneider, Nanau & Parry, 2012). Studies on poverty, substance abuse and related negative social and mental health consequences indicate a global burden of disease that needs a reengineering of interventions to include harm reduction strategies for not only users, but also for families and communities affected by substance abuse (Lund, Breen, Flisher, Kakuma, Corrigan, Swart & Patel, 2010). This social problem needs to be explored because there is an escalation of substance abuse within the research setting resulting in criminal activities that disintegrate families and entrap them in generational poverty. Furthermore South Africa is a developing country and needs a responsible productive force to increase its economy but when family members consume and abuse substance their mental well-being is altered and they cannot function productively, this will not uplift the country but hinder development and studying the factors contributing to this social ill to enable decision and policymakers interventions It

is imperative to explore and describe the effects of substance abuse on the family of the abuser.

1.3 Purpose

The purpose of this study was to explore the effects of substance abuse on the family of the abuser in a selected community of EThekweni district.

1.4 Operational Definitions

Family: A group of people who are legally bound through marriage, adoption and guardianship including rights, duties and obligations of those legal contracts or directly related through a common ancestor (Asprey, 2014).

Substance Abuse: A pattern of continuous habitual harmful use of mood altering, legal or illicit drugs resulting in impairment of functioning (West & Brown, 2013). In this study alcohol abuse and substance abuse will be used interchangeably.

1.5 Research Objectives and Questions

The objectives of the study were twofold. The research questions are presented after each objective for readability.

1. To describe family members' experiences of substance abuse on the family.

Research questions

- How has substance abuse altered family interaction?
- How has substance abuse changed the economic status of the family?
- How has substance abuse changed the mental wellbeing of family members?

2. To describe factors believed by family members as contributing to substance abuse.

Research questions

- How is substance abuse perceived as linked to learnt normative behaviour?
- What socioeconomic factors are perceived to be causative of substance abuse?

1.6 Significance of the study

Knowledge from the study will, through publication, add to the current substance abuse literature. Specifically the results focus on the local context and inform service provisions specifically to families. Information from this study might influence the mental health nurse's approach to mental illness that is related to substance abuse. This might also help strengthen the existing resources for mental health interventions based on new knowledge generated. In nursing education, new information obtained from the effects of substance abuse on the family might be incorporated into the mental health curriculum. Results can stimulate nursing research within the area of families affected by substance abuse.

1.7 Theoretical framework: Social Learning

1.7.1. Introduction

According to Bandura (2011:349) *“human expectations, beliefs and cognitive competencies are developed and modified by social influences and physical structures within the environment.”* Individuals interact with others in their immediate environment and observe and imitate the modelled behaviour. This is facilitated by the meaning attached to the normative standards and values of their cultural practices, that behaviour is then reinforced. These are powerful influences that can determine the life direction for individuals. These factors emanate from the biological, familial and socio-cultural context, but this does not mean that growth and development is a linear process, deviation occurs when individuals learn new erroneous behaviours to please the subcultural group they encounter. Learning undesirable behaviour as acceptable and normative can change the individuals' life direction resulting in undesirable changes especially when there is lack of supportive structures to challenge the new behaviour and its status (Bandura, 2011). Substance abuse is one such learnt undesirable behaviour.

1.7.2. Social Learning and Substance Abuse

Social learning results from the interaction between the individual and the environment leading to socially desired expectations of the modelled behaviour. Those observing this deviance, interpret it as acceptable due to its occurrence within their cultural context of poverty and financial hardships, and family members are tempted and motivated to imitate other substance users as a norm (Tiffany, Conklin, Shiffman & Clayton, 2014).

Role models of this maladaptive act can be parents who are abusing alcohol within the home setting, peers or significant individuals in the cultural community. These unpredictable stumbling blocks alter the family member's life goals resulting in undesirable changes especially when there is lack of supportive social control (Bandura, 2011). Therefore substance use is learnt through interaction with other society members, who in the context of stressful life challenges cope by using either alcohol or other illicit drugs.

Social learning framework is interconnected to cultural identity because it also evolves during the process of life orientation and abuse of substances. Historical inequalities and structural systems of colonial laws introduced alcohol among the Black and Coloured communities in wine farms in South Africa and among the Maori in New Zealand. This orientation of oppression and slavery appraised the Western value system while subjecting the individuals to ethnic dependence and addiction that resulted in cultural breakdown (Marie, Fergusson & Boden, 2012; Jacobs & Jacobs, 2013). This acculturation indirectly impacted on those affected individuals' self-identity because an individual's self-concept is strengthened by being part of a social group fostering a sense of belonging, increases the self-esteem and self-worth. Satisfaction is achieved when evaluating the affiliation value within the group (Manning, 2013; Segrin & Flora, 2014).

Studies conducted in India among Islamic religious members highlighted that family values play a major role regarding substance use, their faith strictly disapproves of this behaviour and emphasises group identity (Mattoo, Nebhinani, Kumar, Basu, & Kulhara, 2013). Alternatively in Greece alcohol use is normative, in spite of the negative effect on their mental well-being (Cohen, 2012; VanderVeen, Cohen & Watson, 2013). Against the backdrop of this information, substance abusers from unstable environments are lured to experiment with illicit drugs out of curiosity or to ease the psychological discomfort; and they learn and adapt to this behaviour so that they can fit in with their subculture members, not realising the unbearable emotional, psychological, financial strain and burden of this journey. The participants from the research setting may have learnt to smoke sugars and mandrax out of curiosity or because of friends who modelled this behaviour and glorified this practice, but they are now finding themselves stuck in a web of addiction. This socialisation reinforces an inappropriate culture which later causes insecurity and instability in families and communities (West & Brown, 2013).

1.7.3 Application of the theoretical framework

Family members are nurtured with limited resources in substance dependent communities and are influenced by their significant others, their role models, to believe that illicit drug consumption is normative and ideal based on their cultural context and poverty. They are encouraged by their value system to learn to conform to these standards of dysfunctional behaviour thinking these experiences reduce the psychological burden of being poor, not foreseeing the outcome of cognitive impairment and limited life opportunities. This study focuses on the presence of role models within a specific community for and against substance abuse. In addition, the consequences of substance abuse on the community's individual and collective behaviour was explored, specifically with parent, siblings and community leaders.

1.8 Summary of the chapter

This chapter introduced the study, described the background, problem statement and purpose of the study, the research objectives, research questions, significance of the study, the theoretical framework and the operational definitions.

Chapter 2

Literature review

The following search terms were used in various combinations with the prime search phrase of substance abuse: poverty, family, effects of, and mental illness. Online databases of Ebscohost, Google scholar, Medline, CINAHL, Science direct and Biomed Central were used to access literature.

2.1 Introduction

Health systems are faced with a great challenge of dealing with the burden of substance related disorders, a public health threat that needs prioritisation to reduce the negative social, economic and physical consequences (Whiteford et. al., 2013).

This chapter reviews current literature that is related to substance abuse, poverty and mental disorders. The first aspect explores the reported extent of substance abuse, internationally and locally and identifies the types of commonly used substances and substance abuse trends. The second aspect describes reported predisposing factors and the effects of substance abuse on the family and community.

2.2.1 Substance Abuse, Patterns and Trends

Substance abuse is defined as “*Psychoactive or dependence producing drugs such as alcohol, nicotine, over the counter and prescription medications including illicit drugs such as cannabis, cocaine and heroin.*”(National Drug Masterplan, 2013 - 2017:19). Dependence is defined as “*a strong desire to take the substance; an impaired control over use; a withdrawal on cessation or reduction of use; tolerance to the effects of the drug and the need for larger doses to achieve the desired physical effect evidenced by psychological harm*” (Degenhardt & Hall, 2012: 15).

Several studies on substance abuse have been conducted globally including, but not restricted to, the history of this behaviour, varied trends and enabling influences, demographics, economic influence and related health problems (Degenhardt & Hall, 2012; Liao, Kang, Tao & Bouey, 2014; Lo, Monge, Howell & Cheng, 2013). Previously

researchers have shifted the blame of alcoholism and drug use to repelled colonial laws and the apartheid system that was replaced by the new dispensation of freedom, as much as structural systems have changed, complete transformation of societies has not politically, socially nor economically improved the lives of the poor (Sorsdahl, Myers, Ward & Matzopoulos, 2014). Furthermore, formation of multipronged trade networks have unearthed non negotiated mechanisms of infiltrating illicit drugs into communities causing instability and insecurity (Van Heerden, 2014). This is evidenced by reports from subsequent studies indicating that there are multiple contributing stressors ranging from personal, familial, community and societal factors that subject individuals to substance abuse (Morojele, Parry & Brook, 2010). An adolescence study reported that substance abuse was peer influenced, but also highlighted the need for family relationships and open communication to deal with stress at home and within neighbourhoods (O'Hara, 2008).

Reports from the literature show that there are unconscious motivations and conflicts within some individuals that are manifested by lack of self-control when faced with difficult life experiences such as poverty and unemployment (McKay & Deshingkar, 2014). Compulsive substance use as a response results in an imbalanced life due to addiction and the inability to function responsibly as pleasure derived from the substance is short lived and needs continuous maintenance (Brady & Sinha, 2014; Moore, Dargan, Wood & Measham, 2013; Moore, Norman, Sly & Whitehouse, 2014). Recognition of the social context that may facilitate substance abuse resulted in political and health related strategies to curb this social problem. Despite this, positive outcomes or gains have not materialised. Statistics show a rise in substance abuse due to new emerging drugs and untraceable web based trading (WDR, 2012; 2015). This suggests that globally there is a need to review harm reduction measures through collaborative partnerships to eradicate the source, supply and demand of these illicit drugs which is compatible with the new policy suggestions of eliminating the global threat through respect of human rights (Parry & Myers, 2011 & 2014).

Globally, findings from the WDR (2014; 2015) indicate that people using illicit drugs have dramatically increased to a quarter of a billion in 2014 compared to 230 million in 2010, 243 million in 2012, with an escalation of 246-324 million in 2013. This is linked to rapid population growth and migration. WDR (2014; 2015) report a remarkable

addition of individuals who developed dependence or substance related disorders from 16 million in 2012 to 27 million in 2014, and that 1:6 users have a dependency problem. This health threat is identified through treatment seeking users with Asia having the highest at 62% for cannabis use and opioid dependency and is found to be prevalent in those aged between twenty five and thirty years; 29% of these are living with HIV infection. Europe has 3.15 million users aged between twenty and sixty four, and 23% of this group contracted HIV although there has been a decline that is related to harm reduction strategies. Africa has 1 million people who are using injectable drugs, 11% are infected with HIV and they are highlighted by the service facilities treatment reports. The WDR (2015) suggests that Russia, China, Pakistan and America are the most affected by injectable illicit drug use. Due to a shift in world economics there are indications of a shift from the use of expensive illicit drugs to consumption of cheaper multiple combinations of substances and this has resulted in 43,000 deaths in 2010, 183,000 in 2012, and to 187,000 preventable overdose deaths in 2013 (Merrill & Sloan, 2013; WDR, 2015).

Statistics revealed that 1:5 substance abusers who overdose receive care while others die immediately due to the nature and the amount of drug consumption and deficit in treatment resources availability. These premature deaths are reported to reduce life expectancy of a substance abuser by 46 years (WDR, 2014; 2015). The United States is reportedly rated with the highest heroin mortality rates (4.6%). Statistics reveal an incredible escalation of premature deaths of substance abusers from 2 million in 2010 to 12.19 million in 2013. These mortality rates, impact not only on the emotional aspect of families but also potentially on the economic and social development of the family, community and country due to depletion of workforce and productive citizens (Paulozzi, Weisler, & Patkar, 2011). In addition to reduced workforce, families, communities and nations are burdened with further costs associated with criminal activities committed by the addicted persons (Plüddemann, Flisher, McKetin, Parry & Lombard, 2010).

Statistics show that one third of substance abusers are at anyone point in time prisoners who are from the limited resource communities arrested for offences related to supply, possession, trafficking and consumption of drugs or for crimes committed to maintain their dependence; who within the legally controlled environment of American, European and South African prisons, are capable of networking with illicit drug pushers and

obtaining cannabis and heroin (WDR,2015). Indications are social learning on substance misuse further occur in prisons worldwide because these institutions are the fertile motivating forces for learning and experiencing with drugs while the habitual users stop using the illicit drugs because of interventions and enter into rehabilitative programs, but statistics from Europe indicate that in 2010 there was an escalation in use among male prisoners from 10-48% and females 30-60% while others change to any available drug when their drugs of choice are inaccessible resulting in multiple substance use, a mental ill health risk (Montanari,Royuela, Pasinetti, & Giraudon, 2014).

Reports from South African prison study assert that because of the manner in which illicit drugs are obtained in jail, prisoners use unsafe methods of drug consumption especially injectables such as heroin that is associated with the practice of unsafe sharing of needles, meaning prisoners open themselves up to the risk of contracting blood borne infections like Hepatitis C and HIV (Schneider, Chersich, Neuman, & Parry, 2012; WDR, 2015). This is a health problem of dire consequences reflected by 1.7 million substance abusers living with this HIV (WDR, 2014). With no strategic preventative measures in place like the use of clean syringes as is happening in Russia and Europe, this impairs the mental health of prisoners and 23% have confirmed mental disorders (Naidoo & Mkize, 2012; Stephens, Gardner, Jones & Sifunda, 2015).These prisoners are serious suicide risk, a leading cause of mortality specifically with substance when they are integrated back into their communities due to maladjustment (Pedersen, Hsu, Neighbors, Lee & Larimer, 2013; Montanari et al; 2014).

The study conducted on the imprisoned males reveal that 51% have substance use disorder emanating from the environmental influences carried from childhood experiences where the continuous psychological pain is a direct result of rejection from the family leading to uncontrollable use of substance carried through to adulthood resulting in mental impairment (Dembos, Briones and Gullegde, 2012; WDR,2015). In addition to substance use in prisons the World Drug Report 2014 highlighted that gender based research shows that men drink noticeably more than females (1:3). Male alcohol related mortality rates range from 6-7.6% and that of female is 4%, in essence 16-39 million of both gender have substance induced ill-health (Popova, Yaltonskaya, Kolpakov & Abrosimov, 2013; Wilsnack & Wilsnack, 2013). Epidemiological studies further indicate that substance users are from the low middle income families with low levels of

education, and are mostly multiple drug users (Gigliotti, Ribeiro, Tapia & Aguilera, 2014; van Wyk, 2011). This is synonymous and a reality for Africa and the South African context where areas with high substance abuse are typically the poorest communities, specifically those who have been forcefully misplaced by political turmoil (Atwoli, Stein, Williams & McLaughlin, 2013). In spite of this global mental health and substance use problem, an effective drug policy lacks collective action that is powerful enough to eliminate this hazardous behaviour (Parry & Myers, 2011; Parry, Morojele, Myers & Plüddemann, 2013). It is possible that a global strategy is hindered by differing patterns of abuse across, and within, countries.

Patterns of drug abuse differ with the countries' social influences, culture, drug availability, acceptance and tolerance of the behaviour and the characteristics of the user (Degenhardt & Hall, 2012). The geographical variations of substance abuse is evidenced by the literature revealing that historically Europe and Australia have high consumption patterns of alcohol and other illicit drugs affecting 8 million people compared to Islamic religion countries (Lê Cook & Alegría, 2015; Marie, Fergusson & Boden, 2012). Cultural rituals illuminate patterns of alcohol use for traditional ceremonies in India, Mexico and Africa, and for social activities in Australia (Bennett, Campillo, Chandrashekar & Gureje, 2013). Influential environments and policies controlling distribution and use, specifically of alcohol and cannabis, clarify cultural trends and their impact over time (WHO, 2014). In addition, international and local border control policies and practices have weak surveillance systems for drug control measures.

This subject vulnerable communities, in the African continent, to illegal invasion by drug traffickers/mules who, because of poverty take this as an income generating option, using the continent as a transit hub from the Eastern to the Western countries and facilitating 52% consumption of both the internationally and locally produced illicit drugs, like cannabis from West Africa (Van Heerden, 2014; WDR, 2015). For example, Afghanistan mobilised heroin markets and accessed entry into Africa by using organised criminal group members as traffickers through commercial planes and later in the 1980, permeated South Africa using the Indian ocean route. Sales of these substances targeted the economically productive young people in recreational environments and negatively subjected them to dependence and altered their mental wellbeing while reducing the economic gains of the country from the related health and crime costs (Csete & Sánchez,

2013; Trenez, Scherer, Duncan & Harrell, 2013). Furthermore the post-apartheid South Africa saw an increase in the new forms of injectable heroin, amphetamine and cocaine trafficking, consumption statistics report 15.2% to 43% in Eastern Cape consumed by Coloureds and Blacks; 3 to 31.1% in Cape Town; 52% use in Mpumalanga, and in KwaZulu-Natal 19 to 30% use mostly by Coloureds and Indians (Pasche & Myers, 2012a). The concern is heroin markets are jeopardising gains of reduction of HIV infection in Sub-Saharan Africa and are reported to account for 10% of newly acquired transmissions from contaminated heroin equipment (Kasirye, 2015).

Preferred stimulants used in Africa are cocaine and amphetamines, famous for boosting the mood and body energy among the depressed; substance users and those involved in laborious employment such as construction and sex work (Xu, Smith, Chu & Ding, 2012) while the popular hallucinogen is cannabis. The continuous use of this hallucinogenic drug leads to physical and psychological dependence and subsequently disintegrates brain functioning resulting in hallucinations and delusions (Brady & Sinha, 2014). A family member consuming excessively these substances predispose self to risky behaviours with undesirable outcomes such as accidental death, physical illhealth and mental ill health such as substance induced psychosis (Brady & Sinha, 2014; UNODC, 2014 and 2015). The social and mental well-being of family members is further derailed by the new emerging non-medical use of prescription drugs like piperazine derivatives substituted for ecstasy and the newly produced psychotropics made from bath salts to enhance the cocaine effect in Europe and America (WDR, 2014; 2015).

Anecdotal evidence links the increase of SA substance abuse statistics to the disbandment of the South African Narcotics Bureau in 2004 (Ramlagan, Peltzer & Matseke, 2010; Moodley, Matjila, & Moosa, 2012). The extent of the problem was revealed through a local epidemiological study conducted to upscale policy formulation on integration of mental health into primary health care using the DSM-IV, and later DSM-V, assessment criteria for all mental impairments (Herman et al., 2009). Aspect of substance abuse were included and gathered data related to history of onset of substance abuse, education level, age and race of the abuser were documented. Results revealed that 30.3% of the population have mental ill-health and 13.3% of these are related to substance abuse, and 11.4% specifically alcohol related (Saban, Flisher, Grimsrud & Morojele, 2014). A dual diagnosis, substance abuse and mental illness, is a family, community and national

burden because the dependent abuser is incapable of functioning responsibly and the co-occurrence of the mental ill-health and addiction is difficult to treat due to its cyclical nature (Herman et al., 2009). Increasingly this difficulty is the diversity of substances used locally. Current research reports show that South Africans are addicted to licit and illicit drugs and are generally multiple drug users consuming mostly depressants, stimulants and hallucinogens (Gopal & Collings, 2014; Watt, Eaton, Choi & Velloza, 2014). The primary substances currently used locally are alcohol followed by cannabis and cheap heroin, prescription drugs and the recently emerging Whoonga, a combination of antiretroviral drugs, heroin and cannabis that is commonly found in peri-urban areas (Pasche & Myers, 2012b; Rhoades, Winetrobe & Rice, 2014; Shembe, 2013). Whoonga contributes to defaulting of anti retroviral (ARVs) due to their street value (Pasche & Myers, 2012b; Rhoades, Winetrobe & Rice, 2014; Shembe, 2013). This evidence is linked to the DSM-V criteria of dangerous or harmful use of substances that disrupt social, occupational and psychological functioning due to dependence (Albrithen & Singleton, 2015; Hasin, Fenton, Beseler, Park & Wall, 2012).

As much as these substances are used nationally there is an increased consumption among the Coloured and Indian racial groups identified through criminals arrested for drug related activities (Dada, Pluddemann, Parry, Bhana & Vawda, 2011). The 2011-2012 drug statistics indicated that 75% of Coloured males were substance abusers, of these; 47% used crack cocaine, 39% methamphetamines, 16-17% heroin (Dada, Pluddemann & Williams et al., 2012). In addition, 59% of these substance abusers were unemployed and assumed to pay for their substance abuse habit through stealing and committing criminal activities, 68% of these were single and 13% have primary school education only (Spaull, 2013). In addition, there is reported provincial differences.

Substance abuse trends vary from province to province with Western Cape having the highest ecstasy and alcohol consumption due to its geographical location to ports and international links coupled with increased urbanisation (Mulia & Karriker-Jaffe, 2012). Cannabis abuse prevalence, as percentage of the population, is reported in Gauteng as 48%, Free State as 42%, KwaZulu-Natal as 48% and in addition, 41% take alcohol and 30% heroin (sugars) with unsubstantiated percentage of the new designer drug, whoonga smoked commonly by the poor nationally and is highly addictive with severe withdrawal effects, cannabis is commonly smoked in Limpopo, and Mpumalanga is acclaimed as the

capital of heroin, while Eastern Cape and Northern Cape have lower consumption (Dada et al., 2011). The greatest concern is how the extent of illicit and licit drug misuse lures the future investment of the society, the young adults. The culture of intoxication is nested within the social class beliefs and desperate desire to have the rewards of getting high. Central to this problem behaviour is the enabling means; the money to buy the substance of choice, which is not an issue for the affluent while the poor engage in harmful and risky criminal activities to find ways of feeding their habit that subject all users to physical and psychological harm, indirectly impacts on health ranging from drug addiction, infections, overdose, injuries and mental illness (South African Community Epidemiology Network on Drug Use (SACENDU), 2012).

2.2.2 Crime and substance abuse

The psychological harm is the direct result of inequalities created by the social structures that denied the working class opportunities of securing social expectations of success resulting in limited resources to sustain their life (Funk, Drew & Knapp, 2012). The human response to these social blockages led to deviation from the set social control norms in order to restore their tarnished image by using illegitimate ways of behaviour that entails violence while under the influence of alcohol and drugs. The socio economic influences indirectly created violence that is associated with criminal activities. (Manning, 2013). This is commonly identified in low income countries like Mozambique, Brazil, Columbia, Russia including the developing South Africa, countries known to international communities as unsafe and for clarity on the concept violence, WHO (2011: 35) definition “*intentional use of physical force or power, threatening the individual or group resulting in injuries or death, psychological harm, maldevelopment and deprivation.*”

The question is, what makes those committing crime violent? Looking at the associated harm and injury linked to the behaviour, is it the colonial history, unemployment and poverty, mental ill health or geographical location for drug dealing syndicates (Leibbrandt, Finn & Woolard, 2012; Noble, Zembe & Wright, 2014). The drivers of this behaviour resonate from diverse socio-political histories of inequalities in spite of the cognition transformation and is reflected by the growing separateness of the rich and the poor, especially those who have little or no education resulting in them being either unemployed or working in low paying jobs that is not enough to cater for their family needs leading to identity and self-esteem problems; this encourages substance using criminals to seeking power, control, authority, dignity and recognition through aggression (Reisman & Lalá, 2012; Goredema, 2013).

Aggression was noticeable when the political system could not affiliate all the former South African soldiers trained in guerrilla warfare into the country's defence force during the transitional period in 1994 resulting in unemployment (Shabangu, 2009). These militants were emotionally stressed and aggrieved by job loss and felt humiliated for not being acknowledged by those in structural power and decided on finding alternative ways of making a living through use of their martial skills, armed with dangerous weapons, using illicit drugs when committing crimes, this concurs with the 100,000 Mozambican soldiers' behaviour (Reisman & Lalá, 2012; Shabangu, 2009). Some escape arrest due to inefficient and corrupt officials, and those caught are imprisoned in overpopulated and less restrictive cells that enable drug smuggling and use, subjecting prisoners to ill health (Pedersen, Hsu, and Neighbors, 2013; Lee, 2012).

There is also an increasing evidence that violence is committed by the noncompliance to medication of the substance abusing mentally ill lacking insight into their condition or experiencing side effects that compel the individual to discontinue treatment and relapse with a prominent symptoms of aggression (Swartz, Swanson, Hiday & Borum, 2014) . Reports indicate that there is an element of violence across different disadvantaged ethnic and racial groups nested in hostile behaviour during commission of crime, 41% of offenders are Coloureds, 37.6% Asiatic, 37.07% Whites and 36% Africans (Swartz, Swanson, Hiday & Borum, 2014). The serious crimes committed are housebreaking at 48%; armed robbery 42.76%; intentional assault 37.36%; rape 37.15%; murder 30.38%;

driving under the influence 27%; possession of dagga 22.46% and theft 18.47%. The concern is 53% repeat offenders test positive for illicit drugs and 46.40% have a history of school dropout, 2% are illiterate and 38% unemployed (Swartz et al., 2014).

There are disturbing revelations from the study conducted in Israel on factors that drive offenders to engage in violent crime while under the influence of drugs. Indications are that there is a growing population of women inmates who had conflictual relationships within their families resulting in homelessness, and to survive in the street life they have engaged themselves in stealing and drug use (Brook, Rubenstone, Zhang, Morojele & Brook, 2011). Some of these incarcerated women have committed crimes while defending themselves from abusive partners, others have developed hostile behaviour because of the harmful environments at home experiencing non-acceptance by their significant others with the outcome of poor relationships. Some, due to lack of money, worked with organised criminals trafficking drugs that demands violence. Statistics show that 74% of these women who have been victimised, are from the poor sectors of the society, lack education, suffer from psychological disturbances due to trauma and have used illicit drugs to self-medicate and heal their injured ego (Gueta & Chen, 2015). These experiences are synonymous with those identified in USA where two thirds of offenders reported to be multiple drug users and have been arrested twice in a 3 to 6 month period as they constantly use violence to get money for drugs (Friedmann, Green, Taxman & Harrington, 2012). In the context of these dynamics, South Africa is known to have inherited the culture of violent behaviour from its historical political regime which is identified among substance users' antisocial behaviours (Van der Merwe, 2014). Now the country is faced with a burden of mortality and morbidity, arising from accidents and violent behaviour that is substance use related (Waller, Gardner & Cluver, 2014).

2.2.3 Impact of Substance abuse on health

Substance abuse contributes to 16.6% of the global disease burden causing 19.1% disability that as stated earlier, manifests in the substance abuser being more susceptible to a shorter lifespan than the average population (Funk et al., 2012). As much as this habit is the product of certain social groups' values and beliefs, and is used to allay physical and psychological stressors and to fit in with the subculture, the consequences contribute to a health burden.

Addiction is a health problem that is linked with morbidity and mortality from violence, victimisation and accidents and 60% of these fatalities test positive to substance misuse (NICRO 2012; 2013; Matzopoulos et al 2014). Furthermore amphetamine lowers the immune system and is associated with viral infections such as HIV and airborne Tuberculosis (Vythilingum, Ross, Faure & Geerts, 2012; WDR, 2014). Globally three million lives are unintentionally lost from violence and accidents when driving under the influence of licit or illicit drugs, estimates are nine million people practice drunken driving and subsequently cause 11.4% of all vehicle accidents, (UNODC, 2013). Statistics from South Africa show that substance related driving fatalities is doubled more than the global incidence, 43 per 100,000 population per annum compared to the global 22 per 100,000 population per annum (WDR,2015). In South Africa these driving fatalities include (53%) cyclists and pedestrians (47%) who themselves are under the influence of various substances (Van Tonder, Herbst & Terblanche, 2013). South Africa has the worst road fatalities followed by Nigeria due to drunken driving and other illicit drug use, losing 36,840 lives and costing the country R37.9 billion for medical care, loss of family breadwinner and road accident funds (Matzopoulos et al., 2014; Pirie, 2014; Sinclair, 2013). In addition to vehicle accidents, accidental overdose causes deaths and potential serious health issues for individuals who survive the overdose.

Unintentional overdose with heroin or prescription drugs such as opioids and benzodiazepams resulted in 11,500 premature deaths between 2007-2009 while 17 deaths were linked to new emerging drugs in USA (Paulozzi, Weisler & Patkar, 2011). Furthermore use of the new designer drugs has become a worldwide problem (WDR, 2015). These psychotropic substances initially developed to map serotonin receptors in the brain are now the most abused substance due to their stimulating effect (Clarke & Adermark, 2015). The literature further reveal that in 2011 there were 228,366 emergency room resuscitations, 38,329 unsuccessful resuscitations (Baum & Neuberger, 2014; Evans & Sullivan, 2014). This concurs with Hong Kong statistics (2010-2012) that of the 203 post-mortem findings of failed resuscitations new recreational drug misuse accounted for 90%, while 84% was from alcohol and other drugs; 41% from self-hanging and other lethal means of killing one's self (Elliott & Evans, 2014). A recent South African study reported that accidental overdose of psychoactive drugs results in 56% of deaths occurring at home and 10% of deaths within the emergency rooms (Wilson,

Derrett, Hansen & Langley, 2012). These fatalities contribute to 9,831 road accidents and 2,597 of these have high alcohol blood levels of 0.18g/100ml and 47% of the users are in Western Cape and 53% are from other South African provinces (National Institute for crime and rehabilitation of offenders, NICRO, 2012; 2013).

2.2.4 Occupational Accidents

This behaviour is seen more among workers using sophisticated equipment in construction sites who have adopted the culture of drinking alcohol during breaks and on return find themselves unable to focus due to impaired concentration resulting in disabling injuries that cost industries exorbitant amounts of money in compensation claims, employee turnover and retraining of new recruits to replace the former employees while the health is burdened by the physically disabled and those in need of long-term care who themselves experience the psychological stress due to lost income (Evans & Sullivan, 2014; Waller, Gardner & Cluver, 2014).

2.2.5 Poverty and Occupational costs of substance abuse

According to Leibbrandt, Woolard, Finn, & Argent, (2010) the definition of relative deprivation is *“Material standard of living independent of that of others, unequal access due to social class of economic and other resources as the key driver of health inequalities because it deprives people of contemporary standards of living.”* This definition is interconnected to the one for poverty, the inability to attain a minimum standard of living measured in terms of basic needs such as nutrition and shelter or income using the South African Index of Multiple Deprivation, 2011 (Kehler, 2013). This measurement was used to evaluate deprivation in the former homeland of South Africa twenty years post amalgamation of these to the country. Findings indicated that there is gross deprivation especially among the female headed household, in spite of the changes that the country has undergone causing concern (Noble, Zembe & Wright, 2014). This trend has been noted in the research setting, where the mother lives with nine family members and only one person is working and providing food and other needs in the household.

Reports reveal that after 21 years of democracy and successful social and economic policies South Africa still faces the vast economic challenges carried forward from the legacy of the past regime, and reduction of the unemployed is a far cry based on the low

levels and quality of education acquired by the potential employee resulting in abundant numbers of unskilled desperate workers with no income benefits (Economic Survey of South Africa, 2013). The employed low earners and the unemployed are caught in the web of South Africa's dual labour markets that have State dominated industries controlled by collective bargaining benefits while on the other hand small businesses are not included in these arrangements and continue to earn for their labour mean wages. These conditions are an obstacle that indirectly excludes and deprives the unskilled or illiterate unemployed to gainfully find employment resulting in anxiety and depression (Economic Survey of South Africa, 2013). The democratic political transformation in South Africa has been unable to bridge the socio-economic disparities, and peoples' lives have not improved by far as the ability to qualify for scarce resources is social class and educational skills based. The most affected are those in per-urban and rural areas (Kehler, 2013). Social stratification, though blurred, still plays a major determining factor for housing in which people live. Income level, wants, health, Govt care and human rights and being poor mean inaccessibility to basic needs for survival, to date 25% South Africans are still without jobs partly due to discrimination of disclosure of the HIV status coupled with less education, and are just not searching for jobs out of despair as they do not have corrupt networks to offer work and 41% of these are the youth that end up with substance abuse behaviour (Leibbrandt, Finn, & Woolard, 2012; Levinsohn, McLaren, Shisana & Zuma, 2013). The concern is there are no promising opportunities of employment as the country is focusing in increasing its economic growth through import and exportation revenue and this deepens the plight of poverty. These structural barriers subject the poor to vulnerabilities, helplessness and mental instability as they are the voiceless (Bhorat, Hirsch, Kanbur & Ncube, 2013).

The Constitution of South Africa that is rights based, as opposed to the Croation structural policy that disregards human rights regarding basic needs provision, outlines that the socio economic status of all citizens shall improve, yet to date this dream has not materialised as one third of the population still live in poverty especially in per-urban and rural areas impacting on women as evidenced in the research setting. These women, if working, cannot guarantee their employment status because of their ethnicity, gender and low education that renders them less valuable than men in the workplace that makes them temporal workers. If the employer experiences hardships, they are the first to be retrenched yet they are heads of families. Losing jobs disempower these individuals and

as they strive to survive against the odds, they become depressed due to feelings of inadequacy, inferiority and rejection (Shinn, 2010; Kehler, 2013; Sauregeres, Thomas & Moore, 2014).

In their desperation to find means to survive, poverty stricken members of the population living in the remote areas, are forced to seek work away from their homes, migrate temporarily to developed societies in order to improve their income levels. This movement may benefit their families while having negative health outcomes for the breadwinner who may encounter adverse circumstances that subsequently motivate substance misuse and risky behaviour in their place of work, this predisposes them to mental ill-health (Collins, 2013). People encounter challenges of ill-health when migrating to better their life, trying to break the chain of familial poverty against the backdrop of the country's adversities. South Africa has an economy that has first world infrastructure in some parts of the country, where the affluent enjoy the fruits of available resources alongside the severely poverty stricken population residing in the grossly underdeveloped sector of the country, the peri urban and the rural former Bantustan (Noble et al., 2014). The South African context is interrelated to both Europe and America that promote dependence on social welfare by the poor, with the outcome of homelessness and anxiety, while increasing wealth is accumulated by the elite (Shinn, 2010).

This country has the economy that is envied by other African countries resulting in many attracted to tour the country, and being the biggest illicit drug market, drugs are also trafficked during this tourism. Indications are that these traffickers are linked to international markets that target specific populations especially the poor distributors who are in need of means to survive, sell and also consume these drugs ending up with mental disorders. The families in the research setting indicated that there is unemployment that motivates the drug lords to lure poor people to sell drugs and they also partake as they see this as a gateway to financial gain (Peltzer, Ramlagan & Phaswana- Mafuya 2010; Peltzer, Louw & Mchunu 2012).

The financial rewards from partaking in drug selling and consumption is short lived because addiction sets in resulting in mental ill health that is noticeable mostly in low middle income countries, such as schizophrenia, depression, anxiety, and the

intellectually challenged (Lund, Myer, Stein, Williams & Flisher, 2013). These labels unfortunately cause individuals to be discriminated and stigmatised thus preventing them to access work and have an income to buy a house, feed their families or have a stable relationship and this leads to poor life and poverty among families. This internalised stigma elicits suicidal thoughts. Epidemiological studies indicate that in UK, US and Australia four out of ten people suffer from mental illness due to substance misuse, and live in grossly under resourced areas, compared to the rich in Brazil and India (Funk et al., 2012). These findings concur with the statement that there is an interrelation of poverty and mental disorders (Lund, Myer, Stein, Williams & Flisher, 2013).

According to Lund, Flisher, Kakuma and Corrigan (2011) poverty is internalised and endures through generations. People living in poorly resourced environments are at risk of internalised emotional stress outcomes. Furthermore the stigma of being perceived as poor destroys people's self concepts, resulting in them being poor role models for family members, which can then indirectly cause emotional stress and substance abuse and may result in mental ill health. The families in the selected research setting live in a disadvantaged neighbourhood that is plagued by financial hardships, poverty, crime, drugs and insecurity. Therefore from the aforementioned context, these individual may suffer from psychological stress. Therefore poverty degrades the poor living in marginalised sectors of society, subjecting them to become the targets of drug-related crime because of their financial constraints; violence when needing money for drugs or when high; and aggression that yields fatalities and decreases productivity. Loss of productive life elicits feelings of depression, dejection, disempowerment, stress and strain that increases mental illness. The stigma attached to mental illness means fewer job opportunities as they are deemed unfit and unable to withstand the expectations of work, which will entrap them in poverty (Lund, De Silva, Plagerson, Cooper, Chisholm, Das, Knapp & Patel, 2011).

In addition to occupational accidents mentioned in health related costs substance abuse also reduce the earning power of the abuser and thus the economic viability of his or her family. The industrial sector is faced with the challenge of decreased productivity due to absenteeism as workers on illicit drugs are constantly absent from work (Evans & Sullivan, 2014). There are several possible results of employing a substance abuser, firstly, retrenchments of skilled and knowledgeable employees may result in pay out

packages. Secondly, as a result of accidents related to substance abuse and employer assistance programmes that require intervention before retrenchment or dismissal the employer may be compelled by labour laws to pay health benefits for injuries caused and or sustained by the substance abusers negligence. This results in employers being reluctant to employ a known substance abuser and this impacts of the economic viability of the abuser and his or her family, and unemployment decreases the Gross Domestic Product (Evans & Sullivan, 2014). Clearly the economic cost of substance abuse can be staggering.

The united States of America paid \$21 billion for substance related ill health services in health care centres and laboratories doing the assessments, implementing alcohol monitoring through roadside blood analysis to enable arrest of the abuser, death compensations, overpopulated prisons, court proceedings for the arrestee, and rehabilitation programs, and war on drugs initiatives (Douglas & McDonald, 2012). South Africa pay R29.7 billion for alcohol related motor vehicle accidents R9.68 billion for crime and R100,000 million annually for overdose that contributes to mortality, addiction, infections and mental ill health (NICRO, 2012 & 2013). The literature reveals that the impact of costs on health care is further seen among 40% of HIV infected individuals using illicit drugs among certain demographics resulting in substance use ill health (DeLorenze, Tsai, Horberg & Quesenberry, 2014). The South African department of trade and Industry has revealed that the total cost for substance related ill health has increased from 579 in 2009 to 789 euros in 2011 (Douglas & McDonald, 2012; Parry & Myers, 2011). The South African Liquor industry has donated 94 billion rands to the country's economy to enable development of substance use reduction programs, in spite of these efforts there has been no fruitful gains due to emerging new illicit drugs resulting in an increase in health burden (Jerry, Collins & Stroom, 2012; Measham, Moore & Welch, 2012).

2.3.1 Contexts of abuse

Substance abuse is associated with an interconnectedness of environmental factors that degrades human rights, living in poor physical infrastructure with no proper sanitation, families overcrowded in small housing with no human space for privacy and occupants having no legal means of verbalising their concern due to poverty (Funk et al., 2012). The other motivating factors are driven by the learnt culture of the community behaviour

contributing to normalising availability and misuse of drugs, coupled with the internal biological human behaviour associated with genetic factors, neurobiology and psychological development within the unstable context of lawlessness (Kendler, Myers, Dick & Prescott, 2010; Sloboda, Glantz & Tarter, 2012). Family members experiencing harsh circumstances are subjected to reduced healthy coping mechanisms that render them vulnerable to hopelessness that drive them to risky behaviour, such as substance abuse (Eytan, Munyandamutsa, Nkubamugisha & Gex-Fabry, 2014; Lai, Sura & Curry, 2015). These individuals tend to disregard effective problem solving skills and externalising their distress in substance abuse behaviour, reducing the emotional stress in a harmful manner that increases the risk of dependence (Matheson, White, Moineddin, Dunn & Glazier, 2012).

The other reported drivers of excessive use of substances among the economically disadvantaged families are problems occurring within the household. These obstacles range from substance related domestic violence, or from being discriminated ethnically and misplacement by the social system or family conflicts to homelessness, with no access to desired goals due to lack of education resulting in frustration and status inconsistency, these factors lead to stress and subsequently excessive substance use (Mulia & Karriker-Jaffe, 2012).

Previously researchers have placed the blame of alcoholism and drug use to colonisation laws and apartheid system (Estreicher, 2014). Historically South Africa was dominated by the colonial masculine leadership powers economically and politically dividing social classes racially using exclusionary militant social systems and crafted inequalities (Jacobs & Jacobs, 2013). This was the exploitation of the working class who were removed from their indigenous place of living to the cities to work in mines and create wealth for the elite. The continued oppression drove the workers to depression and indirectly substance abuse (Morrell, Jewkes & Lindegger, 2012). The post-apartheid Government diverted this leadership style and promoted unity, but because of the inherited economic inequalities previously disadvantaged people remain unemployed and poor (Horn, 2013).

It is believed that excessive alcohol intake among the poorer Coloureds is rooted in the history of the dop system used by the wine farmers to pay labourers for work done with substandard wine instead of money (Estreicher, 2014). This payment system entrapped

them to excessive drinking, dependency and ill-health in South Africa and when this system was abolished in 1960, workers continued collecting this wine and developed their own mobile shebeens that sold liquor on credit which indebted the addicted and contributed to cyclical poverty (Russell, Eaton & Petersen-Williams, 2013). The literature further reveals that the culture of intoxication was perpetuated by the local structural authorities that influenced substance use by building beer halls in the townships rather than in the city centre as a source of funds for the social development of peri-urban communities, containing migrant labourers who live far from their rural families within these context of alcohol away from their places of work, indirectly making them spend more of their free time drinking. Research reports that this resulted in dependence, risky behaviour, crime and psychological disorders (Jacobs & Steyn, 2013 a and 2013 b).

This moulded social life of the working class was a precursor for ill health and is affirmed by current studies emphasising that there is an interplay of human and environmental stressors that subject individuals to be vulnerable and at risk of substance abuse behaviour (Morojele, Parry & Brook, 2010). This poses a challenge on how best this socio economic and health problem can be resolved especially in low middle income countries such as South Africa that are faced with other challenges such as poverty and communicable diseases (Funk et al., 2012). In essence a person is born within the microsystem that involves the family context, where there are significant others who socialize and guide new family members, nurturing them to be independent and fully productive society members.

Social learning occurs throughout this socialisation process that is also undertaken by social institutions, such as education, peers, neighbours, community, workplace and media. The major goals are to instil the family and societal cornerstone, the cultural practice, knowledge, skills, language and cultural identity. Expectations are that people shall internalise the culture and conform to these normative standards, with the goal of promoting cohesiveness and good interpersonal relationships within the family, ensuring the context that moulds and supports consistent changes in the person as this is critical throughout the developmental stages (van Zyl, 2013). However growth hindrances and environmental challenges makes the individual vulnerable to pressures and strains, resulting in impulsive decision making when coping and problem solving skills are then depleted and cause anxiety and depression resulting in rebellious deviation from set

ideological beliefs and choose mechanisms that provide psychological comfort and reduce stress such as alcohol or drugs (Larsen, Engels, Wiers, Granic & Spijkerman, 2012; Morojele et al., 2010; van Zyl, 2013).

Impulsiveness is linked to pathological neural abnormalities that compel the individual to episodic binge drinking and intoxication within 2 hours which is a health risk. The behaviour is an intrinsic individual characteristic of borderline personality and is attributed to risky drinking and suicidal tendencies when faced with adverse life situations where a person feel abandoned and lonely after divorce or widowhood with poor support systems (Koller, Preuss, Lü, Soyka & Pogarell, 2015). Repetitive drug use is therefore reinforced by feeding the desperate inner desire to indulge in excessive consumption followed by the response and satisfaction obtained after use, that of getting high indirectly becomes the main driver in the stimulus response process, resulting in maintenance and supporting of the craving overtime, the outcome of this learning leads to dependence (Tiffany, 2014; Townshend, Kambouropoulos, Griffin, Hunt & Milani, 2014). This transformational behaviour of continuous drug intake leads to pathological changes in the brain resulting in dysfunctional and competitive mind functioning that alters the normal cognitive processes and self-control compelling the individual to submit to powerful thoughts and feelings of addiction rather than suffer withdrawal symptoms when wishing to stop using these illicit drugs.

This learnt behaviour is further driven by the availability and accessibility of drugs within the community leading to family members making choices that are detrimental to their social life as it reinforces inappropriate culture which later cause insecurity and instability in families and communities (West & Brown, 2013). There are various reasons given for substance misuse ranging from cultural rituals to recreational use, the latter is the economic night life, the clubs that are fertile grounds for the introduction of illicit drugs to cement newly developed social relations through this deviant practice resulting in dangerous consequences (Manning, 2013).

2.3.2 Substance abuse and policy

The inappropriate cultural practices of trafficking, selling and abusing illicit and licit substances flourish under the lawlessness of the neighbourhood's political structures to the detriment of human life and strengthening of these can reduce the harm to families

(Parry & Myers, 2011). The current drug policy focuses on increasing tax on alcohol; apprehending those found in possession or are under the influence of substance and detaining them in prison (Parry & Myers, 2014). Anecdotal evidence globally indicate that these measures have failed with 2.5million deaths in 2010 from substance related poor health (WDR, 2012). South Africa had 130 people dying daily contributing to economic and health burden (Pirie, 2014). The WHO (2012) noted the dangerous use of alcohol in South Africa, and urged policymakers of the need to change policy to the one that eradicate the root source of drugs (Parry & Myers, 2011; Van Tonder, Herbst & Terblanche, 2013).

Reports from studies conducted asserted that the current policies should be reviewed as suggested by the international communities, in order to alleviate morbidity and mortality as well as the negative effects on the families and neighbourhood (Parry & Myers (2011). Structural and cultural factors have predisposed individuals to misuse of substance and to undo the harm needs new strategic policy that will not decriminalise the behaviours associated, but eliminate the manufacturing and distribution of the harmful substances because their origins are known as reported in World Drug Report (2014). Ineffective substance abuse policies has cost the Australian Government exorbitant amounts of money, \$5288 million, for substance abuse related awareness campaigns and criminal offenses, but this has not deterred the behaviour as numbers increased more than before leading to policymakers redirecting focus on production and manufacturing of illicit drugs rather than control of those in possession of them (Birnbaum, White, Schiller and Waldman, 2011). Deliberations on decriminalisation of illicit drug use have met with mixed responses and opinions among politicians and decision-makers because the perception was the public will be misinformed and do as they please, disregarding the law. The lesson learnt from the Portuguese is that there has been a great reduction in substance abuse since 2001 with the inception of a decriminalisation and depenalisation policy with positive health gains (Hughes & Stevens, 2010).

Policy formulation has been an uphill battle among international communities trying to reduce harm because in the United States there are divisions related to legalisation of cannabis for medicinal purposes and utilise the profits for social development projects, and one South African member of parliament and the Rastafarian religious group lobbied for the bill on this controversial issue in the context of emerging dangerous illicit drugs,

yet the global and local communities are facing the escalation of injectable illicit drugs in Europe, Russia, China and in the context of HIV_AIDS, increasing mortality and morbidity due to fatalities impacting on health and economy (Brown, 2014; TOTTEN, 2013; WDR, 2015). Efforts in Canada are directed on preventive intervention that will strike a balance between safety use of licit drugs and elimination of the source that is manufacturing the product (Nasr & Phillips, 2014). South Africa and Africa lag behind in these interventions in spite of its burdensome socio economic and health threat because harm reduction strategies on banning alcohol advertisement, the primary substance abused met with an uphill due to concerns of potential 2,500 job losses and an economic loss of 228 million euros, with the negative impact of the social burden as it will increase the already overstretched budget on the Government's social assistance provision (Twillman, Kirch & Gilson, 2014; Van Tonder et al., 2013).

The challenges facing policy formulation is a lack of consensus on the valuable content of these initiatives. This is in spite of interministerial members included along with other stakeholders responsible for making the decisions. The media plays an important role in shaping these discussions on the political platform. Furthermore it frames illicit drug use as a moral decay instead of looking at it as the end product of social pathology, the mental health perspective (Lancaster, Hughes, Spicer, Matthew-Simmons & Dillon, 2011). Ethically the public opinion and that of the users must be involved in informing policy development but the political structures have silenced these voices which are also essential in social policy formulation. The stakeholders defend themselves by stating that substance abusers with mental disturbances have dysfunctional cognitive processes and are unable to give valuable input (Lancaster, Ritter & Stafford, 2013). This labelling and discrimination of drug users in these deliberations deprive the policy context and direction of the powerful contribution that considers the lived experience of family members that can be of great value.

The reason behind the lack of a comprehensive drug policy is, debates held in a summit in Durban, in 2010, were still based on the criminalisation of substance misuse and more on preventive strategies with no clear implementation guidelines, due to individual provincial task allocation of policy development that entails fragmented inputs as each came with its own strategy. The Western Cape recommended resource distribution that can better people's lives while others came with criminalisation of offenders. The

cornerstone of the policy is penalising drug use, while users do not correct the behaviour but overload the justice system with individuals who are caught in possession of these illicit drugs and detain them for prolonged periods without trial and in the process subjected to inhumane treatment by hard core offenders and further encourage multiple drug use while incarcerated (Parry & Myers, 2011).

2.3.3 Difficult lives of abusers and their families

The hardships experienced by family members are the product of the stressors within the vulnerable social environments in South Africa that are pertinent to inequalities (Lê Cook & Alegría, 2015). The disregard of family values by the person abusing substances may not only be due to hardships in life, but may be driven by the personal attributes such as antisocial behaviour, elicited by the adverse home environment and living in socially disadvantaged neighbourhoods (Waller, Gardiner & Cluver, 2014). People are sometimes motivated by the type of up-bringing, the culture, perceptions, values, needs, aims and personality to follow certain behaviours in life, based on the knowledge that they have. Saugeres, Thomas and Moore (2014) postulated that addiction derives from the interplay of early developmental crisis and non-conducive family experiences that may be psychological, physiological and social in nature. Psychologically if the person does not conform to group culture, norms and behaviour because of maltreatment and high family expectations, feelings of inferiority, inadequacy, fear of rejection develop coupled with the negative criticisms for failure, resulting in low self-esteem and worry about social isolation. This emotional vulnerability drives the person to adopt the imitative behaviour to overcome being physically alone and withdrawn, by using illicit drugs in order to redeem the altered relationship with family. This decision results in loss of control in using the substance with negative consequences of dependence (Small, Suzuki & Maleku, 2014).

According to Nduna & Jewkes (2012) indications are the deviant behaviour that evokes the psychological stress and strain is also precipitated by the structural factors that deprive the young people of power and self-integrity that lowers their self-esteem. Fear and anxiety also occur where conditions within the family environment lack provision of warmth and cohesiveness that is culturally expected, because parents are not spending enough quality time with the family members due to certain commitments, or are substance abusers themselves (Jacobs & Jacobs, 2014). Parents who misuse substances

pose a negative influence to their family members because they not only learn the behaviour but role reversal occurs when they have to care for adults, which is a stressor (Saugeres, Thomas & Moore, 2014). Families from the research setting have their intergenerational blueprint, culture that has been passed from lineage links, which entails interrupted education, unemployment, poverty and substance misuse due to boredom and helplessness which indirectly is a precursor for mental illness (Lund, Flisher, Kakuma & Corrigan, 2010; Lund, De Silva, Plagerson & Cooper, 2011; Lund, Myer, Stein & Williams, 2013).

Addiction has also been seen among the young who find themselves isolated and emotionally distanced from the family due to experiences of physical, sexual and psychological abuse by the family members especially those without parental support, motivating the person to run away from the adverse family context and opt to live in the streets for safety. In order to survive from the street culture, sex work becomes an alternative, this entails drug use because of the nature of the type of work that needs a calm mind for coping with aggressive behaviour in the industry, depriving them of future life opportunities such as education and employment resulting in mental disturbances (Clarke, Clarke, Roe-Sepowitz & Fey, 2012).

This non-caring and distressing attitude produces disunity among families and an alternative comfort may be finding comfort in the company of the available and loving friends who will lure the dejected person in uplifting their morale and lowered self-esteem through use of illicit drugs (Brook, Rubenstone, Zhang & Morojele, 2011). Family members in this research neighbourhood have presumably been driven by structural influences affecting their adverse developmental stage, life experiences, and misused substance to deal with hardships of deprivation, and being raised by unemployed single mothers or grandparents living on social welfare (van Zyl, 2013).

This life challenge that promotes illicit drug use do not warn families and communities of the negative effects that these factors have on their future (Orford, Natera, Davis & Nava, 2013). Some of these harsh influences such as living in units in close proximity to each other contribute to antisocial behaviour that is associated with aggression. The risk factor for violent behaviour may be related to loss of parents early in life, as South Africa has 3,7million orphans, resulting in internalised post-traumatic stress and depression; in

this context illicit drugs and alcohol use is self-treatment for the traumatic situations experienced instead of making good decisions in dealing with stressors and assessing the future effects of the newly adopted behaviour (Hunter, 2010; Cluver, Orkin, Gardiner & Boyes, 2012; UNICEF, 2013). War conflicts have separated family members and interrupted the education in Uganda in the context of poverty and HIV/AIDS thus affirming that cultural factors that are embedded in the socio-political context predispose people to depression and suicide (Atwoli, Stein, Williams & McLaughlin, 2013; Kinyanda, Woogburn, Tugumisirize & Kagugube, 2011).

Despite loss of parents, substance use may be due to biological factors, where there is a known family history of excessive alcohol intake that is linked to monoamine oxidase processes and alcoholism due to neuronal damage caused by either an increase or decrease in serotonin dopamine and norepinephrine and is presumed to be genetic (Duncan, Johnson & Ou, 2012). This behaviour is detrimental as parents are the role models unto which young members of the family look up for guidance and good behaviour, and if they are alcoholics due to these pathological changes, this genetically linked behaviour is imitated resulting in mental disturbance. Other consequences of the modelled and learned behaviour result in break-up of kinship ties due to poor parenting as they are frequent users of alcohol or drugs, and have less or no time to see to the needs and wants of their children but only give them ill-treatment attitude. The stress experienced by these children leads to maturational crisis that is exhibited by conduct disorders and an increased risk of using licit or illicit drugs later in life (Shin, Miller & Teicher, 2013). In addition, social factors such as generational economic disadvantage increases the vulnerability of drinking and smoking mandrax as a means of coping through self-medication against struggles in life, resulting in some cultural and religious beliefs putting restrictive gold standard or norms protecting society members from engaging in dependent substances by regulating patterns on how substances should be used in a particular cultural context (Badr, Taha & Dee, 2014).

Neighbourhoods are not just places where people make independent decisions and are obliged to set norms or are empty vessels that are dictated to by the external structures, but are the indicators of the quality of human life that endures overtime reflecting on the connection between the past and the future, that of economic inequality resulting in creation of a salient unpleasant family setting that decreases and impairs close-knit family

relationships. This hostile environment leads to depression and hopelessness that drives individuals to numb the emotional pain with substance abuse (Murry, Simons, Simons & Gibbons, 2013; Sampson, 2013).

A study on adolescent smoking behaviour as a coping strategy for developmental and family experiences indicated that adolescents were from a marginalised and disintegrated community (O'Hara, Harker, Raciti & Harker, 2008). These authors argue that the behaviour was peer influenced and highlighted the need for supportive family systems in order to deal with stressors at home and in the neighbourhood (O'Hara, Harker, Raciti & Harker, 2008). The family challenges causing the psychological pain were further identified in a study conducted among the HIV positive women who were abusing alcohol due to emotional stress resulting in treatment non-compliance and mental illness (Kader, Seedat, Koch and Parry, 2012). This altered mental well-being is further identified in the qualitative study conducted by Mohasoa (2009) on male adolescents. Findings revealed that personal, familial and environmental vulnerabilities motivated them to consume alcohol to escape life challenges.

The unpleasant environments expose individuals to high levels of substance misuse to escape their dilemma of living in informal settlements because of their low economic status; inadequate education that deprived them of knowledge of the dangers of substance abuse but instead are encouraged by their beliefs to consume various available substances that decrease their quality of life (Mokwena & Morojele, 2014). The rationale or environments for excessive substance misuse are related to poverty, family breakdown, enjoyment and curiosity and the end results are negative effects on families who become psychologically traumatised and subjected to mental illness (Pickett, Wilkinson & Chafer, 2011).

Substance abuse becomes a burden and causes the family continuous emotional stress because it breaks the bond and unity formed during the socialisation process. Instead of family members supporting conformity to expectations of the ecological process, they find themselves caring for the burdensome user, worrying about the negative outcomes of drug use (Orford et al., 2013). Furthermore it impedes the functioning of the family, and disturbs the social and recreational life resulting in financial crisis as money is spent on drug-related problems. Recurrent arguments change the communication patterns, leading

to the pain and withdrawal of non-users (Mattoo, Nebhinani, Kumar, Basu & Kulhara, 2013).

There is a great challenge when living with the substance abuser because the individual, the family and society feel the negative consequences that leads to disequilibrium and failure to maintain the normal family functioning. Finding out that the family member is consuming the illicit and licit drugs is shocking, causing feelings of anger and frustration because they had expectations of this person. Confusion and fear set in as they worry about the shame that is associated with such behaviour. This fear leads to the problem being hidden from close friends and extended family, while trying to deal with the situation on their own. The feeling is the socialisation process was a failure on their side, but they choose to suffer in silence as they cannot alter the social ill and drug availability that has turned their home life into a nightmare, especially when this addiction is coupled with gender-based power relations and domestic violence after the use of drugs. This makes relatives feel ashamed and embarrassed (Fereidouni, Joolae & Fatemi, 2014). Hiding the problem becomes a burden when the family member is also taking on the addict's disregarded responsibilities and expected roles, which results in further emotional and physical strain (Orford et al., 2013).

The stress develops from the pain of seeing a deeply rooted family relationship replaced by aggression, shouting, deceitfulness and disagreements if not isolation and less participation in family gatherings or obligations. The fights make the presence of the addict in the house uncomfortable as the lack of trust means family members have to watch the addicts's movements to safeguard their possessions. Feelings of anger develop when things are stolen, gifts are sold for drug money, and the user continues to deny any knowledge of any theft (Orford, Velleman, Copello, Templeton & Ibanga, 2010).

Disregard of family ties and responsibilities by the user are of concern for close relatives as they see the person losing touch with reality as a result of their substance abuse. They stop paying attention to job demands resulting in decreased productivity and spending money inappropriately while accumulating debt, which can result in drug lords making threatening calls to the house. Sometimes these drug pushers forcefully enter the home to collect assets in exchange for drugs used, which is a safety concern for all family members (Orford et al., 2013). These sorts of invasions are traumatising and lead the

family to become isolated, choosing to avoid social situations out of embarrassment and fear. The demand for drug payments deplete the limited resources within the household, and drive families to a state of poverty and emotional stress (Orford et al., 2013). Fear also prevails about the user's safety, particularly if they are often driving while under the influence of alcohol (Wang, Liu, Zhan & Shi, 2010).

The uneasiness is also identified by the breakdown in communication that is characterised by a lack of trust; violence that is gender power-based; and the arguments caused by the constant demand for money for drugs and over the misuse of household funds for drugs (Cox, Ketner & Blow, 2013). When the user is out late at night, worry and uncertainty about safety set in. They may fear their loved one is involved in criminal activities or indulging in alcohol or drugs that will put them in a deep financial crisis. The family is relieved when the user returns home and is safe, but conflict soon ensues when trying to warn the addict of the effects of the substance abuse and of the bad company they find themselves in. Dependence makes the family feel angry and let down as it creates a tense atmosphere due to disagreements on how to deal with this predicament. Some feel the user must be subjected to tough love and thrown out, while others stand between the fighters, fearing they may kill each other (Orford et al., 2013).

The fights destabilise the unity and cohesion between family members, resulting in disturbed interpersonal relationships. This cause some people to withdraw, preferring not to deal with the social ill. This kind of withdrawal has seen other needy family members neglected due to a lack of social interaction. Reactions to life problems differ from person to person. Some family members see that there are problems, but decide to put up with the deviant behaviour for cultural reasons or because of powerlessness or lack of assertiveness within the family structure. Studies conducted in the UK, US and Canada on families with problematic illicit drug use highlighted that siblings who are non-users deal with the stressor by focusing on their own life and rights, totally ignoring the deviant (Orford et al., 2013). They engage in activities that direct their attention away from the negative setting, either travelling or leaving home and starting a new life away from the dynamics of the unhealthy place as a way of coping (Moriarty & Stubbe, 2011). Stress and uncertainty about the future increase when one recognises the deteriorating quality of family life that is complicated by the suffering and loss of an ideal family member to drugs. Families miss doing the things they used to do together with this affected person,

not taking into consideration the added stress of being poor and struggling to raise their offspring (Orford et al., 2013).

The cost of living with an addict is high, both financially and emotionally. Lost job opportunities put a strain on other family members who have to cater for the user's needs, often at the expense of their own. They are also expected to provide support and care when the user is physically and mentally ill, and pay for hospitalisation and treatment in rehabilitation institutions. Family may also have to pay for carers if the user is cared for at home (Orford et al., 2013). If the user is unemployed and steals from their family for drugs, this causes conflict as stolen items need to be replaced and damaged ones repaired. Limited financial resources are further depleted by the need to have counsel devastated carers, who themselves are affected by the behaviour they have to put up with on a daily basis (Copello, 2010).

Stealing at home and in the neighbourhood can land the addict in trouble beside ruining the trust and interconnectedness of the family with neighbours (Church II, MacNeil, Martin & Nelson-Gardell, 2009). The family then has to pay legal fees which are beyond their means. Discussions on how to raise the money further disrupts family relations as arguments arise over whether they should provide the funds or whether the addict should stay in jail, while other families may form a renewed bond (Church II et al., 2009). Renewed family cohesion is essential because communication between family members is of utmost importance. Moving away as a means to escape unresolved issues impedes personal growth as it leaves deep emotional scars and may lead to depression, loneliness and anxiety (Smith & Segal, 2012).

2.3.4 Institutional and community awareness in South Africa

Globally suggestions to review harm reduction measures through collaborative partnerships and change in drug policy instil hope to communities (WDR, 2015). Mothiba and Malema's (2009) study based on community perceptions regarding alcohol use by the youth reported participants beliefs that substance abuse result in poor education due to physical and psychological dependence. Policies related to Drug and drug trafficking Act of 1992; road traffic policy on drunken driving and Substance Abuse control have been developed to deal with the production, selling and use of alcohol and illicit drugs, but seemingly these are ineffective (Lee, 2012). Debates around new policies

need to focus on decreasing supply of illicit drugs rather than arresting people consuming drugs for substance related crimes. The fruits of these policies challenge the new bill that suggests opening of liquor stores on Sunday in South Africa (Parry & Myers, 2011; Schneider, Cherish, Neuman & Parry, 2012). The Government has devised a national plan that declares war on drugs and does not acknowledge the proposal on legalisation of cannabis for medicinal use that may increase dependence as an undesired side effect though some other countries like America have legalised the drug in the state of Colorado for medicinal use (Howell & Couzen, 2015). There are also strategies to review the current drug policy to curb the use of pharmaceuticals associated with the new psychoactive drugs and development of an effective policy that will eradicate the manufacturing of these illicit drugs (Howell & Couzyn, 2015; Lee, 2012; Parry & Myers, 2011)

2.4 Summary

This chapter described substance abuse, the extent and patterns of use and misuse, the beliefs contributing to the behaviour, factors causing substance misuse and the effects on the family and community.

Chapter 3

Research Methodology

3.1 Introduction

This chapter presents the research design, the research setting, sample and sampling technique, data collection, data analysis and the ethical considerations.

3.2. Research Paradigm and Design

In an attempt to gain a detailed description of the effects of substance abuse on the family, a qualitative exploratory approach guided by social constructionism paradigm was used to describe families' experiences of the effects of substance abuse.

A social constructionism paradigm focuses on the complex network of human life within their cultural context (Yang & Gergen, 2012). Social constructionism views individuals as encapsulated in a network of relationships within the specific cultural context facilitated by conversation using language to create personal truths. The ontological question of what is the truth, what is real, is seen as a social construction and epistemology, knowledge or knowing, is discovered by personal descriptions. A qualitative exploratory approach was selected using face to face interviews where language was a vehicle that enabled the researcher to interact through conversation in exploring the participant's experiences to identify individual realities in their own self-descriptions (Creswell, 2007). The unpacking of the perceived origins of stress associated with the experience of substance abuse helped the researcher find the socially constructed personal truths of family members because only the human mind can create the meaning attached to their life world (Appleton & King, 2002).

The qualitative research process of inquiry was used with the researcher interacting with families in their natural setting to obtain detailed information in order to understand the holistic picture of the complex human problem and acknowledge the possibility of multiple realities (Creswell, 2007; Polit and Beck, 2012).

3.3 Research Setting

The study was conducted in a selected urban community that is situated 20 kilometres from the central city on the North West of Durban and lies on the West of Chatworth. This community was first developed in 1976 with 602 housing units, with a population of three thousand people. Most of the family members have low education and are unemployed. Family members of the selected community are the beneficiaries of the apartheid regime and, although the country has undergone transformation, socio-economic inequalities within this community have not been bridged Nduna & Jewkes (2012) reported that families feel worthless and powerless, with low status, chronically low self-esteem, and with the perception that they are trapped in intergenerational poverty. These authors indicated that such context of no hope is facilitative of substance abuse and crime. The political system of that era structurally imposed that the marginalised be forcefully removed from their ancestral arable land that had good infrastructure and proper houses with industries providing employment, and relocated the families to an under-resourced peri-urban area with poor development and no occupational opportunities. This resulted in hardships and substance abuse. To date the area has not been developed, despite the social change that the country has undertaken.

Families live in two-bedroom units, which are inadequate for accommodating three to nine intergenerational family members. Houses are mostly municipality-owned and are interconnected, and have limited space that impedes total ownership and privacy for each family. Living among these families are drug dealers in every fifth house, manned by illegal security guards who observe the dynamics of the area. All the houses need renovations as they are delapidated, but because of political processes that need to be followed this area has not yet benefitted from free government services. However the majority of occupants meet the criteria as they are unemployed and cannot afford to do renovations as the little money they get from the social assistance is used for food. Living in the area with its limited resources and illicit drug-related subcultural groups, coupled with its internalised poverty status, subjugated family members to poor education and marginalised job opportunities that rob them of their dignity. As they are paid mean wages, both the employed and the unemployed are dependent on State social grants (Jacobs & Jacobs, 2013; Jacobs & Steyn, 2013a, 2013b).

They experience financial hardships and chronic stress, and subsequently turn to excessive alcohol use, which threatens the physical, social, work and family life (Jacobs & Jacobs, 2014). Roads are tarred, but have been eroded by floods and have large potholes that pose a danger to users. Since 1976 the population has risen to 3,000. Residents are multicultural and the dominant language is English. The religion commonly followed is Catholic-based. There is one library that is not conducive to quiet reading as it is close to the tuck-shop and taxi drop-off site. The library is not fenced off, nor does it have proper security, and anyone, including substance abusers, can come in as they wish, which is a security risk for users. It is not resourced to meet people's needs, lacking computers to access the internet for the children's school projects.

There is a public swimming pool, but it is not well maintained and there is no trained lifesaver on duty. There is a soccer field for recreational purposes that is not fenced off, which puts the players as well as the spectators in danger of mugging. Community members avoid using this facility because some people are afraid of the violent substance abusers who hang around this venue looking for targets to get money for their next fix. Transportation means are trains and taxis for the most part, although some people do own cars. Taxi owners provide some form of low-paying informal temporary employment for the youth. Community leaders report that money earned by the youth is most commonly used to buy drugs. One volunteer, who asked to remain anonymous, said school is sometimes disrupted by substance-abusing gangs. Pupils demand that lessons stop and leave class, especially when the class is being taught by a teacher with a firm stance against drugs. Sometimes pupils come to school, but remain standing outside the school gates, which equates to absence from class. This further hinders future employment opportunities. These interruptions also result in school dropouts with low levels of education.

Information verbalised by the gatekeepers indicated that the majority of residences are impoverished due to the lack of community development; the availability of illicit drugs in the neighbourhood, leading to drug-related crimes; the mugging of children when sent to the shops and the elderly on pension collection days; car hijackings; sexual assault as reported by family members; low levels of education and unemployment resulting from inequalities. All this contributed to the inaccessibility of basic needs such as proper housing and food security. One community leader reported that it was of great concern

that the excessive substance abuse seemed to be intergenerational and associated with the cultural identity of living an impoverished life, resulting in needy community members feeling that the only way to cope with financial hardships is by engaging in a substance abuse-related lifestyle.

Participants in the workshop that was held in the area indicated there was tension between neighbours, evolving from disillusioned families whose relatives are using illicit drugs that are provided by ruthless drug dealers, who are protected by the police, who actually guard their houses. There is a police station in the area, which is too poorly resourced to attend to reported criminal activities, especially when there is physical threat. This often results in suspects not being apprehended, enabling them to commit other crimes as reported by volunteers during the community conversation workshop and this increases fear, anxiety, depression and frustration within the community. The clinical psychologist who came and counselled some of the conversation participants later reported that some families had lost the breadwinners from criminal activities and drug-related HIV/Aids.

These people had left behind orphans, who had no role models or parental guidance and were living with other unemployed relatives. This further perpetuated the cycle of drug use, poverty and mental disorders. The area social worker said the extent of illicit drug use had resulted in some family members being removed from their biological parents who were substance abusers. They were declared incapable of nurturing their children and were also unable to provide food and money for schooling as they themselves needed rehabilitation. There are no rehabilitation centres in the area and the available ones are far away and inaccessible to the family members as they are expensive, private and cannot be subsidised by the government.

Social development is impossible in the area, resulting in those wishing to relocate to well-developed and peaceful areas staying there because of financial constraints. This is reflected by small groups of young people roaming the streets during the day and some gathered in groups of five to ten actually doing drugs openly. This has resulted in the community members mobilising and engaging in community conversations, where they discuss their experiences of living with substance abusers amidst crime, poverty and unemployment, and how this has affected their social lives. We were invited to partake in

this workshop by our co-ordinator and we met the gatekeepers of the community, who introduced us to the families. As we listened to their life stories I identified a need to probe more into their experiences by doing a study. The decision taken was to empower community members to engage with community problems as they relate to their individual lives and personal identities (Miles, Huberman & Saldaña, 2013; Petty, Thomson & Stew, 2012). They mobilised and participated in a peaceful march on the 13th August 2013, to voice their concerns to the political structures so that initiatives to eliminate drug dealers and provide a rehabilitation centre be established. They also lobbied for the provision of better houses to ease the overcrowding of families and develop industries that will provide employment and alleviate poverty.

3.4 Population

The population in this study was family members of a person abusing substances (Polit & Beck, 2012). The target population were “coloured” (mixed race) families living in a poverty defined area, the majority accessed less education due to substance related behaviour and are unemployed. They were gathered at the local high school for a community conversation project. The estimated population in the research setting is three thousand and the area is about 20 kilometres from the city centre, lies on the Western aspect of Chatsworth and North West from the city of Durban.

3.4.1 Sampling and sampling strategy

In qualitative research, to obtain rich descriptions participant selection is guided by the concept of interest, which in this study is substance abuse, and the research question of how families experience substance abuse (Polit & Beck, 2012). Purposive sampling was used to select the specific target population. The community purposively sampled was engaged within the community outreach programme described above (research setting, point 3.3). This community was selected due to the researchers’ prior knowledge of the community through the community outreach programme attended on two occasions, where a conversation on cultural and intergenerational substance misuse was a topic of great concern. The researcher was motivated to conduct the study to learn what there is to know about the effects of substance abuse on these families. The setting was easily accessible to the researcher, both geographically and through established contacts within the community. The selection of key informant families was also done purposively in consultation with J, who is the leader of the community conversation project catering for

domestic violence. She helped identify the families living in this peri-urban area, with no sustainable income, and with males and females aged between 24 and 67 years of age with substance abuse problem (Curtis, Gesler & Smith, 2000; Ritchie, Lewis, Nicholls & Ormston, 2013). The agreed inclusion criteria for participating families were: they should have experienced substance abuse within their household in the last six to eight months, from January to August 2014; participating family members must be over the age of 18; and lastly, families must be willing to participate.

3.4.2 Sampling Process

A letter was e-mailed to the community gatekeeper, who is working for the community conversation project and is one of the community leaders, asking permission to enter the community and discuss potential key informants (Appendix 5). A face to face meeting was held on July 23, 2014, where J verbally agreed to talk to the Municipality Area Councillor, and advised the researcher to provide a written request for the ward councillor. This was done on July 28, 2014 (Appendix 6) and included the aim to explore the effects of substance abuse on families in order to understand and describe their experiences, hoping this knowledge would highlight the effects of substance abuse on the family and community (Wilson, Derrett, Harry & Langley, 2012).

The gatekeeper identified 4 possible key informant participant families with experiences of substance abuse and verbally requested their participation in the study (Babbie & Morton, 2010; 2012). Two families agreed to participate. She visited these families, provided them with an information sheet (Appendix 2) and asked their permission to introduce them to the researcher, which they agreed to. The gatekeeper provided the researcher with information on each family. The first family has four members, including the substance user. The family structure consists of the grandmother, 67, who is the head of the family; her daughter, 47; the daughter's 27-year-old son, who is an addict; and her two daughters, aged 24 and 20. The younger daughter was in Cape Town and could not be interviewed. The second family comprises a mother, 47, as the head of the family, living with two daughters aged 33 and 30, and two sons aged 25 and 23. The younger son is the substance abuser. The younger daughter in this family could not be interviewed due to work commitments.

3.5 Data collection process

Data was collected only after permission was granted by the Ethical Committee of KwaZulu-Natal University (Appendix 4) and by the Municipality Area Councillor of the research setting (Appendix 7). As described in the sampling process (point 3.5, page 38) letters were written to the gatekeepers of the community seeking permission to access the target population who met the inclusion criteria, and favourable responses were received that allowed the researcher to do the study (Appendix 5).

Arrangements were made to return to the research setting without the gatekeeper to conduct the interviews on weekdays at 10am. The families indicated that weekends were unsuitable because of security and safety risks. The researcher met with each family in their home, acknowledging their cultural context and re-establishing rapport. The contents of the information sheet was reviewed and participants were asked if they had any questions before confirming their agreement to participate in the study and signing the informed consent (Appendix 2). At each of these initial meetings the participants assumed the interviews would begin immediately and were keen to start.

The researcher interviewed each member of the family after they had signed the consent forms and were assured that information verbalised by each participant would remain confidential and anonymous, and that there were no dangers associated with being a participant. Data was collected using audio-taped in-depth individual interviews of each family member who met the inclusion criteria and field notes. The interviews were conducted in English, which is the cultural language of communication used in the community. Interviews were conducted in the privacy of a designated room as substance abuse is a sensitive issue and privacy is necessary to facilitate the revelation of participants' beliefs, feelings, values and insight into the problem, as well as the culture in which illicit drug use prevails and the associated behaviour of the user and the effect of drug abuse on those closest to the addict. (Quintero, 2012).

The researcher, a psychiatric nurse, began each individual interview with one open-ended question: "What is substance abuse doing to the family?" The researcher then used probing questions and empathetic statements to facilitate and encourage verbalisation and obtain detailed descriptions of the experience (Rowley, 2012). The researcher maintained

neutrality by adopting an ‘ignorant’ perspective, although empathetic statements were made and no opinions were expressed while listening (Mack, Woodstrong, Macqueen, Guest & Namey, 2005; Watt, Eaton, Choi & Velloza, 2014). Each family member was interviewed for 20-30 minutes to an hour, while allowing fifteen minutes between interviews for the preparation of the equipment, audio tape and writing material for field notes. In family number 1, the first participant, the grandmother, was interviewed for 20 minutes on the first day as she became very emotional and needed counselling to allay her psychological stress. She was interviewed for another 30 minutes on the second day. The daughter was also interviewed for 30 minutes. At the end of each interview the participant was given the chance to ask questions while the audio tape was on. The recorded material was verified and identified gaps were bridged with detailed field notes (Appendix 8) documented (Turner, 2010). The researcher had to return on two separate days to allow reflection by participants on the information given: this exercise provided time to listen to data and clarify certain aspects (Appendix 8 and 9). Data collection continued until saturation was met and is described in detail in the data collection process (point 3.7).

3.6 Data analysis process

Analysis of data is a method of organising collected data to find responses to research questions and, in qualitative research data collection and data analysis, is done simultaneously in the research setting while still fresh in the researchers’ minds (Graneheim & Lundman, 2010; Lindgren, Sundbaum, Eriksson & Graneheim, 2014). The inductive data analysis process was used to identify the interesting themes from the raw data relevant to the research question: the experiences of families with substance abuse (Braun & Clarke, 2006). The following is a detailed explanation of how the steps described by these authors were utilised throughout the process by the researcher.

The researcher started by familiarising self with the data and generating the initial codes by first listening attentively to the audio-taped interview of each participant, and transcribing the verbal details of the interview as narrated by the participants. The accuracy of the data was checked by listening to the recorded material again while checking the transcripts (Clarke & Braun, 2013). The researcher identified meaningful patterns of information and organised them into groups as verbalised by participants, as they were noted as potential categories related to the research questions. These potential

interpretations of family experiences of substance abuse were therefore changed and written in italics, bracketed and marked in colour and noted as emerging codes. This information was read, analysed and identified as potential answers to the research objectives. A copy of the raw data is attached (Appendix 8, page 85).

The researcher began searching for themes within the codes by looking at the patterns of descriptions, and many themes emerged. The content from the emergent themes was organised together as it related to the twofold objective of the study of family members' descriptions of substance abuse and their beliefs about substance abuse as a contributing factor (Clarke & Braun, 2013). The reviewing process followed the searching for potential themes that involved definition and naming of these themes, and for the purposes of accuracy, at this stage it was decided to consult the research supervisor. A copy of the raw data was forwarded to her and the response was that the researcher review the raw data following the naming and defining of the themes. The emergent themes were: learnt behaviour and poverty and despair.

The following is the final report and includes the extracts from the participants to outline the themes. The researcher has tried to ensure that a coherent, correct and logical report is presented. (Braun & Clarke, 2006).

3.7 Trustworthiness

According to Shenton, (2004), trustworthiness in qualitative research is essential in indicating the congruence of findings to reality, and the criteria used are credibility, conformability and transferability.

Credibility is believability and value of findings, or how congruent findings are to reality (Houghton, Casey, Shaw & Murphy, 2013). The study focuses on substance abuse and the selection of the research setting where the illicit drugs and alcohol behaviour is practised. Credibility was further promoted by the appropriate selection of research method, which was qualitative. Qualitative research is ideal for revealing a detailed description of the human experience which is substance abuse. The sample selection, using purposive sampling of participants of varied age and gender who gave detailed information about their experiences of substance abuse, confirm the correctness of the findings. The data collection method that is evidenced by the transcriptions and the audio

tapes uncovered the truth from the interviewed participants. The analysed data presentation the effect substance abuse has on the family (Erlingsson & Brysiewicz, 2013). The language used related to the personal meanings from the past, present and future of selected families (Wiklund-Gustin, 2010). The researcher first visited the study setting in order to familiarise self with the practices or behaviours of the participants before the commencement of the study. Prolonged engagement with the participants facilitated the establishment of rapport and collection of information rich data (Shenton, 2004, Holloway & Wheeler, 2013). The researchers' field notes provided in Annexure 8 for verification of data analysis and interpretation were used to make up for each other's shortcomings, uncover and highlight the complex human experience of substance abuse among participants (Houghton, Casey, Shaw & Murphy, 2013).

Confirmability made use of **triangulation** of different methods of data collection to ensure that findings reflected the situation (Cope 2014). Different techniques such as in-depth interviews, observations and field notes were used to collect data in order to obtain a detailed description of the phenomena that highlight the complex human experience of substance abuse (Houghton, Casey, Shaw & Murphy, 2013). The researcher maintained neutrality during the interviews to ensure the information was exclusively the product of the participants, allowing the participants freedom to narrate their lived experiences of substance abuse but using various strategies of probing that highlighted experiences to ascertain the truth. Reflective comments by the researcher on how the data was collected and analysed also add to the study's credibility. In addition, **member checking** was also done to verify the accuracy of the collected data at the research setting and after the interview. Detailed descriptions of the factors contributing to substance abuse, as well as the associated effects, indicated the reality of the problem (Erlingsson & Brysiewicz, 2013).

Confirmability is linked to credibility and is also facilitated by an audit trail to give a comprehensive, step-by-step, methodological description of how the initial research design was developed and of the formulated data collection and analysis method (Shenton, 2004). Findings from the substance abuse study clearly indicated they are the real experiences where the substance abuse behaviour is practised, and the accurate opinions and beliefs of the informants. Therefore the data collected is the experience of the participants not the researcher's assumptions. A contextual report, also known as the

inquiry audit, was written indicating how the research plan was used to collect data on the experiences of families, using face to face interviews while audio-taping responses, also observing attitudes, culture and symbols used and writing detailed field notes (Erlingsson & Brysiewicz, 2013).

Lastly, **Transferability** refers to the possibility of transferring research findings of the experiences of families with substance abuse to other settings or groups (Polit and Beck, 2012). Essentially the data is contextual and not transferrable. However, the researcher gave a detailed description of the research setting, the sample and data analysis, including copies of raw data, and ensured the reader could determine the value of the results of this study to their context. In this study, transferability will not be possible because what substance abuse is doing to the selected families is specific to them and may not be generalised (Cope, 2014).

3.8 Ethical consideration

Permission to do the study was requested from the Ethical Committee of the University of KwaZulu-Natal Human and Social Sciences Research Ethics Committee (Appendix 4).

Informed consent: The head of the family and the other willing family members were requested to give their consent to participate in the study after they had read the information sheet (Appendix 2) and been given an opportunity to ask questions. The participants were informed verbally and in writing about the nature and aim of the study in order to obtain the informed consent. Permission to take field notes and to use audio tapes was requested (Shenton, 2004). In addition, pertinent information such as the length of interviews was disclosed.

Collaborative partnership: Permission to conduct the research was requested from the leader of the community (point 3.5, page 38). The leadership of the selected community and the families were aware of the problem of substance abuse, therefore their values and cultural practices were acknowledged and respected while working together. Benefits will be shared through information sharing (Tsoka-Gwegweni & Wassenaar, 2014). The **Scientific validity** and feasibility of the study was enhanced through working together with the community leaders in identifying the representable sample for the study, which also gave value and benefit from the results of the research, which may influence policy

change (Creswell 2007). The study was only commenced when the University of KwaZulu-Natal Ethical Committee gave its approval (Appendix 4, p50).

Voluntary Participation: Participants were informed that participation was voluntary and that there were no medical risks associated with the study. They were informed they could withdraw at any time and would not be penalised. They were told that the benefit of the study would be that it would highlight the problem of substance abuse within the families and community (Babbie, 2010; Wassenaar & Mamotte, 2012).

Confidentiality: Participants were told they had the right to choose whether or not to disclose information because substance abuse is a sensitive issue. Interviews were conducted in the privacy of their homes and responses were kept confidential. They were informed that allocated numbers to instruments were for data collection purposes only and they did not compromise confidentiality. Anonymity was maintained when publishing results by not disclosing their true identity, thereby adhering to the no harm principle. Participants were informed that the study might benefit the family and the neighbourhood through the sharing of the study results in a community gathering while maintaining anonymity to protect vulnerable family members. Family members were individually given the feedback (De Vos, 2002; Wassenaar & Mamotte, 2012).

Protection of vulnerable participants: Reflecting on the sensitive effects of substance abuse by family members triggered unpleasant emotions. The researcher was prepared for such situations. A clinical psychologist and social worker was organised before the interviews and the therapist counselled traumatised family members. If the participant needed a moment's silence, this was also granted. Fortunately no participants wanted to withdraw at this stage. Furthermore, a specified time was set aside at the end of the interview to accommodate questions from participants to clarify unresolved issues (Hunt & Godard, 2013; van Wijk & Harrison, 2013).

Favourable risk-benefit ratio: The participants were informed that the risk of disclosing sensitive information about the effects of substance abuse within their families and neighbourhood would be outweighed by the benefits gained through new knowledge that may lead to the development of effective substance abuse and community development policies (Wassenaar & Mamotte, 2012).

3.9 Data Management

Data was stored on a personal computer that has a personal code and material used was kept in a lockable cupboard and will be destroyed after 5 years. This material was stored in a secure place under lock and key. Used paper was shredded and the stored information in the computer will be erased.

3.10 Summary of the chapter

This chapter outlined the research design and the paradigm that was used, the ethical considerations, data collection and analysis, and trustworthiness.

Chapter 4

Data analysis and presentation

4.1 Introduction

This chapter presents the analysis of the findings from the in-depth interviews with the seven research participants from two families, the field notes and observations from the research setting. Exploration of the effects of substance abuse on families was guided by two research objectives: family members' beliefs related to contributing factors to substance abuse, and secondly, their descriptions of the impact of substance abuse on the family. Content analysis was used to interpret findings from the study to describe the participants' socially constructed reality. Raw data was analysed using the inductive process with the purpose of identifying common themes that were pertinent to the research question of exploring the effects of substance abuse on the family (Babbie, 2010, Clarke and Braun, 2013). In addition, the socio-demographic information was collected to allow for a detailed description of the research participants. This description is presented before the analysis and allows the reader to consider the potential transferability of results. The chapter presents this detailed description of the participants, followed by the presentation of the main themes that emerged during the analysis of content, themes and sub-themes. These are supported by extracts from verbatim transcriptions of audio recordings.

4.2 Detailed description of participants

As briefly stated in the introduction, participants a total of seven constituted members from two families within the selected community, belonging to the coloured cultural group. During the implementation of the Group Areas Act in 1977, both families were forcefully removed from their ancestral area, to the research setting, a partly urban township that is currently an area known for a high incidence of substance abuse behaviour, mostly among young coloured males. The popular drugs used here are sugars and mandrax.

Both families are female-headed families. Male partners are absent due to separation, desertion or death from drug-related violence. Both females are struggling financially and live in government-owned (subsidised) two-bedroom flats. There seems to be no limit to the number of people that can live in each of these two bedroomed flats. The first family has five adults living in this unit, while the second family has seven adults and three

children in their flat. A detailed description of the two families, their composition, the members that participated in the research project and the researcher’s description of participants, including field notes, are presented below. Table 4.1 provides a brief summary of the participants’ demographic data.

Table 4.1. Participant demographics

Family Research Participant		Age	Gender	Highest education level	Occupation	Marital Status
Family 1 (F1)	<i>Grandmother</i>	67	F	Grade 8	Pensioner	Widowed, husband and brother were shot dead
	<i>Mother</i>	47	F	Grade 9	Unemployed, obtains casual jobs at times	Widowed, first husband abandoned her and the second one was shot dead.
	<i>Daughter</i>	24	F	Grade 12	Contract post	Single
Family 2 (F2)	<i>Mother</i>	49	F	Grade 8	Unemployed	Widowed
	<i>Daughter</i>	33	F	Grade 11	Unemployed	Separated from Husband
	<i>Son</i>	25	M	Grade 12	Employed	Single
	<i>Substance user</i>	23	M	Grade 12	Unemployed	Single

Family 1

This family included a 67-year-old retired widow (*the grandmother*), who, although she lives with her daughter, is the economic head of the household. Her widowed daughter, 47, (*the mother*), a grandson who is an addict, 27, and two granddaughters, aged 24 (*the daughter 1*) and 20.

The historical context of these family members begins with the grandmother. *The grandmother* was born and bred in a small village outside south of Durban, in KwaZulu-Natal an area traditionally dominated by mixed race and coloured families. She has her primary school education from the area where they were forcefully removed and her highest educational standard is Grade 6. She married at a young age and became a single

parent to her daughter after her husband died in 1992 due to complications of substance abuse. Her brother was also shot dead in drug related conflicts. She was, prior to her retirement in 2008 employed as a labourer in a clothing factory, and now is funded by a government pension. She had two siblings a sister who is married and lives away from the research setting, and a brother who was shot and killed due to drug-related conflict within the current family home in 1998. Her reasons for living with her daughter and grandchildren are firstly, to assist her daughter and grandchildren who are unable, due to financial reasons, to maintain their own accommodation. Essentially, her pension supports the entire family much of the time. Secondly, she cannot be placed in an old age home as there are none in the area. This participant appeared able to engage and make rational decisions. This is reflected by the fact she applied for a court interdict three months before the interview to protect herself and her family against her substance-using, aggressive grandson. He had physically manhandled the grandmother. She had scars on the left side of her face and was slightly limping from a sprain sustained during the argument, but had a supporting bandage on her left leg.

She said the grandson uses profanity and terrorises the family when demanding money for drugs or when coming back home from the streets high. Twice during the interview she cries uncontrollably when talking about not knowing how to stop him, or help the substance abuser. On two occasions she has to breathe through the emotion while smoking and pacing the length of the interview room, praying out loud for Jesus to help. She is wearing shabby clothes and although the morning breeze is cold, she seems not to feel the cold as she opens all the windows to let the smoke out of the room. She keeps taking long puffs on her cigarette and staring into space, and spitting on the dusty floor and throwing her hands while also shaking her head.

The mother was born in in their ancestral place and started primary school there before completing Grade 9 at the local school within the research setting. She has spent most of her youth and adult life within the research setting. Currently she has no permanent employment, but works as a casual employee when she is able, and earns minimum wage or below. She was deserted by her first husband, with whom she had one son and two daughters. She later remarried, but became a widow when her second husband died in 2007 during a drug-related altercation in the current family home. She verbalised that it is unfortunate that drug-related deaths of family members happen in the same environment

when hassled by drug dealers for unpaid drug debts, or when they are fighting with their drug-abusing friends during the use of these illicit drugs. In addition, her second son from her first marriage was killed in gang-related violence in 2012. Her eldest son, aged 27, is the substance abuser and refused to participate in the study. Accounts of this family member are from other members' perceptions as he did not make himself available for any interviews. *The mother* stated that he did not complete his education as he had started on illicit drugs. He demands money from the grandmother and shouts at her when confronted about lost items in the house that are stolen and sold at a cheaper price to support his habit, and fights with his mother resulting in her giving the money obtained from casual labour or given by grandmother for household needs, which deprive them of necessities such as food.

She appears distraught and has short brown hair that is untidy. She keeps scratching her head, does not maintain eye contact and her voice trembles when she is talking about the drugs, with tears rolling down her cheeks. She accepts tissues with shaking hands and apologises for her emotions. Her facial expression displays despair when she verbalises the pain of having a messed up life and a son who is hooked on drugs, in spite of the history of substance using family members. She has had eczema since 2010 and says she is on treatment and attending follow-up care at a nearby government hospital, but sometimes medication are out of stock and she has no money to substitute treatment, which accounts for the unhealed patches on her arms. But her lower limbs were covered as she was wearing a long printed ill-fitting skirt. She is wearing white shabby running shoes that she keeps tapping on the floor when she is speaking, as if emphasising the point.

The daughter is the fourth member of this family and she is 24 years old. She appears tense and sits curled on a chair, but is neatly attired in casual clothes. At first she was reluctant to be recorded because she was afraid that the brother might come in the room and accuse her of giving information for his pending arrest, but she later agreed to be taped, provided the equipment was concealed. She has short black hair and is looking around like she is trying to locate something. Loud noises frighten her, but she soon regains her composure. She completed matric in 2010 and because of financial constraints could not further her university studies. She is working in a temporary contract position for a local non-government organisation (NGO) as a personal assistant,

hoping to save some money to fulfil her desire to study further, but the home drug related financial dilemmas have hindered this dream. She is not in a relationship because of her fear of the drug-related history of deaths and experiences within the family and the community. She says she is afraid to commit to a relationship with unpredictable males who may drive her to emotional stress and hurt on top of the burden they have with the brother, and she also describes how their father ignored their effort to mend their poor relationship when they tried to reach out to him when he was hospitalised after a car accident. She is living with the extended family because she cannot afford to find and maintain alternate accommodation and there are no vacant units within this community. Lastly, a second daughter and fifth member of this family was driven out of the province by the lack of jobs in the area and a poor education, as she did not complete matric, to explore other avenues, and was in Cape Town seeking employment during the data collection period.

Family 2

This family included the head of the household, a 49-year-old unemployed widow (*the mother*) who lives with her extended family of ten in a two-bedroom unit. These members include *the mother's* two daughters, the eldest daughter (*the daughter*) is 33 and married and lives with the husband and has two children, aged seven and three. The youngest, aged 30, is unmarried but lives with the life partner in the same unit and they have a 4-year-old daughter, was not available for the interview because she was looking for a job. The eldest son is a single 25-year-old (*the son*) and the youngest son (*the substance user*) is 23 years of age.

The mother was born and bred in the previous residence, where she obtained her Grade. She was not willing to say much about her biological family except that she had a sister who died a long time ago. She expressed regret at the forced relocation of the family seeing the way the family life has unfolded compared to a warm and loving family life they had there. Her husband, who has been working and a resourceful provider for the family died in 2005 of substance misuse complications, leaving her with four young children to provide for. In the same year, 2005, she was retrenched from work as a result of the new dispensation that needed skilled individuals. She has never been able to find work again because of her limited education and the lack of job opportunities, and now relies on her eldest son for financial support as she is too young to get social assistance.

The dilemma is she uses the same money for food and rent to replace items stolen by the drug-using son within the household to maintain peace, hoping he is going to stop stealing after heated confrontations with other siblings. She says this is terrible because the person using the drugs does not care for anyone but themselves. She is a well-built middle aged woman with a gloomy look and is dressed in night attire, although it is midday. Her unkempt hair is thin and sparse with a mix of brownish grey colour and has not been washed or groomed for some time, based on her account as she verbalised that she does not see the need to waste money on haircare when they have less to spent on food and bills. Her lips are dry as if she has not eaten and when asked by the researcher if she needs something to eat, she says she is not hungry. Though there is a chair for her to sit on, she occasionally stands up and walks barefoot around the room and has dry, cracked heels and the room is very tidy and well ventilated. She frowns and her mouth gaped when she is speaking and raises her voice when relating how she felt when hearing through the grapevine that her son was on drugs, and was hoping that this is just not true.

She said she confronted him only to find the shocking the truth that worry her a lot because when they were struggling with money after losing her job he was a good boy and doing well at school. She indicated that this keeps her awake at night especially when he is not home. She was startled and started shouting when the substance abuser burst into the interview room unannounced demanding her cell phone and she quickly disclosed that it is on top of the wardrobe in one of the bedrooms. She appeared distraught and stated that she has a premonition that her mobile phone was already sold. As her son re-emerged he told her that he threw it through the window so that the sisters seated outside may not see the exchange between him and the drug dealer waiting downstairs on the opposite side of the flat. She was livid and stood up only to see the dealer walking away and showed the man to the researcher through the window and said she too was afraid to confront the man that is most feared and illegally protected by the justice system. The family members explained that the youngest daughter who could not be interviewed lives with her boyfriend and a four-year-old daughter who gets a two hundred and fifty Government social grant, and the word is the boyfriend who was also not in the house at the time of the interview is also not working, but sometimes find piece jobs and now lives here following his dismissal from his home by his biological parents.

The daughter is unemployed with an educational standard of Grade 11. She was working as a labourer in a clothing factory but left work in order to look after her children in 2012 so that they can be socialised well in the drug ridden community. She is well groomed but has a noticeable blue eye on the right side of the face with clean healed scars above both eyes and said it resulted from the family feud. She is seated with clenched fist that she uses to punch the seat on which she is seated but her eyes are fixed on the researcher and keeps on saying 'you know what I mean' after responding to questions. She indicated that she smokes a lot because of the stress she is facing at the moment. She has been married to a drug addict for five months following twelve years of cohabitation. She is currently separated from her husband after recurrent substance misuse related disagreements. The husband is working and earns R18, 000 per month; but on payday comes home with only R3, 000 or nothing having paid all the debt owed to drug lords and 'shebeens'. She is also unhappy that they unintentionally moved from the in laws residence because it was drug infested and thought he was going to behave when in the research setting not realising that it was the worse decision in their lives.

This has made her realise that she needs to look for work as the income has dwindled and is unable to provide food for her children and to sustain her eldest son's education with the three hundred social grant. She is angered by the irresponsible multiple substance using husband and brother stating that she is deeply hurt by the brother they have supported during more difficult times following the passing of their father but now steals and lies or denies when confronted about missing valuable items, and become physically aggressive threatening the mother with the knife, she appears very upset by this behaviour that is stressing the mother and dividing the family. She was very keen to participate as she is experiencing the double burden of substance abuse, that of the younger brother and the husband. She now realise that the husband is irresponsible and soon she will not be able to use the social grant money to raise her children.

The son is matriculated and completed school in 2001; is the only working member of the family. He is a shy young man who is well-mannered soft spoken with a good command of English and does not use slang words like the sister and the drug user. He is wearing a light t-shirt and jeans and the weather is cold but verbalises that he is feeling well. Essentially he uses his salary to meet the basic needs of the ten family members within the household. He is unmarried and indications of the desire to relocate were

identified but because of an intense and conflictual family climate coupled with financial dilemma of being trapped in a web of economic support to the family and cannot abandon his struggling mother and his siblings at this time with the hope that this situation may change but sounded very concerned regarding the brother's behaviour and the disputable manner in which he treats the mother and is praying for a miracle to change his behaviour. He verbalised ambitions to improve his life later in life but is trying to find a rehabilitation facility for his brother.

The substance user matriculated and completed school in 2011 despite having started using illicit drugs in 2010. On completion of school he was employed as a labourer but decided to leave work in 2013 due to escalating substance abuse during working hours causing inability to work productively, recurrent absenteeism leading to decreased payments, this caused him to borrow money from work colleagues and this informal credit system resulted in him coming home with not even a cent on paydays. He is currently unemployed and spends his days with his friends. He appeared dishevelled with an unpleasant odour; his small bloodshot and teary eyes are roving and stated that he is looking for the straw he had smoked earlier on and left on the shelf of the cupboard that was placed along the interview room and assumed that her sisters have taken it away, his lips are dry and have a crack on the left side and he speaks in a monotonous voice with a slurred speech but is able to hear and respond to all questions appropriately, his teeth are stained yellow and has a missing front tooth; his fingers have brownish black stains and he indicated that those are dagga related, his nails have not been trimmed and are long and dirty.

He moves aimlessly during the interview and keeps on wringing his fingers. He is wearing the same ill-fitting clothes on an underweight frame, and used minimal eye contact during the three occasions the researcher met him while keeping appointments with other family members. He is very manipulative when needing money for drugs, this was noted on the first meeting when he asked for taxi fare to the hospital to see a doctor for arrangements to rehabilitation but the researcher organised alternative transportation with the social worker and he was not pleased and did not take the offer but instead postponed the appointment with the doctor. He is aware of his unacceptable substance misuse and verbalised that his observation from his friends show how ineffective was the rehabilitation process because of its cyclical nature as the person comes back to the drug

infested community and continues with the habit. He also highlighted that addiction is a painful experience and if one tries to stop the withdrawal symptoms such as sweating and muscle aches set in and to alleviate these he is compelled to continue use, but in the same breathe feels everyone in the community is using it to be at that level of getting high so to fit in with the friends he has to smoke to ease his mind. He is aware of the lost trust and the hurt he is causing to family members by stealing and consuming drugs and the fact that sisters want to throw him out but that is not his major concern because the mother always tries to make peace by standing between other family members and him or diffuse the volatile situation. He is aware that the mother protects him from other family members by covering for him as she replaces the stolen objects before owners notice at times after they have identified that their valuable items are missing and he is later forgiven, his pressing need is the next straw as he started complaining of the stomach discomfort but cooperated with the researcher.

4.3 Data Analysis

4.3.1. Introduction

According to the content analysis process outlined by Braun and Clarke (2006; 2013) initial coding of data was done using highlighters to organise the raw data into meaningful groups of statements that reflected the possible themes and subthemes. Many emerged linked to the research objectives and were divided into categories and themes (Braun and Clarke, 2006). Themes identified included; leant behaviour, poverty and despair. Themes were then reviewed to identify if there was a need to combine similar themes or separate even further based of support for their diversity. The original list of themes was not changed. The next section presents these emerging themes, and categories, and is supported by verbatim extracts from transcribed data (Clarke and Braun, 2013). The section is presented according to the research objectives; firstly perceptions about contributory factors to substance abuse followed by effects of substance abuse on the family. The themes structure the presentation with categories and sub categories within each theme highlighted within the presentation. In addition, each section begins with a tabulated summary for readability and orientation prior to the detailed written analysis.

4.3.2 Family beliefs about factors contributing to substance abuse

As displayed in table 4.2 on the next page, the two themes related to contributory factors included learnt behaviour, and poverty and despair. Categories and or sub categories, within learnt behaviour and within the themes of poverty and despair are presented in the second and third columns within the table.

Theme 1: Learnt behaviour

Although there was recognition of curiosity to explore substances, particularly if these were believed to relieve emotional discomfort, this was a sub category of the acceptability of substance use in this community. Social learning and culture are highlighted as the fundamental root influences in this context that motivate and enhance beliefs that experimenting with illicit drugs in the context of friends increases fun and eases the mind not realising the associated negative consequences (Tomlison & Brown, 2012; Heinström, Bruce, Davis & Hughes, 2014).

Table 4.2. Family beliefs about contributory factors

Theme	Categories	Sub-categories
Learnt behaviour	Acceptability	Curiosity and experimentation Abdication of responsibility In the blood
	Role models	Sense of belonging Lack of male role models
Poverty and despair	Financial hardships	Limited educational achievement Limited self-efficacy
	Survival of the fittest	Unemployment vs entrepreneurship Lack of social control

The literature further indicated that for culture to be transmitted among family members it has to be modelled verbally and symbolically by those with expert knowledge and skills, formally by family and informally by peers, and through observations of such practices, individuals learn what they hear and see without anybody correcting what they hear (Bandura, 2011; Houghton, Casey, Shaw & Murphy, 2013). Findings in this study reveal that participants in this research setting have listened and imitated the behaviour because of their socio-historical and cultural attachments in order to fit with the group (Emslie, Hunt & Lyons, 2014). One participant reported that her children's observation of their father substance use behaviour is going to result in use of substances. This supports current literature that substance use is normative within specific contexts (Matheson, White, Moineddin & Dunn, 2012). Participants stated the initial experimentation with friends led to increased desire for the drug/s.

F1 grandmother: *"My late husband started using drugs in 1992, my grandson who is 27 years is on these drugs, and it's the influences."*

F1 mother: *"Friends, children are given these drugs from school, but in this family it's a curse it runs in the blood."*

F2 Mother: *"You know from my point of view when I sat him down, my son, he said it was out of curiosity meaning they were just experimenting, trying being forward."*

F2 Substance user: *"Everyone is using it, to tell the truth, I started this thing when I was in matric, it's mainly my friends we were all one level high, and the company that I use to keep with were on the same. A lot of people are smoking it especially the youngsters"*

F2 son: *"they do things, they don't think twice."*

F2 Mother: *"I had to speak to him to find reasons, he said everybody is using it, he has to fit with the group and not be the outsider and he does not want to be called names."*

However, this curiosity was strongly presented as a result of social historical context that portrayed the substance use behaviour as an acceptable practice within the family context, and that this 'acceptability' has endured through generations causing the psychological stress (Doweiko, 2011; Wilkinson, Khurana & Magora, 2013). Some statements suggested that the substance use was 'in the blood' thus the generations were burdened with this risk.

F1 Grandmother: *“It’s the influences; my husband started taking drugs in 1992.”*

F1 mother: *“I feel hurt, disappointed and afraid that something is going to happen to him just like my own father and brother, my mother’s brother who was drug users.”*

F2 mother: *“his father had hypertension.”*

Intergenerational influences result from the family system and functioning from an early age and becomes more noticeable in adult life, reflecting the socialisation of the family where the family member feels compelled to adhere to family patterns of behaviour to maintain emotional attachment and failure to practice learnt behaviour of substance misuse from role models revoke feelings of separateness (Kaminer, 2013; Wilkinson, Khurana & Magora, 2013). As indicated in current literature, participants reported that role models using illicit drugs resulted in family members modelling such behaviour, and assuming that it is a way of life in various situations, for pleasure and fun or to respond to life’s problems (Wiesner, Arbona, Capaldi, Kim & Kaplan, 2015). Specifically there were reports of adult male family members as substance abusers indicating a specific lack of male role models within both families, and an implicit expected abdication of responsibilities amongst males (Kluck & Raiford, Carriero, Dallesasse & Bvunzawabaya, 2014; Knight, Das, DeMicco & Raiford, 2014).

F2 Daughter: *“My husband smokes mandrax; he came from Seaview not smoking. It’s like normal, I can’t stop him now and it’s like normal will say to my husband my children are looking at you, tomorrow when they smoke drugs you won’t be able to control them because they saw you doing it. He got the money to pay for these drugs.”*

F2 mother: *From me it’s terrible because the person that takes drugs does not care about you as an individual, he cares for himself only.”*

F2 substance user: *“I was working from 2011 and left the job in 2013.”*

F2 son: *“you see people changing from what they have been to nothing and they don’t care what will happen.”*

F1 Mother: *“.....Just like my own father and brother who were shot dead, my mother’s brother was also killed by gangsters who were drug users....” “My father, nephew, brother, all were using many drugs.”*

This intergenerational substance abuse experience may be influenced by ideas of social identity, and the need to fulfil the sense of belonging and fitting with the social group, and possible notions of ‘maleness’ (Jackson, Denny & Ameratunga, 2014; Matheson, White, Moineddin & Dunn, 2012). Despite evidence of negative consequences of substance use, specifically amongst the males within these two families, there continues to be what appears to be an acceptable abdication of responsibility for own actions amongst males within this community.

F1 Mother: *“I have told him that his step father died of this, that he needs to go to school and be something better, he has seen how his stepfather was when he was on the substance, we were struggling.” “my father was an alcoholic and he died of a gangster related argument, my brother was using mandrax and was involved with gangsters and was shot dead, my nephew also died like that and they were all shot in the family kitchen.”*

F1 daughter: *“He went to look for his father but met with rejection as his father had remarried.*

F2 daughter: *“His father died and we looked after him.”*

As these extracts illustrate, non-substance using family members spoke of consequences that are self-evident within the community, and explicitly stressed by them, as ignored by the substance user. As if substance users accepted the possible negative consequences as part of their future, and normative. This fatalism is linked to the second theme of ‘never ending poverty and despair’.

Theme 2: Poverty and despair

The data indicated that financial hardships are the determinants of families living in a poorly developed area with limited infrastructure, where there is overcrowding, ten family members residing in a single unit with one working person who sees to their basic needs. In addition, data highlighted a noticeable pattern of the family structure in this research setting, where poorer families are headed by women with limited educational achievement and self-efficacy following deaths and or desertion by spouses leaving them with the burden of maintaining homes with no means to survive the youth, specifically

males, using substances to escape the unbearable life challenges (Small, Suzuki & Maleku, 2014).

F1 mother: *"There is nothing else to do. I do piece jobs"*

F2 mother: *"I am not employed, I was retrenched in 2005 the same year his father died and we battled to get him through school We never had it easy; there are days when we would go to bed without eating, I struggled to put them to school."*

F2 substance abuser: *"I got no job."*

F2 son: *"My mother is not working and he is not working, but he does not understand that he ruins the whole house."*

F2 daughter: *"When we grew up things were not easy, it was hard. I give my mother board money, it's not too much but that's what I can."*

Within this community survival of the fittest prevails; unemployment is seen as linked to self-employment or entrepreneurship in the marketing of drugs in the area. People live different lives. There is no social order or social control because people do as they please knowing that they have the backup of the law enforcers. Illegal sheebens and drug lords flourish and target the most vulnerable, the young in sustaining their livelihoods. Drug pushers who has missed opportunities due to unemployment engage in this undesirable behaviour as a means to provide food for their own families while indirectly exploiting the poverty stricken (Jackson, Denny & Ameratunga, 2014).

F2 mother: *"It's the people in this area."*

F2 son: *"I get the drugs in the community."*

F1 mother: *"I know that there are people selling and are known."*

F2 daughter: *"Every fifth house sells drugs. Drugs are easily available, every corner has drugs. The people are known but people are afraid to stand out."*

Lack of social control to curb the destructive behaviour because of limited and ineffective law enforcement has contributed to the community developing tolerance of this practice. Specifically, families have learnt to fear physical harm that may result from challenging

the status quo in spite of existing policies that are set to control this behaviour. (Tandon & Collective, 2015). Findings reveal that the thriving drug market is operating under the protection of the law enforcers. Family members are frustrated by the lack of social responsibility from the law enforcers that devalue the rights and independence of the citizen over that of drug markets (Funk, Drew & Knapp, 2012). The drug lords have close relationships with the police, when community members blow the whistle about wrongdoing, the drug lords will be informed first to clear up, they have bodyguards who are from the system and they are never confronted with any wrongdoing but those who have reported them have been killed with no arrests thereafter.

F1 grandmother: *“My husband was killed in drug related gangs.”*

F1 mother: *“My father, my nephew, my brother was killed in drug related conflicts and my second husband was killed.”*

F1 daughter: *“He fights with grandma when demanding money but she calls the police to take him away. People are afraid to come forward because the man is known that he can get people to kill you.”*

F2 daughter: *“Every fifth house sell drugs. Come let me show you see that man he is a body guard.”*

4.3.3 Family members’ description of the impact of substance abuse on the family

In describing families’ perceptions of the impact of substance abuse on their families two themes emerged.

Table 4.3 : Impact of substance abuse

Theme	Subthemes	Categories
Emotionally charged home climate	Impaired communication	Period of denial Lying
	Protection of mother	Subterfuge between members of family Alliances to protect mother
	Aggression and violence potential	alliances to keep the ‘peace’ Anger at substance user Potential for violence from substance user Potential for violence from ‘drug

		lords' and or 'police'
	Hope vs Hopeless ness	Nothing works or helps Maybe he can get better
Families economic and social standing	Maintaining the substance use habit	Increased need for money Theft. Availability of drugs
	Hiding the substance use	covering up theft

Theme 1: An emotionally charged family climate

The data reveals that family members' social life has changed due to living with addict to the extent that they do not value the importance of living as a family because of lack of healthy social interaction that result in impaired communication leading to periods of denial of the painful truth that substance users are addicted to drugs and have resorted to theft of other family members' possessions and lie when questioned about these missing items; this creates conflictual situation and lack of trust; the quality of life and the mental well-being of family members are negatively affected by these mood changes, resulting in weakened bonds but family members try to avoid stressing the already distraught mother by forming alliances in dealing with the abuser (Cox, Ketner & Blow, 2013; Dayton, 2014).

F1grandmother: *"It's terrible. Its breaking our hearts. We can't even talk to one another nicely because it's in the talk, we can't really talk that's it."*

F1mother: *"The fights, the arguments, we do not talk as a family, we do not talk nicely to each other, it's shouting, and everyone watching what I said, that's why I keep quiet."*

F1daughter: *"I would say that she (F1 mother) is a bit in denial. I would think it's a sensitive issue but when she is not there(mother) I lock him out."*

F2 mother: *"If I must tell you from my experience with my family, other family members do not want him in the house."*

F2 substance abuser: *"I steal sometimes rob people of their money, I lie for the money and say I will do this or that meanwhile I'm not I'll smoke the money, can ask me to do things just to get the money. My sisters do not want me, want to throw me out in the streets, want me locked away because of the things I have stolen from them."*

F2 daughter: *"Me I don't really talk to him, I just look at him because he makes me angry."*

F2 son: *"I don't wanna stress my mother. I have tried to talk to him but he just looks at me and continues the next time. He does not open to anyone. We do in a way but not everyone will talk about it; whenever we are here he is never here. He does not talk with the family, is never at home, and comes home at midnight when the drugs are ok with him. He is usually up very early. No sitting together time."*

Findings indicate that confrontations are substance abuse centred, resulting in subterfuge between family members, such as avoiding talking about the problem behaviour to protect the mother who is caught between calming the other siblings by replacing the stolen items while indirectly feeding the abuser's habit. Formation of alliances aims at diffusing the outburst of potential violent behaviour when the substance user is high and exhibiting aggression that makes the family to live in fear and anxiety (Grant, Jack, Fitzpatrick & Ernst, 2011). Family members are also stressed and experience emotional exhaustion due to family disintegration caused by drugs but are afraid to report the drug dealers in the area due to fear of potential violence that can erupt in the neighbourhood as some community members gain financially from selling drugs for the drug lords (Eaton, Kalichman, Pitpitan & Cain, 2014).

F1 grandmother: *"I'm scared to talk to him about drugs but try to minister to him about Jesus to change. My daughter does not talk and now has severe skin condition for stress. Hes pushes me when demanding money. He threatens me if I don't give him money but now have got court papers against him"*

F1 mother: *"We don't talk as a family because of fear of these drugs; we end up shouting and blaming each other. He fights with grandma when demanding money and threatens her but she calls the police to take him away, that make sus fight."*

F1 daughter: *"I think we bottle a lot because he is my brother; when not high he is violent and when he is high he is dangerous and fights with everyone with anything."*

F2 mother: *"We do not talk nicely to each other; it's shouting that's why I keep quiet. We are not taking care of each other."*

F2 Substance user: *"Children can't go to the shops, they are kicked and blindfolded so that money is dropped and the abuser picks it up"*

F2 daughter: *"A lot of time my mother and I got into arguments because of him. I have decided to just keep quiet, my daughter keeps quiet and I can see she is paining.He"*

opened the knife and threatens my mother. He pressurises mother to give him money. He is aggressive, very, very aggressive.”

F2 son: “Try to talk to my mother but I don’t like to over talk because I can see my mother worries over this too much and more me coming and telling, she can see. I don’t want to power my mother with more stress load her with more things; she is already stressed as she sits up at night waiting for him.”

Families expressed feelings of despair because of the structure of the family that is headed by women, thinking there is something wrong with the socialisation of their children who grew to be substance users when they are burdened with poverty. There is an element of untrustworthiness when the addict is home because family members have to constantly watch his movements within the house though they become very stressed when he leaves home early and comes back late. Frustration results from continuous stealing in the home, despite many confrontations which impact on their limited finances. Stress and anger towards the substance abuser arise when straws of drugs are left unattended and are picked up by the children in the family kitchen (Mason-Jones & Cabieses, 2015). They have tried in vain to find ways of reducing the behaviour by attending support groups and enlisting the help of an expert to place them in rehabilitation.

Findings on what this substance is doing to the family revealed that the families experience a lot of hurt, frustration and a lot of psychological pain and loss of hope as the substance user had passed matric and not taking responsibility to aspire for a better future. Family members were hoping that after the collective effort of seeing him through school, in spite of economic hardships, he was going to assist the family financially. However, as addiction set in, and he became jobless, their hope faded and they became uncertain about his future. The substance abusing son was suppose to see a clinical psychologist who was to assist with rehabilitation, but he is refusing to attend these sessions stating it is of no use because he will be coming back to this drug infested community and continue as everyone is using it and is also easily available (Padgett, Smith, Henwood & Tiderington, 2012). Family members are hoping the situation might improve as they pray for Jesus to change his behaviour (Saugeres, Thomas & Moore, 2014).

F1 grandmother: *“It’s terrorising the family, its bad we can’t even talk, she sobs this is terrorising the family we can’t even talk, we can’t even talk...cries inconsolable.....silence..... I pray that he changes.”*

F1 mother: *“terrible, terrible, because at first I didn’t know my son was on these drugs, I was shocked and didn’t want to admit, it was not sinking in me that my child is on drugs. He has seen how his stepfather was when he was on substance, we were struggling. I tried drinking with them hoping they will stop but didn’t help”*

F1 daughter: *“Embarrassment, frustration, brings a lot of hurt, a lot of pain, seeing them at their lowest. It’s not a good thing, for me it’s hard because from what I know it’s a terrible experience.”*

F2 mother: *“Terrible, terrible because a person who takes drugs doesn’t care about you as an individual or even as a mother, a non- caring attitude prevails, the person cares only for himself, he only cares for himself. Feel that it’s terrible .If I must tell you; other family members do not want him in the house.”*

F2 substance abuser: *“Everyone is using it.”*

Theme 2: Families economic and social standing

Family members stated that the abuser has an increased need for money to maintain their substance use habit though they have lost their jobs and are unemployed. This burdensome behaviour prevails against the strains and stress of financial hardships experienced by the entire households who live from hand to mouth but the abusers seem obliterated to the family dilemma. Indications are the abusers steal money that is obtained from the only working brother in family two and the pension allowance from the grandmother in family one and take family members’ possessions to finance the habit. This affirms the literature that reports that substance use is a psychological flaw or weakness because the economic status of the family is threatened yet they cannot reason in that context (Dembo, Briones, Gullledge & Karas, 2012). Findings further show that abusers also engage in washing of local Muslim taxis to get the money. The family two mother is continually buying and replacing what has been stolen with the money given by

the working son as a cover up for theft. This entails a continuous need for money while hiding their dilemma from friends and distant relatives (Orford et al., 2013). The behaviour has altered the mental well-being of the family due to its impact on their socio-economic status.

F2 mother: *“It’s not a good thing as it changes people from what they have been to nothing, they do things, they don’t care what will happen, they don’t think twice, they just do it because they need this drug.”*

F1 grandmother: *“Wash taxis for Muslim boys. Parent give, also takes mother’s things, do small jobs and sold a radio and lied about it. He threatens me if I don’t give money.”*

F1 mother: *“Sometimes I hide this problem from friends and distant relatives, I am ashamed but I try to live with it but I brush it off. He is a thief in the house and neighbourhood, one time he stole a water tap and water was seen spilling all over and was seen by someone and there was a fight, I cannot run away, I have no means.”*

F1 daughter: *“They steal your money, it hurts.”*

F2 mother: *“I am not employed, was retrenched in 2005 the same year my husband died. You know that previously times were hard and now? Sometimes I have to replace stolen things before they notice.”*

F2 son: *“The money that I get is not enough because there are things that I have to do before I say this is my money. I can actually go to the police but I don’t want because it’s my brother he’s gonna be in big trouble and who knows maybe one day he is gonna be locked up for these things.”*

F2 daughter: *“I need to find a job now because my husband earns R18,000 but he pays money for drugs. You know because I’m not working, I am at home so I was sitting here so I heard a package falling through so I said what you doing there, he said nothing and I got up and saw my mother’s takkies.”*

F2 mother: *“He steals, wash taxis and work for the Muslim boys. I was drinking thinking they will not drink much. I am afraid that something is going to happen, he is living a dangerous life.”*

Availability of drugs in the community has contributed to easy access especially those who are unemployed they find means to survive at the expense of family members’ lives.

F2 daughter: *“I don’t know why he turns into drugs whether it’s out of naughtiness. He was in standard five when my father passed on, he could have done that in the time but only started doing this in matric. I thought he is just experimenting but now he is in a bad space. He does not listen to anyone he just looks at you. He is supposed to be good because children like up to him but it’s disappointing. My mother attends the support group and she is doing what she is taught but it would be better if my brother attends too”*

4.4 Summary of the chapter

In this chapter data analysis process was presented, and the demographic profile of the family participants and how themes were identified and supported by the extracts from the research interviews was outline.

Chapter 5

Discussion on research findings

5.1 Introduction

The previous chapter presented the main themes from data analysis. This chapter presents the summary of the research findings guided by the social learning theoretical framework in exploring the families' beliefs on substance abuse contributory factors, and the impact of this behaviour on the family. The evaluation of the strengths of the study, limitations, recommendations and my reflections are also presented.

5.2 Family members' beliefs about substance abuse contributory factors.

5.2.1 Learnt behaviour

Within this study participants seemed to suggest that substance use originated for curiosity and possibly availability. However, the most persuasive finding is the consistency of substance use within generations of families, and within the community as a whole (Kaminer, 2013). The various factors within this environment (substance use as normative behaviour, easy access to illicit drugs, poverty, lack of interventions and control of state services such as policing) seem to sustain substance use. Both families who participated had several incidences of substance use extending back at least one generation.

Findings from this study revealed that there are multiple factors responsible for substance abuse among families ranging from generational learnt behaviour, poverty and despair. Bandura (2011) postulated that the behaviour is enabled by both the personal and environmental interplay that elicit thinking patterns resulting in beliefs that trigger emotions and behavioural manifestations of these (Costello, Eaves, Sullivan & Kennedy, 2013).. This is evident in this study that the environment, role models and incidence of substance use, suggests substance use to be normative. Studies conducted in the United Kingdom and Australia assert that friends as social influences have driven family members into misusing substances because they believed that in order to fit with the cultural patterns of behaviour and achieve the group identity they are normatively bound to experiment with drugs (Dewing, Tomloson, le Roux and Chopra, 2013; Emslie, Hunt & Lyons, 2014).

This cultural behaviour of substance abuse was driven by the powerful motivator of curiosity, that edges the mind to continuously think about the need to engage in the newly discovered activity (Heinström et al., 2014; Litman, 2005). Curiosity has resulted in excessive consumption of illicit drugs by family members because of repeated exploration and initiation by substance users, with the desire to experience the pleasure of feeling high after learning about the new information from friends at school (Bandura, 2011). Reports from studies conducted in America affirm that curiosity is like when a person has been deprived of enjoyment and suddenly finds an opportunity that liberates him to access that desired feeling, this acts as a motivator to the user to want to know the risks (Doweiko, 2011).

Curiosity arising from social learning has also been linked to the genetic make-up of individuals who have an increased desire to experience the rewarding effect of drugs (Doweiko, 2011). Findings from studies conducted in Australia revealed that genetic make-up contributes to 50 percent addiction, in conjunction with an interplay of emotions, personality traits and environmental factors (Meurk, Carter, Hall & Lucke, 2014). This seems evident within these study results and similar to the intergenerational study findings conducted among the displaced Asiatic in America that learnt to cope with stressful identity loss through substance abuse (Myhra & Wieling, 2014). The learnt behaviour has been widely adopted as acceptable in other parts of the world, with studies conducted in Europe and Australia reflecting the normative behaviour of having fun and socially in urban areas (Valentine, Holloway, Jayne & Knell, 2007).

According to Niland (2013 & 2014) studies conducted in New Zealand concur with the research findings on social learning revealing that imitative behaviour across generations has been influential in motivating the targeted young adults to consume alcohol for pleasure and socialising, instead of using self-control to resist potentionally relaxing with friends while drinking and consuming drugs dangerously, especerful pressures that perceive substance use as the way of life. The reports show that UK, New Zealand and South Africa are experiencing an increased culture of substance misuse with China rated as having the fastest increase (Babor, 2010; Babor, Miller & Edwards, 2010). The concern is that the extent of this behaviour in urban areas has dramatically changed because of the new competitive technological factors, where dangerous consumption of

substances is also shown on social networks by subcultures, indicating how intoxicated the users were at a particular time of their socialising with friends. This is acceptable in their culture as modelled by their role models.

Substance consumption, information sharing about the expectations of feeling high increases the desire and behaviour of trying to experiment, cultural values were motivated by the relationship they have with their role models, tolerance of the available illicit drugs within the community, what they see, experience and believe when intoxicated, highlighting the benefits of fun and relaxed minds to supersede the other groups (Fry, 2011). In this study family members' attitudes were developed and adapted to the risky behaviour and had a lasting impact despite the fact that these modelled maladaptive behaviours are taught by role models who have experienced difficult times. This perception is related to Bandura (2011) who asserted that modelled behaviour and attitude change through learning is promoted through social interaction with friends or family and promotes a sense of belonging.

Beliefs played an essential role in changing substance users' attitudes and decision making, though their curiosity to experiment with illicit drugs resulted in a negative generational role taking; that of addiction, a mental health burden, which results (Collins, Insel, Chockalingam, Daar & Maddox, 2013). Reports from the South African statistics indicate that there are rising levels of unemployment (30%-40%) among the low skilled living in underdeveloped sectors of the population (Leibbrandt et al; 2012). This has resulted in a reduction in foreign investments and decreasing economic growth. The country's decreased workforce is rated among the highest globally, and is noticeably high amongst young people, despite strategies set to create jobs through revitalized labor legislation. This legislation, however, inversely hinders employing low skilled workers with low educational achievements and self-efficacy. Therefore, mechanisms of eradicating hunger seem unsuccessful especially in historically low income environments such as the research setting Leibbrandt et al; 2012). Studies reveal that the majority of these reside in KwaZulu-Natal and are unable to escape poverty and are at risk of mental abdication of responsibility and hardships (Othman, Suhaimi, Yusuf, Yusof & Mohamad, 2012).

5.2.2 Poverty and despair

The intergenerational socialization and acculturation within these families included the introduction and use of new illicit drugs in the context of disparities and unemployment, luring the jobless to learn selling and consumption of these self-destructive substances for a living as verbalized by family members. Findings in this study showed that the head of these families are jobless, unskilled single women who are struggling to survive with their children against adversities of their poverty status & illness (KwaZulu-Natal Income Dynamics Study (KIDS). Leibbrandt, 2012, affirms these findings, and further postulates that 90% of these are black people.

Findings from this study indicate that there is an intergenerational pattern of low levels of education among families. That is characterized by youths leaving school at an early grade, because of a lack of school fees or social pressures luring them to substance abuse consumption. Continuous use of illicit drugs coupled with inadequate education, act as a self-induced barrier that socially exclude them from finding suitable work in the labor market, leading to families experiencing financial hardships for life. Poor education and low socio-economic status that prevent the culturally, ethnically disadvantaged and misplaced families from employability could have been avoided if resources were equally distributed, considering that education is a socio-economic right and the basis of future life opportunities (Hall & De Lannoy, 2012). Spaul (2013) asserted that high levels of education increase opportunities for awarding individuals access to work.

The new South African dispensation in education today is rights based, but this has not been realized in previously marginalized schools with poor infrastructures, cultural and social influences that promote social ills like in this neighborhood. Systems are still in disarray with an inadequate culture of learning and instability, resulting in dysfunctional schools that are fertile grounds for deviant behaviors such as substance related absenteeism. Statistics showed that in 2011, Coloured's absenteeism rate from school was 94%, and this was attributed to the social background and lack of social control with subsequent school dropout and entrapment in poverty (Spaul, 2013).

Bayat, Louw & Rena (2014) concurred with Spaul (2013) that the altered socio-economic background has a strong influence on the culture of leaving school early because of a family environment that is less motivating, especially where there is lack of

money for school needs, overcrowding and lack of privacy, and a neighbourhood that is crime infested with gangsters negatively affecting peoples' lives. Findings indicate that the circumstances in the research setting have the same attributes of poverty because of unavailable individual space due to extended family living together in a two bedroomed unit. Safety is also compromised by subcultural activities of the drug lords and users, recurrent frightening family conflicts, and the mugging of children for drug money by substance abusers.

The social life and the future of these young adults is doomed because despite them being productive members and working to support their families, their altered lifestyle deters them from securing a job to sustain their life and contributing to the economy. Instead they remain dependent on social welfare. Hammer and Hyggen (2010) state that in Norway individuals live on social welfare assistance from childhood to young adulthood resulting in unemployment of supposedly able people while in South Africa poverty, substance abuse and mental disorders exclude family members from getting a job. Findings from this study indicate that the socio-economic disparities and displacement of these families from their ancestral land contributed to poverty, substance abuse and mental disturbances (Lund et al., 2013).

Australia is rated among the well developed countries globally but the disturbing issue is part of the population still live in poverty because of low levels income which raises concerns. However, the evidence based reports show that this affects single parent families and the elderly living in rural areas, due to unequal distribution of economic resources, especially among 92% of woman headed households. This subjects them to altered mental well-being. This is similar to family members from the research setting (Miranti, McNamara, Tanton, & Harding, 2011). Similar reports from the concurring studies done in US indicate that substance abuse among African young adults is interconnected with racial, class and ethnic inequalities (Lê Cook & Alegría, 2015; Seth, Murray, Braxton & DiClemente, 2013). These authors agree that substance misuse results from the stress of residing in neglected areas of the city because of structural systems subjecting these inhabitants to binge drinking that subsequently predispose them to criminal activities. This is synonymous with the South African context research, setting dynamics of impoverished substance users who maintain their substance use cultural

practice by stealing from their family members and neighbourhood (Kalichman, Watt, Sikkema, Skinner & Pieterse, 2012; Kehler, 2013).

There is a noticeable lack of social control and survival of the fittest that is central to dysfunctional behaviour that alters the socio-economic status of families in the research setting, perpetuated by social influences that seem to disregard the detrimental outcomes of this self-destructive practice for personal gains, and support and maintain the addicts' valued needs, by supplying the dangerous old and emerging drugs in the market that entail inclusion of dangerous constituents such as rats poison in its production for human consumption (Doweiko, 2011). The availability and accessibility of these harmful substances within the poorly developed neighbourhood is a tool that facilitates flourishing of the drug culture. Participants reported that there is an increase in unlicensed shebeens and drug houses and drug lords are protected, have body guards supplied by the law enforcers which makes it difficult for families to alert the justice system to initiate social control.

The lack of effective restrictive measures in reducing the socially undesired behaviour of selling and using illicit drugs has resulted in community tolerance, as families are aware that there is drug misuse in the area that is facilitated by lawlessness, but have decided to live with it because of powerlessness, and nobody wants to be killed for whistle blowing because the drug lords will end up knowing the reporter. Families have resorted to silence due to fear and have decided to deal with the effects of substance abuse in their own way by looking after their own addicted member. Failure of the legal system in curbing distribution and consumption of substances has failed in many countries and is reflected by reports of substance related traumas, mental illness, criminal activities, loss of productive members to unemployment and unintentional deaths that cost countries millions (Doweiko, 2011).

5.3 The impact of substance abuse on the family

5.3.1 Emotionally charged home climate

The family environment is supposed to be a place that fosters safety and security and promote a sense of emotional bond, and any situation that destabilises this understanding promotes division within the household, especially where deviant behaviour challenges

the emotional ties (Dayton, 2014). The availability of illicit drugs and poor social control measures within this neighbourhood is terrorising and frustrating the families who are trying to cope with their low socio-economic status but now have to deal with the burden of illicit drug use resulting in disunity within families. Waller, Gardener and Cluver (2014) postulated that individuals living in poor communities are prone to inherited antisocial behaviour and violence that is related to early developmental problems, unstable family life and a disorganised neighbourhood, with survivors driven to learn coping by using substances.

This is consistent with the research findings because research participants reside in disadvantaged areas and have experienced conflicts that are drugs related from an early age. The manifestations of dysfunctional family structure are salient in reports of terrible experiences. This causes a lot of pain and hurt because drug users are individuals who have been dramatically transformed by addiction to become untouchables, with a non-caring attitude, who hardly find time to socialise with the family as they wake up in the early hours of the morning to be with their friends in the streets and return home only to demand drug money. This fuels feelings of anger, hurt and powerlessness and this decreases family interaction and subsequently alteration of the mental well-being (Wong, Silva and Kecojevic, 2013).

Previous studies indicate that healthy interpersonal communication is essential among family members in their everyday life because it enables social learning of culture and formation of social identity, cements relationships, experiences of sadness and frustration are shared and problem solving is initiated. This interaction promotes the basic needs of individuals as they develop a sense of belonging and feel safe when in the company of a family that fosters emotional and personal growth (Woods, 2012). Findings in this study contradict this thinking as communication is not functional in these households, because addicts do not listen or communicate with family members except when demanding money for drugs, therefore this causes an uphill when trying to solve drug misuse problems (Wood, 2012, 2015). Furthermore findings from the other studies reveal that joining a subculture and learning the new cultural beliefs, values and behaviour result in the newly socialised person distancing self from the family and disregard the initial socialisation. This increases the vulnerability to problem behaviour and disorganises the family relationships, a risk to mental illness (Hwang & Wood, 2009). Psychologically

this puts a strain on the formed relationships essential for their mental well-being resulting in emotional stress (Saugeres et al., 2014).

Orford, Natera, Davis & Schragger (2013) affirm that regardless of the socio-cultural background, living with an addict is a stressful experience that destabilises family functioning. He also states that families with high religious beliefs who migrated from low income communities, like Mexicans and Asians and are living in America, experience generational trauma of discrimination, and because of that exposure have acculturated and underestimated their traditional upbringing and are abusing substances that are unacceptable in their country of origin.

Reports from participants revealed that the disturbing issue is the revelation that a family member is consuming illicit substances, the knowledge produce anger and anxiety, thinking about the embarrassment and stigma entailed, resulting in denial and edging the family members to keep this discovery a secret, while trying to figure out how to deal with this terrible destructive behaviour, that is undermining the image of the family. Dayton (2014) further asserts that social interaction patterns change in the household leading to shouts and fruitless confrontations while the normative hazardous substance misuse behaviour continues to the detriment of emotional ties and functioning of the family that result in mental ill health (van Der Goor, 2011; Moolstart & Chirawatkul,2012).

This is evident in this study because these families reported an emotionally charged home climate where lying is used to gainfully access the drugs by the user stealing from family members which evoke feelings of anger, disappointment and embarrassment. This is worsened by the irresponsible behaviour of the alliances formed to protect the addicted by the mothers who out of the motherly instincts cover up for stealing by replacing stolen objects and standing between her children during fights to make peace. Furthermore findings indicate that as much as family members are angered by this destructive behaviour, they choose to avoid arguments with the abuser to prevent outbursts of violence and also protect the mother by not telling her all the burdensome issues but try to support her efforts of hope in the midst of hopelessness with an obvious decrease in quality family life that has endured for generations. The literature affirms that exposure to hard and difficult life experiences of poverty, poor housing and violence produces

feelings of hopelessness, powerlessness and suicidal ideation (Padgett et al., 2012). The study conducted in Mexico and UK show similar findings on the stress and hopelessness, it further emphasise that drug related concerns are the same whether in a developing or affluent countries because they subject the family to chronic emotional strain regardless of their value system (Orford et al., 2013).

Studies conducted in Australia by Moore, Norman, Sly & Whitehouse (2014) and Kumari, Uddin, Premkumar & Young (2014) in UK affirm that substance related mental disorders are presumable linked to early disturbances in nurturing of family members subjecting them to dysfunctional emotions, vulnerability and antisocial personality behaviour (Cranford, Nolen- Hoeksema & Zucker, 2011). The South African studies reported that violent behaviour is associated with substance abuse (Van der Merwe, 2014). These mood swings are predictive of substance abuse behaviour by family members and violent behaviour that may lead to unintentional deaths though in this study suicidal tendencies have not been reported (Moore et al., 2014). Studies concurring with these findings affirm that in South Africa inequalities and poverty experiences indirectly causes violent behaviour (Plüddemann et al., 2010). Families live in constant fear because of mood swings and not having interventions to alleviate their helplessness and anger (Ferguson & Meehan, 2011).

5.3.2 Families economic and social standing

Education is the fundamental basis essential for individual and economic growth as it enables accessibility to employment and creation of economic capital that allows promotion of people's good mental health and alleviates poverty. However geographical disparities hinder this privilege where there are emotional disturbances emanating from limited resources among those in developing countries like South Africa and specifically the research setting (Finn, Leibbrandt & Oosthuizen, 2014; Funk et al., 2012). Family members living in this research setting have low education and were unable to attain gainful employment and have lived in multigenerational culture of substance abuse and trauma of poverty (Wilkinson, Khurana & Magora, 2013; Costello, Eaves, Sullivan & Kennedy, 2013). This subject them to dual vulnerabilities (Cross and Singh, 2012).

Family members reported that substance abusers have physically and verbally threatened them when demanding money for drugs to maintain their habit. This display of the

antisocial behaviour instilled both anger and fear to other family members (F1 grandmother) to the extent that they have alerted the law enforcers to intervene while the F2 son was overwhelmed by family ties together with feelings of denial and empathy, and decided to live with the situation fearing that the abuser may be locked up and face harsh treatment in prison. Reports from this study revealed that family possessions are stolen by the substance user; causing a lot of hurtful feelings because this person is supposed to understand better the socio economic status of the family but because of the learnt behaviour continues to let them down.

The cost experienced by the family is immeasurable, ranging from money given unwillingly to the user while hiding the problem from relatives and families; continuous stealing from home to maintain the substance user's habit; substance related job loss resulting in generational poverty; treatment of those in need of physical and emotional care like the F1 mother's eczema and the F2 daughter who verbalised that she attends counselling sessions to resolve her financial and marriage problems by the area priest; money earned is wasted paying debts accumulated in shebeens and with the drug pushers. This has altered the socio economic status of the family as it deepens their financial hardships and uncertainty about the future as they see themselves entrapped in the intergenerational culture of limited economic standing poverty.

There is a great concern about the cost associated with both supply and use of these illicit drugs with suggestions pleading for decriminalisation policy of these mood altering substances because the war on drugs is ineffective and is not rights based (WHO, 2014). Arguments are drugs lords deviates users' cultural beliefs and socialises them into dysfunctional thinking patterns that entails pre-occupation with drugs, criminal activities of stealing, and affects addicts' rights to health while enriching the suppliers and negative economic gains.

5.4 Evaluation of the study

The strength of this study was the ability to illuminate how culture predisposed families to addiction and poverty. The methodology used was ideal because the qualitative inquiry uncovered the burden of substance abuse experiences through individualised face to face interviews that illuminated the families' beliefs on the contributory factors predisposing

to substance abuse, and a thick description of the impact of this behaviour on the family. The theoretical framework supported the research findings and clarified how social learning shaped and maintained the cultural practice believed to be benefitting the family members, who were curious to experiment with illicit drugs with the expectation of having fun and feeling high in the face of dire poverty resulting in dependence. The freedom of indulging in the mood altering behaviour has led to poor family interaction due to inability to solve the problem through effective communication but instead met with aggression that was indicative of antisocial behaviour altering the mental well-being of family members. Financial hardships led to loss of hope of ever improving their changed socio-economic status because of the impact of the cost of substance abuse.

The key findings indicated how the socio-economic influences and culture oriented family members to substance abuse, deprived them of education that could have enabled them to financial freedom through employment and alleviate poverty and despair. The research findings answered the research question on what is substance doing to the family because the implications of the behaviour resulted in an emotionally charged family climate that altered the family relationships, with aggression impairing their mental well-being and drug related costs changing their economic standing for the worse but are hoping that someday their situation may improve.

5.5 Limitations

This study was conducted in a peri-urban area and if rural families were included in the study this could have given a perspective on how these families view and experience this behaviour considering the extent of poverty in these environments that pushes rural people to migrate to the cities to find jobs in urban areas that subsequently result in stress and substance abuse. The other limitation was racial variation which was not possible as this is (a mixed) coloured residential area only and it could have been beneficial to find experiences of other racial groups living in affluent communities. A mixed method could have been used to find the percentage of substance users among the target families.

5.6 Recommendations

Future research should include samples from both rural and urban population, to get a better understanding of these experiences, but it will be interesting to have a study on the drug lord's perceptions on illicit drugs. Findings illuminated that substance abuse is a

complex socio-economic and health problem and eradication should focus on re-orientation to cultural values, poverty alleviation and lawlessness using the multisectoral approach. **Poverty alleviation** is critical, and difficult to achieve (National Drug Master plan 2013-2017,WHO 2011). Regardless, the rights of the families in relation to respect and dignity need to be realised by ensuring that they are assisted in accessing liveable houses (Funk,Drew and Knapp, 2012). This can be achieved through revitalisation of the research setting which is a costly exercise for the government. Spaul (2013) postulated that it is vitally essential to promote empowerment of family members through compulsory education funding for the disadvantaged to relieve the pressure of school fees from the unemployed parents, to enable the young to have skills essential in the workplace and increase the ability to contribute to the economy rather than be predisposed to mental illness due to poverty or be subjected to mental illness because of their poor status.

It is strongly recommended that **development and strengthening mental health facilities** is essential for relieving family distress by attending the available support groups in the community because they can access psychoeducation on the social ills tearing their household apart and adding further family therapy and crisis counselling services (UNODC,2013). Sessions in cognitive therapy can help family members to correct their dysfunctional thinking and enabling behaviour. Regarding the mood swings and aggressive behaviour family members can benefit by attending anger management therapy. To relieve boredom for the unemployed family members, revitalisation of the current recreational facilities that are not user friendly, to promote a culture of healthy social life using social influences in a positive manner.

As with all change it is guided by policy development. While South African policy guiding poverty alleviation and mental health, and health, care is well established policy related to substance abuse is not. Globally war on drugs has failed as criminals come up with varying methods of producing and distributing illicit drugs resulting in other countries such as Portugal implementing decriminalising of these substances. South Africa has been focusing on a drug free society with ineffective interventions due to poor leadership heading these initiatives, resulting in the country rated as having the highest substance users (Parry, Burnhams & London, 2012). Therefore there is a strong suggestion that a new policy must be developed taking into consideration the benefit and

risks associated with decriminalisation and criminalisation of these illicit drugs. The policy needs to outline how the human rights and health will be safeguarded because internationally there have been contradictory gains when cannabis was legalised that negatively contributed to road fatalities, negative psychosocial development, dependence, mental impairment and crime (Dada et al., 2011 & 2012; Parry & Myers, 2014).

5.7 Reflections

I am an educator of Social sciences and Psychiatry and from discussions with learners I discovered that the training institution is in the midst of a crimogenic and drug ridden community. I was also overwhelmed by the full bed occupancy by the mental health users of this destructive behaviour admitted for 72 hour assessment in the health service area, and the prevalence of the substance related mental illness cases seen at the community based psychiatry clinic where I had the opportunity of meeting them when accompanying learners. This increased the interest of attending a community conversation workshop, where families from the research setting were gathered to deliberate on the availability of illicit drugs in their community and their experiences regarding the prevalence of substance abuse and lawlessness in the area, which targeted the future investment, the young people. After attending that workshop I was motivated to do a study that was going to explore the effects of this cultural behaviour on the family because the focus on that day was substance abuse problem in the community.

The personal observations made informally during the encounter with families showed that the area is grossly underdeveloped with no skills development facilities that can empower them to have means to an end. However the people in these families are very respectful of the researcher and among themselves except for the user who is not communicating with his family but just came in the room and demanded money from his mother, but calmed down after seeing the stranger. They also show concern for each other during interviews though they revealed horrendous stories of their experiences. The noticeable behaviour among the family participants was extreme worry and emotional stress; this was initiated by relentless cries and apologising for the embarrassment. What was of great concern is the research area has a noticeably vast amount of poverty that is reflected by the type of housing in which families lived. They need immense renovations that is conducive for human survival and more space is needed to relieve the pressure of having nine family members of varying gender and age sharing the same space with no

privacy. During the interviews other participants had to sit outside the house while awaiting their turn for the interview and to enable their siblings freedom to express their experiences.

It is obvious that the dynamics of this family is rooted in generational socio-cultural exposure that has disregarded the value system or religious beliefs, though the majority are Catholics, and have chosen to follow the social influences with the culture of independence that teaches substance abuse as a way of life. This destructive behaviour have made the people not to realise the importance of self-actualisation through education that is a key to work and healthy lifestyle choices but have chosen the learnt stressful life options that are affecting the entire family in a negative manner. The current state of these families is far from being uplifted from its web of impoverishment because the young have already shown signs of disliking school.

Another prominent indication of the poor state of these drug users is the consumption of the cheapest and easily affordable drugs such as mandrax and whoonga, because the straw cost between R10 and R20. This shows that there is no money to purchase the expensive drugs, yet because they have lost control to resist the craving, they continuously indulge on these not realising that it is impacting on their limited economic resources, and is disrupting the family life and cause chronic emotional stress. The emotional pain arises from seeing the course that socialisation has taken, misleading the young generation to follow drug related culture instead of embracing the new constitutional developments that are rights based. This violation of the value system is perpetuated by the drug lords who have their own interest while depriving the family members a vehicle to employment, education, and lack of this tool predispose to poverty. These families suffer in silence as they feel the strain of financial hardships gripping their lives with no hope of ever getting out of their strain while trying to deal with the social ill of substance abuse.

Conducting the study was an eye opening experience to the inner world of families traumatised by the persistent misuse of illicit drugs and alcohol and having to live with addicts, reliving the emotional scars as other family members have been killed in the drug related conflicts. They were happy to share their stresses with someone who was willing to listen to their stories of pain though one wonders how they manage to laugh in their

sorrow and powerlessness. The saddening part of my observation was to see that in this day and time in South Africa, people are still living in fixed debilitating houses that are insecure for human survival and verbalise that they go to sleep without eating while the taxpayer's money is grossly misappropriated.

5.8 Summary of the Chapter

This chapter discussed the summary of the research findings and used the theoretical framework of social learning to foster a better understanding of contributory factors and the impact of substance abuse, the strengths and limitations were highlighted, reflections and recommendations were presented.

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ANNEXURE 1: PARTICIPANT INFORMATION SHEET

My name is Nondumiso Radebe employed at R.K.Khan Campus as a lecturer. I am currently a student studying Masters in Mental Health Nursing at the University of KwaZulu-Natal, School of Public Health and Nursing and as part of the requirements; I am expected to conduct a research and I kindly request your participation in the study. The title of the study is exploration of the effects of substance abuse on the family. I invite you to share your experiences. The purpose of the study is to describe what is substance abuse doing to the families and community in a selected EThekweni district.

An audio tape will be used during the interview to collect data. Permission from the family members will be requested to use the audiotape and they will be requested to indicate with a tick whether they are willing or not. The duration of the interview may take 1-2 hours. These tapes will be kept in a safe and private place that is lockable. Confidentiality and privacy of your home will be maintained by conducting the interview in a private room and your name and family name will not be revealed for anonymity purpose.

Participation is voluntary and withdrawal will not pose any penalties. There are no medical risks associated with the study. There are no financial gains for participating in the research. The benefit will be knowledge may influence new policies in control of substance use and promote community development. If during the interview you feel uncomfortable do indicate so that counselling can be provided by a specialist accessible at the following number 031-4596000. The answers that you provide will be analysed using computer software and the results reported in a dissertation format.

The feedback will be given to individual families to maintain confidentiality and protection of vulnerable participants since the effects of substance abuse is a sensitive issue.

The dissertation will be obtainable from the University of KwaZulu-Natal library, KwaZulu-Natal College of Nursing library, as well as the campus library.

If you agree to be part of the study you are kindly requested to sign the attached consent form which shows that you are aware of the study process. Thank you for your participation. If you feel at a later stage that you need clarity on certain areas, do not hesitate to contact the following numbers:

Student: Nondumiso Radebe

Work: 031-4594085

Home: 031-4623796

Cell phone number: 0825635265

Email Radebe.Nondumiso@kznhealth.gov.za

Research Supervisor: Amanda Smith

Contact number: 0312602513

Email address: smitha1@ukzn.ac.za

UKZN Ethics: Pumelela Ximba:

Contact number: 031 2603587

Email: ximbap@ukzn.ac.za

ANNEXURE 2: INFORMED CONSENT

I..... agree to participate in the research regarding the effects of substance abuse on the family. The purpose of the study has been explained to me and I understand that I freely agree as I may benefit from sharing my experiences. I have been told that there is no financial gain and that participation is voluntary. I have also been informed that I can voluntarily withdraw without any penalties. I have been informed that audiotapes and field notes will be used to collect data during the interview in a private room that will ensure confidentiality. Anonymity will be maintained. The audiotapes will be kept in a safe lockable environment. My name will not be revealed in published journals. The study outcome will be disseminated to me. Contact details of the researcher has been given to me.

If you are willing to be interviewed, please indicate(by ticking) whether or not you agree to be interviewed, please indicate (by ticking as applicable) whether or not you are willing to allow the interview to be recorded using the following equipment:

	Willing	Not willing
Audio equipment		

I can be contacted using the following:

Email: ndumi54@gmail.com

Cell: 0825635265

My supervisor is Amanda Smith who is located at the School of Nursing, Durban Campus of the University of KwaZulu-Natal.

Contact details: email:smitha1@ukzn.ac.za Phone number: 0312602513

Signature of participant-----

Date-----

ANNEXURE 3: INTERVIEW GUIDE

DEMOGRAPHIC INFORMATION

Dear participant,

Kindly respond to the following questions below:

Gender _____

Age _____

Educational status _____

Occupation _____

With whom do you live? _____

How long have your family been living in the area?

QUESTIONS RELATED TO SUBSTANCE ABUSE

How do you feel about substance abuse?

What are the reasons that contributed to substance use?

What is substance doing to the family?

ANNEXURE 4 ETHICAL APPROVAL



23 June 2014

Mrs Nondamiso Gladys Radebe 9113 40361
School of Nursing and Public Health
Howard College Campus

Protocol reference number: HSS/0615/014M

Project title: Exploring the effects of substance abuse on the family in a selected (Ethelwin) district.

Dear Mrs Radebe

Expedited Approval

In response to your application dated 20 June 2014, the Humanities & Social Sciences Research Ethics Committee has considered the above-mentioned application and the protocol have been granted FULL APPROVAL.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

Please note: Research data should be securely stored in the discipline/department for a period of 3 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

Dr Shonuka Singh (Chair)

/pk

cc Supervisor: Charlotte Engelbrecht
cc Academic Leader Research: Professor M Mar
cc School Administrator: Mrs Caroline Dhansraj

Humanities & Social Sciences Research Ethics Committee

Dr Shonuka Singh (Chair)

Wardens Campus, Govan Mbeki Building

Postal Address: Private Bag 324001 Durban 4000

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Website: www.ukzn.ac.za



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ANNEXURE 5

P. O. Box 53174

Yellowwood Park

4011

23 July 2014

The Gatekeeper

Marianridge Municipality

Pinetown

Dear Jenny,

Re- Advice on request for permission to conduct the research

I am currently registered at the University of KwaZulu-Natal for Masters in Mental Health and one of the requirements is that I do a research project. I kindly request a one to one meeting to discuss who to contact regarding the permission to enter the community, and how to access the potential participants.

The title of the research is “Exploring the effects of substance abuse on the family in a selected EThekweni district.” The purpose of the study is to explore what is substance abuse doing to the families.

Participation is voluntary and face to face interviews will be done with no medical risks involved. Safety of participants will be ensured as these interviews will be conducted in the privacy of informant’s homes.

Thanking you in advance.

Regards,

Nondumiso. Radebe.

ANNEXURE 6

P.O Box 53174
Yellowwood Park
4011
28 July 2014.

Attention: Mr M. Gumede
The Ward Councillor
Marianridge
Dear Mr Gumede,

Re: Permission to conduct a research study in the Marianridge community

I am a nursing master's student at the University of KwaZulu-Natal, School of Nursing and Public Health. I hereby request your permission to conduct a research study in the Marianridge community under the supervision of Charlotte Engelbrecht.

The research topic is: EXPLORING THE EFFECTS OF SUBSTANCE ABUSE ON THE FAMILY IN A SELECTED ETHEKWINI DISTRICT.

Data will be collected from the families using face to face interviews. Measures to protect participants have been considered and are spelt out in the research proposal attached. The University of KwaZulu Natal Ethics Committee have granted ethical clearance for the study. See attached clearance letter with clearance number.

Please find attached:

- Ethical clearance letter form University of KwaZulu-Natal
- Research proposal
- Participant information sheet
- Data collection instrument

Your permission is highly valued.

Kind Regards,

Nondumiso Radebe.

Contact details: 0825635265 Work: 031-4596085

Email:ndumi54@gmail.com



Councillor

Ukuzalwa/Floor Shell House
Cnr. Anton Lembede & Simons Michel Street, Durban, 4001
P O Box 1014, Durban, 4000
Tel: 031 322 7030, Fax: 031 311 3827
www.durban.gov.za

Our Ref:

Your Ref:

CLLR MP GUMEDE

Enquiries:

083 957 5514

DATE: 25 AUGUST 2014.

**MRS. NG. RADEBE
P.O. BOX 53174
YELLOW WOOD PARK
DURBAN, 4011.**

Dear Madam,

RE: RESEARCH APPROVAL FOR MASTERS NURSING (UKZN) NURSING.

I refer to your e-mail date 28th July 2014, of which the contents have been noted.

I am pleased to inform you that authorisation to conduct the study on **EXPLORING THE EFFECTS OF SUBSTANCE ABUSE ON FAMILIES.**

I therefore would like to take this opportunity and wish you the best in your future endeavours and look forward to the presentation of the results on completion of your exercise.

Yours faithfully

MP. Gumede
CLLR. MP. GUMEDE – WARD 13
CONTACT Nos.: 031 706 5606 /083 957 5514

CLlr Mduduzi Phineas Gumede
MP. Gumede
COMMISSIONER OF OATHS
ETHEKWINI MUNICIPALITY
BX OFFICIO DISTRICT OF DURBAN IN
TERMS OF SECTION 6 OF ACT 16 OF 1987
(AS AMENDED) CITY HALL SECRETARIAT
Dr. Pixley Ka Seme Street, Durban, 4001

ANNEXURE 8 : Transcriptions from in depth interviews

Family number 1: Interview transcriptions

Participant 1: 67 year old grandmother

Education: Standard 6

Marital status: Widow, husband shot dead in drug related conflicts

Occupation: Was working as a labourer before retiring

Lives with daughter who is currently single.

Has lived in the research setting from 1977.

R: Tell me what is substance abuse doing to your family?

F1 grandmother: Oh no it's really not right, the way I look at it, because just in a sentence that I can give you it's just making, it's breaking our heart, it's breaking our hearts. We can't even talk to one another though nicely, because it's in the talk, you can't really talk that's it.

R: There is always fighting?

F1 grandmother: There is always fighting we can't even talk, can't talk to him it's fight.

R: Tell me you said there is always fighting, who is fighting?

F1 grandmother: My late husband started taking drugs in 1992 and was shot by the African bloke, connected to drugs; also my brother was killed in drug related gangs. My grandson who is 27 years is on these drugs and he is causing a lot of pain to us all, he fights when demanding money, his mother becomes very upset but does not know what to do. His mother always tell him to stop saying, you break my heart, you want me to throw my child outside like a dog.

R: Do you know what drugs your is grandson taking?

F1 grandmother: Mandrax, he is very relaxed when having taken drugs. He becomes very rude, dangerous and angry when he has not taken.

R: Where does he get the money to buy drugs?

F1 grandmother: Wash taxis for Muslim boys. Parent gives, also takes the mother's things, do small jobs, steal, and he sold a radio and lied about it. He threatens me if I don't give money, but now I have court papers against him which makes his mother angry and tries to make him stop.

R: What do you think are the reasons that he is taking drugs?

F1 grandmother: It's the influences. He was very bright at school especially in Maths, no girlfriend but stopped in grade 7, takes drugs with friends, his father was shot dead in my mother's kitchen, same kitchen where my brother and husband were killed.

R: How does this make you feel?

F1 grandmother: [A moment of long silence, tears seen rolling down her cheeks, hands on her head, she cries uncontrollably]. Painful, sometimes he does not bath, scared of water, looks like a hobo. Does not talk with the family, he is never at home, comes at midnight when the drugs are ok with him, he is usually up very early, there is no sitting together time. I am scared to talk to him about drugs but I minister to him about Jesus, to change. [Started crying uncontrollable, requests the tape to be put off.]

Field notes

The environment is very noisy, taxis are dropping passengers and playing loud music, children are playing outside in between the houses where there are broken beer bottles, and making a lot of noise. She is irritated by them as they are supposed to be at school. Granny is very disturbed emotionally by the grandson's behaviour, she looks around anxiously as if watching someone but there are family members in the house. She wishes he can be taken away from the house. She is a religious person who is caught between the dilemma of what she has already experienced in life and the daughter, who as much as she is disturbed by this behaviour does not want the son to be disciplined due to fear that she might lose this child. The grandmother is experiencing a lot of emotional pain; this is reflected by moments of silence, staring in one space for a long time with one hand on the lower part of the cheek and sometimes stands and walk aimlessly, putting both hands on her head and verbalising that, "Jesus must help this child". She notes that the daughter does not say much due to stress and she has eczema. There is lack of control, children are supposed to be in school, and fear as the informant is looking around. The area is not developed or these children would be playing in a proper play area.

Family number 1

Participant 2: 47 year old mother.

Education: Grade 9

Marital Status: Widowed

Occupation: Unemployed, does piece jobs

Lives with her two children and her biological mother, who is 67 year old and a pensioner, since 1977 in a two bedroomed unit.

She has three live children her eldest son was shot dead by gangsters. The children are; a 27 year old, a substance user; a 24 year old, matriculated and working as a PA in an NGO; and a 20 year old in Cape Town, seeking employment.

She did not want to be recorded but agreed to talk.

R: Tell me what is your experience with substance?

F1 mother: Terrible, terrible because at first I didn't know that my son was on drugs, sugars and Whoonga, I was shocked and didn't want to admit, it was not sinking in me, that my child is on drugs. [silence...].I have told him that his stepfather died of this, that he needs to go to school and be something better, he has seen how his father was when he was on this substance, we were struggling. The arguments, fights...[Voice trembling] I was also drinking thinking they may not drink much if we drink together, but it did not work and I stopped. Neighbour would come and try to help during fights but it didn't work, and the man was like not right upstairs. People do not know what I went through [silence, tears rolling down] and then this. I did suspect that this boy was going through something but was afraid to ask, I feel hurt, disappointed and afraid that something is going to happen to him just like my own father and brother who was shot dead, my mother's brother was also killed by gangsters who were drug users, but they are all dead.

R: Tell me what was he doing that makes you suspect that he was on drugs?

F1 mother: Things will go missing in the house and neighbours started talking about this thieving, but I denied it because I was embarrassed. Sometimes there will be fights because of this stealing or when he is high, neighbours did not like us.

R: How does this make you feel?

F1 mother: We as a family feel let down by my own son. There is always worry, stress, it's not nice to live with this drug addict. Sometimes I hide this problem from friends and distant relatives. I'm ashamed but I try to live with it. I do not have a good relationship with him in the house because of disagreements caused by this boy, life has changed, and in the house because there is no peace, no happiness, as we do not talk nicely to each other, it's shouting, that why I keep quiet [starts crying and apologises for this embarrassment]. I have asked him why drugs? Why worry us so much? I wish he could change, he was initially a good boy, now this. I do not want to think about what people are saying because they are talking badly and it goes to my heart. We argue in the house about what has happened, always thinking drugs, drugs, drugs, we are not taking care of each other, like my mother is old and need not stress but we are worried about this one who care less. I'm afraid about the one in Cape Town, what if the same happen? [Puts her hand on the check and stares in space] What next with my children?

R: What are the reasons he is taking drugs?

F1 mother: Tried to speak to him to find the reason. He said everyone is using it because there is nothing else to do and besides...maybe the pain of growing without a father, because I struggled to feed them as I do not have a real job and my second husband dying in gang related shooting. Friends, also drugs are easily available here as every corner has drugs. Children are given these drugs from school but no one cares. But in this family it's a curse, it runs in the blood

R: Why do you say it runs in the blood?

F1 mother: My Father, nephew, my brother, all were using many drugs.

R: How does he behave when not high?

F1 mother: When not high he is violent, demanding money and when high he is very dangerous and fights with everyone and with anything. I will put myself at risk trying to protect him from my angry mother and daughter.

R: What makes him take these drugs?

F1 mother: I have tried to speak to him to find reasons, he said everybody is using it, he has to fit with the group and not be the outsider, and he does not want to be called names. But I think it's the pain of growing without the father, who left me and got married to someone else and not taking care of them, I struggled to feed them as I do not have a proper job. My second husband was shot dead in a drug related situation and that makes my heart sore, why me? [Starts crying] But seemingly in this family it runs in the blood.

R: Why do you say it runs in the blood?

F1 mother: My father was an alcoholic and he died of gangster related argument, my brother was using mandrax and was involved in gangsters and was shot dead, my nephew also died like that and they are all shot in the family kitchen.

R: Your son is not employed, where does your son gets the money to buy drugs?

F1 mother: He is a thief in the house and neighbourhood, one time he stole the water tap and water was seen spilling all over and he was seen by someone who told the neighbours, there was a fight, this worries me because I cannot run away from this place because I have no means of doing that, but I wish I could just leave and start somewhere. Besides stealing he washes the local taxis for money and work at the scrapyard to find money just for drugs and nothing more. He fights with grandma when demanding money and threatens her but she call the police to take him away, that makes us fight, and he also steals from the house.

R: How does this drug taking and stealing make you feel?

F1 mother: I worry you know asking why drugs. The family does not want him here, they lock him out if I am not there because he is threatening them. He is living a dangerous life that makes me worry every time. I have no peace in my heart, I pray that he can change, I just imagine his father lying in the pool of blood in our kitchen, and become very afraid you know that one day he is going to die. We don't talk as a family because of fear of these drugs, we end up shouting and blaming each other. It hurts because whenever he is in the house everyone is watching what is said, I can't throw him in the street, there in the street, how is he going to survive? They sometimes call cops and want him locked up. He fights with grandma a lot and she now has court papers for him in the

house, so I keep quiet It hurts a lot I fear that he may use this a lot and die or may go to jail [she cries]. I can't sleep at night and am on treatment for my skin disease because of this.

Family number 1

Participant 3: 24 year old daughter

Educational level: Matric

Ethnicity: Mixed Race

Regional Location: peri- urban

Occupation: Temporal PA with NGO

Living with extended family grandmother, mother and brother, the addict

R: Tell me how do you feel about substance abuse?

F1 daughter: There is a lot that I feel towards it, eh... Frustration, there is many things especially you get frustrated, you get attacked because it's hard, disappointments, there's many I'm trying to think, it's a whole lot of stuff that I feel about substance abuse.

R: Tell me the whole stuff. What is the whole stuff that you are experiencing?

F1 daughter: Mine experience is that I have a brother that is going through substance abuse at the moment.

R: How old is your brother?

F1 daughter: He is older than me, he is 27 years, ja at the moment I'm not sure what he is smoking but think I think its whoonga but I'm not sure whether he is smoking buttons but I know that whoonga is one of the things he smoking.

R: What is your experience?

F1 daughter: Disappointed, a lot of hurt because a lot of things that you are fighting, you see them at the lowest then you... there comes a point that they start stealing from you, so it hurts though, there is a lot of pain because, pain and disappointment together, because they steal your money, they break that trust that you had, they break it.

R: Tell me the things you used to do with your brother?

F1 daughter: Like I could send him willingly knowing that he is trusted, because he was very honest like before, now you first calculate exactly how much change you going to get or stuff like that.

R: Now he has changed?

F1 daughter: Yes.

R: Tell me what are the things that made your brother take drugs?

F1 daughter: I'll tell you, friends could also be... I can't really say it because of maybe its personal issues that he is feeling and way through, so i would not know exactly because...

R: What are the other reasons?

F1 daughter: With other reasons I think a lot of people have personal reasons that is what causes many people to take the drugs maybe personal issues, maybe there is something that happened in the past but I think this is one of the main focus, maybe the environment they grow up, no family, I'm not sure, family could be a lot of stuff.

R: Is there any way that this can be changed?

F1 daughter: I think if they can have a form of counselling so that they can deal with the personal issues and change this instinct of how they see things because it's not everybody who see things the same way, certain people see these things as a problem while others see them as stepping stones.

R: Tell me you live with your brother and who else?

F1 daughter: Grandma, my brother and my mother.

R: Tell me how does it feel, seeing your brother who has changed?

F1 daughter: It's very hurtful, it's hard, hurtful.

R: Hurtful in what way, the behaviour or the way he acts? The way you feel.

F1 daughter: I would say the way you feel, not as a way in, because it's hard to see someone so close go through that.

R: How are they when they are on drugs, the way they behave and talk?

F1 daughter: They talk slow they go on slow, I don't know how to explain. Therefore my brother for an example and cling and like he goes on clinging things will just cling like in a daze.

R: And seeing your brother in that state, dazed, how does that make you feel? What are your thoughts?

F1 daughter: A lot of hurt.

R: A lot of hurt?

F1 daughter: Yes.

R: Your mother?

F1 daughter: I'm not sure how she feels; I haven't spoken to her about it.

R: Have you discussed this situation with someone else?

F1 daughter: No

R: Why not?

F1 daughter: I'm not sure, but from my side we had spoken but, it seems to be a sensitive issue, you see my brother is my mother's spoilt child, she like brush it off like it hasn't really settled, hasn't settled with her.

R: Tell me do you think she is sort of protecting your brother?

F1 daughter: I would say she is in a bit of denial.

R: Denial?

F1 daughter: Yes.

R: How long has this person been taking drugs?

F1 daughter: last year so that is why there is a bit of denial.

R: Tell me, your brother, where does he get the money to buy the stuff?

F1 daughter: You see he is a very hard working somebody, he washes the cars and fix cars, he is very useful, he can do anything for it, like someone coming and asking him to come and fix the car. He is very a helpful person, so he does a lot of work with cars, washes someone's car do the garden and stuff like that.

R: Do you think he is taking the stuff from the house to get the money?

F1 daughter: No it s only from the cars.

R: Nothing goes missing from the house?

F1 daughter: No, once I think he tried, I caught him by my bag, I think he was trying to take money but then once I caught him, but a few hours later it was put back, maybe he spends there and then get the money and put it back, I'm not sure.

R: Then how does this make the family feel does it have certain effects on the family?

F1 daughter: Yes I would say because we are very angry, I would say a lot of anger.

R: So there is anger, is it something that you can talk about or something that makes you do certain actions because of it or you just look?

F1 daughter: I think we bottle because he is my brother.

R: Tell me what is it that you are scared of?

F1 daughter: I'm not, I speak when I see him in that state, I talk, I shout at him and say I would lock him out, stuff like that, I get very angry and chase him out of the house, he must go and sit outside until he comes right then come back.

R: So after that what does your mother say?

F1 daughter: She don't see because she works maybe from seven to five or seven she is like hardly around she does not like to see him in that state.

R: Tell me during the weekends she does not see him like that?

F1 daughter: She does but only on Sunday he does not do it. If he keeps himself busy then he is ok, he does spray-painting but the minute he is free he starts taking it.

R: How does this drug taking affect the neighbours, does he steal from the neighbours?

F1 daughter: Our neighbours not really, I don't think they have been affected because with him it's so definite he keeps himself busy to get the money, he does not take from the neighbours.

R: How do neighbours feel about this drug taking?

F1 daughter: My one neighbour keeps him very busy because she has resigned from work, he spends most of his time by her, he does like things for her because she has just bought the taxis, trying to fix something or washing or go with her, go everywhere around just to release him from friends and smoking and stuff like that.

R: Looking at support from your family you said you don't talk about it?

F1 daughter: No we don't really speak about it.

R: But you all know that there is something is not right?

F1 daughter: Yes

R: Do you have time to sit together as a family?

F1 daughter: Yes all the time.

R: When you are seated you do not talk about what is happening in the house?

F1 daughter: Not really.

R: Why? Because as a family you may say ok the thing that you are doing is not right?

F1 daughter: Well my mother is a very ,eh she is not a talker, she is very quiet she will rather finish without saying anything, we had a discussion but she was very quiet there won't be any input from her, yet she is just sitting and not saying how she feels. So it's very hard to have that kind of a discussion between family members because my mom is very quiet and she sits and listen.

R: Don't you have a father in the house?

F1 daughter: No

R: What happened to him?

F1 daughter: Hey we never grew up with him.

R: Do you think that the pain of not having the father is causing....

F1 daughter: Yes I think so; that is where the personal issues come in.

R: Ok personal issues are affecting...

F1 daughter: Yes. One of the main.

R: You said your father is away, how was life without him?

F1 daughter: Growing up we grew with grandparents, grandpa was like a father figure, he was like our father and then I think I was in STD 2 when he passed away.

R: The grandfather what about you father?

F1 daughter: No he has never been part of our life, I had never known him.

R: Have you ever tried to be part of his life?

F1 daughter: No

R: How does that make you feel?

F1 daughter: Very hurt and then I think it was last year because I speak about it openly that last year someone told me that he has met with an accident and went for the spine operation, so I went to visit him and then I think I got I think it made things clear for me, how do I put it? There was some closure.

R: Have you asked him why he was not part of your life?

F1 daughter: Yes he is married now and he's got family so it's very hard I would think that is very hard for him because it's like his wife has an influence on him and I'm not sure but I think that's it.

R: Do you think your brother is having the same pain you have spoken about?

F1 daughter: Yes, I think he's having the same pain, just that he does not know how to deal with it or he hasn't found any closure on how to deal with it. I have.

R: So how does this make the family feel knowing that your mother is the only person who is there for you?

F1 daughter: Well it has not really had an impact on me because my mother has also given me support.

R: Do you think has given you the same support as your brother?

F1 daughter: No my mother has spoiled my brother. My mother is a bit hard on me but my brother I think she is spoon-feeding him [laughs].

R: Your brother is a spoiled child?

F1 daughter: I'll say yes because he is not working she won't tell him to go and look for the job but with me she does.

R: What has the community done about drugs?

F1 daughter: They had a march, they run the support group for the addicts and parents everybody gets together, and the youth go for counselling.

R: Have you spoken to your brother about stopping drugs?

F1 daughter: I have spoken to him many times, it's just that my mother is a single parent and cannot afford the funding for rehab. It's expensive.

R: What kind of crime is found here?

F1 daughter: Yes theft, break- in and stuff like that.

R: Any abuse? Domestic violence?

F1 daughter: No

R: How is policing in the area?

F1 daughter: They don't respond, I would say now, but before you would phone and they will say there is no vehicle in the police station, they only come when it's an emergency.

R: How does the drug user get their drugs?

F1 daughter: There are people supplying in the community.

R: Do you know them?

F1 daughter: Some yes.

R: what is done about it?

F1 daughter: There is not much you can do about it because they have people in the police department that they are bribing whenever they go.

R: In other words, they are protected?

F1 daughter: Yes.

R: What is the feeling having suppliers who are known but nothing can be done?

F1 daughter: Hurtful, a lot of pain and anger and frustration because you can't do anything because they are protected.

R: What do you wish to happen to suppliers?

F1 daughter: Big difference if people can stand up together because a lot of people are afraid to stand against these people selling scared to voice that they are selling. Now if you can get many community members that are willing to stand against these sellers I think that will make these voices heard. They are afraid and not willing.

R: Are there any incidents that make people afraid?

F1 daughter: No not that I know of.

R: Do you think drug lords are decreasing or increasing?

F1 daughter: They are increasing because each year there is a new drug lord in the block.

R: Tell me, why do you think drug lords like this place?

F1 daughter: Maybe because the community people are too laid back, they are not standing up

R: Besides that, are there any other reasons?

F1 daughter: People sell to make a living they are not employed.

R: Do you think they are selling to make a living at the destruction of other individuals?

F1 daughter: It is their way of making a living but I would say that should not be an excuse of making a living destroying somebody's life.

R: What do you think they could be doing instead of selling drugs?

F1 daughter: Bake, sell chips, make dry chips, there are other options.

R: Do you think unemployment has contributed?

F1 daughter: Yes.

R: What are the reasons for this unemployment?

F1 daughter: Many people are dropouts, they did not complete school left in middle of high school, did not complete matric.

R: What are the reasons for not completing school?

F1 daughter: Financial reasons we have two schools that are not paying school fees, it can be that and people think selling drugs will meet their basic needs.

Family number 2: Transcriptions on the effects of substance abuse on the family.

Participant 1: Mother

Age: 49 years

Gender: Female

Education level: Standard 6 (Grade 8)

Occupation: Unemployed since 2005, was working as a labourer and was retrenched.

Lives in the research setting since 1977, was born and bred in Thornwood. She lives with her extended family in a two bedroomed unit.

R: Tell me how do you feel about drugs?

F2 mother: From me its terrible, because a person that takes drugs doesn't care about you as an individual or even as a mother, he cares for himself only, cares only for himself. Feel that it's terrible.

R: Why do you say it's terrible, you feel that it's a bad habit because people care only for themselves?

Family number 2 mother: If only I must tell you from my experience with my family, other family members do not want him in the house.

R: He is not wanted by other family members?

F2 mother: Yes.

R: How old are you?

F2 mother: I am 49 years.

R: Are you employed?

F2 mother: I am not employed. I was retrenched in 2005.

R: What is your educational standard?

F2mother: Standard 6.

R: How long have you lived in this place?

F2 mother: I have been living here since 1977, was living in T... Where I grew up.

R: Here in this place what are the things that make you unhappy?

F2 mother: I love M... Even if I can go anywhere I love this place, it's not the place, it's the people in it, it's a beautiful place, and it's a lovely place. We came from T... With a lot of people, we have grown together, we more of a family.

R: What do you think are the reasons that make people take drugs?

F2 mother: You know from my point of view when I sat him down, my son he said it was out of curiosity, meaning they were just experimenting, trying, being forward let's say that.

R: With whom does he smoke drugs?

F2 mother: He's got a lot of friends.

R: So which one is smoking drugs?

F2 mother: The 23 year old.

R: Smokes with friends?

F2: yes

R: Besides out of curiosity what else is making him to take these drugs?

F2 mother: I did ask him that is the answer I got. He started this thing out of curiosity.

R: Because he is supposed to be studying?

F2 mother: Oh no he finished matric.

R: He finished matric?

F2 mother: He completed Matric even got a Matric certificate

R: But is not working?

F2 mother: He was working, because of this drug he left the job.

R: He left the job, was he expelled because he was unable or...

F2 mother: If I tell you, he was one of the bad debt collectors where he was working because of this drug and he was owing everybody money, so by the time he was paid at the end of the month, he does not even have the money to give me, so he left the job.

R: So how does that make you feel?

F2 mother: As I said in my first words, it's terrible it does not make me happy at all.

R: For you it doesn't make you happy? It makes you unhappy?

F2 mother: The reason being is that his father died in 2005, that is when I was retrenched, and I battled to get him through school, then even came to a stage when he wanted to quit school, and I said to him, boy you going to school for yourself because when I'm gone... And we never had it easy, there are days when we would go to bed without eating but will sacrifice and go to school, and when I saw his name in the paper. I didn't believe it that he has actually passed matric and I said what will all that. I said why the drugs because we had it very hard when his father died because he was a breadwinner, but he made it through.

R: If I may ask, how did the father die?

F2 mother: His father had hypertension, high blood pressure.

R: So you were worried when he was taking these drugs as they are jeopardising his future?

F2 mother: I didn't know that he was on drugs when I sat him down and have a meeting with him on one, I wanted him at home and said [interrupted by the sudden entrance of the drug addicted son who barged into the room without knocking and walked straight towards us, the interviewee suddenly stood up and said to him "on top of the bunk in a brown paper"].

F2 mother: I said to him, where was I? After the father died I struggled to put them to school then and I was sick and tired, I kept hearing that he is on drugs, this is what he is doing and called him and asked him, come and tell me now why drugs? Then he said ma to tell you the truth, I started this thing when I was in Matric, and he was in Matric in 2010 if I'm not mistaken its 2014 now, its four years exactly.

R: You said you live with your daughters, how does this taking of drugs of your son make the family feel?

F2 mother: Very miserable, he is taking their things stealing their things and selling them and he denies it. [We were again interrupted by the drug abusing son asking for the mother's phone, she responded that it's on top of the wardrobe, the audio tape was switched off].

When the tape was off she indicated that she is under a lot of emotional stress because of the stealing. She has to make peace by replacing the stolen things from other family members before they can see but sometimes she does not have the money as she relies on the son's support. She said she is tired of fights between her and daughters because there are poor relations within the family, centred on this son, this is seen through her unkempt hair and her emotionally drained appearance, she wears night attire during the day but is clean. She also said that she sits up at night waiting for the son to come back and when he comes back he is high and will not listen to anyone. She worries about his health and continuous stealing and selling of family things because it is costing the family. She indicated that he is going to see a doctor, who is preparing for him for the rehabilitation process, on the day of the interview. She is also attending the local support group that teaches her how to handle the son but the son has not agreed to attend this group. The family live in a two bedroom unit on the second floor of the five block flats that is debilitated with doors that have unreliable locks, it needs renovation and is supposed to houses five families, but there are many more occupants.

Family 2:

Participant 2: Substance abuser

Age: 23

Gender: male

Educational Standard: Matriculated in 2010 at a local High School

Occupation: Unemployed, was employed in 2011, lost job in 2013

Lives with mother who is 49 years and unemployed, two sisters aged 33, 30 who are not employed, the brother aged 25 and is the only working person in the house. There is also the eldest sisters' husband and the younger sister's live in partner and five grandchildren ages ranging from seven to two years.

Father died in 2005 from substance related hypertension complications.

The family has been living in the area since 1977, previously resided in Thornwood.

R: Tell me what is your experience with drugs?

Substance abuser: I got no job. I was working from 2011 and left the job in 2013.

R: Why?

Substance abuser: The drugs and all that.

R: Tell me what drugs are you taking?

Substance abuser: Sugars and Mandrax.

R: Why did you prefer these sugars and mandrax?

Substance abuser: For me it's better, I use to feel much happier when on sugars and mandrax.

R: Are you unhappy about anything?

Substance abuser: No won't unhappy, I can't, it's just that the company I was going with were all on the same and friends we were all one level high and just enjoyed that part and every time we looked to be at that level and every time got worse and worse and worse and worse.

R: What are the things that make you take drugs?

Substance abuser: I don't have no other thing maybe it's mainly my friends, the company that I use to keep with were on the same.

R: How do drugs make you feel?

Substance abuser: When on sugars, so the sugars make you feel happy? Before you smoke, you have pains, you sweat and everything, so it's once you smoke the pain, sweat

and headache, goes away, like you have to smoke this, like you have to smoke [smiles] After taking drugs I feel better, eases my mind. I wanted to get at that level, because sugars as one can see its one of the best, its number one. A lot of people are smoking it, especially the youngsters. I take the drugs alone or with friends.

R: Where do you get the money to buy drugs?

Substance abuser: I steal, sometimes rob people of their money. I steal, rob people. I lie for the money and say I will do this or that meanwhile I'm not, I'll smoke the money. I can do anything, I can do anything. Can ask me to do things just to get that money, can ask me to take these books and table and forward them for R20 or whatever, I'll do it. Its like eases your mind and feel better once you take it. Get the drugs from the community

R: What do you think this is doing to your family?

Substance abuser: It's bad. Family stopped trusting me. They do want to give me money anymore. Do not sit with family because I'm out always out worrying about this drug or to get the next fix or with the friends. This is breaking the family, it's breaking them, making the family unhappy, like they can't stand what I'm doing. Take things from them, and steal their phone, mother doesn't want trouble and come and ask me if I had taken it and I will deny it, then it's sorted out. They will forgive me but three days later I'll do it. I steal R50 from the other sister, and they are now getting angry with me and my mother also but she says ah my son I'm the youngest in the family she does not want me to go to the streets and keep peace and I just keep on doing it doing it. I don't think it's good doing drugs but it's like I have to. I have thought of stopping many times but the pain keeps. Sisters always give me good treatment. I'm the youngest brother, was always talk about what clothes I buy while I was working until they caught me up and told me "you are on drugs". My sisters do not want me, want to throw me out in the streets. There is arguing and fights and all boils down to me as my mother protects me, she replaces what I steal sometimes even before my sisters notice, keeps standing in front of me to keep peace. My sisters want me locked away because of the things that I steal from them over and over. There is no happiness, they are always watching and they are saying because you steal. I go out at 8 in the morning and come back late, 11pm or later. I don't eat, no appetite. You may be hungry but once you smoke you don't feel hungry.

When audio taping was not on:

He said he also gets the money from the mother, pressures mother to give money to buy substances. Mother is angry but she also try to keep peace by replacing what he has taken and sold before sisters could notice what has been taken from them because she does not want the son to be thrown out or put in jail.

Audio tape on:

R: Tell me what is substance doing to the neighbourhood?

Substance abuser: Terrorising people I won't lie. People can't leave stuff outside as it will be gone. Crime, stabbing by drug dealers for a R10 owed to them. Fighting. Community not at peace because of drug taking. Neighbourhood can't say much, though they marched, called cops. Cops go to wrong people, lock up the wrong people, they do not catch the right people. Cops are sometimes paid not to catch the right people. Drug lords are sometimes warned before the cops come. Since sugars came around children can't go to the shop because of crime, they are kicked or blindfolded so that money is dropped and the abuser pick up the money.

Drugs taken:

- Sugars is the fastest and most sold
- More people smoke sugars than mandrax
- I do smoke cigarettes, sugars and mandrax.
- I do not take alcohol, it became funny, do not taste nice, it's not me, can't sit around people drinking alcohol.
- Alcohol does not give the feeling of being high, makes you drunk
- I can sell alcohol for drugs

Family number 2: Transcriptions on the effects of substance abuse on the family.

Participant 3: Son

(The eldest brother to the drug user neatly attired and shy but as the interview progresses he appear relaxed)

Age: 25 years

Gender: Male, unmarried

Education: Grade 12 completed in 2008

Occupation: Working as a labourer since 2012

Lives with mother who is 49 years, and two sisters aged 33 and 30 and a 23 year old brother. There is also the eldest sisters' husband and a live in partner for the second sister and five grandchildren ages ranging from seven to two years.

He was born and bred in the area but works outside the community which is also costly and adds to the financial burden of the family.

R: Tell me what is your experience with drugs?

F2 son: From what I know it's not a good thing as it changes people, you see people going from what they have been to nothing whereas you can't even do things that can even affect you in your own personal life, like me have a bad experience with the person you live with who does drugs. They do things as they say, they make the impossible possible, they don't care what will happen when you do this, they don't think twice, they just do it because they need this drug to feed the habit, this craving, whatever they need to smoke.

R: How does that make you feel?

F2 son: For me it's hard because from what I know, I had a terrible experience, whereby things that I worked hard for, it just goes, whereby I can just actually do something about it but I chose not to, at the end of the day, I mean it's my brother. Those are the material things. I don't want, I don't want actually to see him go off, and he is already on an off time, he is a possibility he can come back, though by putting peer pressure on him, these things are going to make him worse. Meaning when he does things for an example, things that had to go missing, there are steps that I can put together, things that I can actually do to get these things back, for an example going to the police, but I don't want because it's my brother, he is gonna be in big trouble, and who knows maybe the day he is locked up for these things he'll end up worse than he is where we can't even see him, so it's better off even though I don't like it but I have got to accept it.

R: Tell me, have you confronted your brother about this?

F2 son: I have told him many times, that it's not right what you are doing, you must think about it at the end of the day, fair enough we all brothers and sisters and we stay together, but at some point we split and live different lives and we won't be there to try and assist where we can, we gone be on our own spaces, getting our own families. We are not going to worry about our brother, where as we told you about that it's not right. It's gonna be sore but we all have to go someday.

R: What was your response when finding that your brother was on drugs?

F2 son: At first I did not worry whatever, I thought maybe it's just something you know bad company by trying new things because we all do that, experienced new things but as we grow older we all do things just meeting different friends, I thought it will stop, then I find out that it's getting serious which I told him "it is not right what you are doing". Then things started getting missing and stealing, I'll rather keep quiet which I didn't like but due to the fact that I don't want to go to the police station, who knows, it could have turned worse than think.

R: Do you think there is something better that you can do for your brother?

F2 son: I told him that I'm willing to try; I am willing to try, I can, whatever it takes; like I don't know may be like starting with something that is going to get him away from the habit that is on, try to keep him busy, getting his mind concentrated on this thing that he needs to actually take.

R: Why do you think he is taking drugs?

F2 son: To be honest, I don't know he is just not an open person.

R: are there reasons within the household that pushes him to take drugs?

F2 son: I won't really have to say because he does not speak open to us.

R: From your understanding, you able to meet the basic needs within the household?

F2 son: concerning that I'm not too sure, I play my part, I work, I do but the money that we get is not enough due to the fact that there's things I have to do before I can say this is my money. Things are not actually personal, it's my mom, it's my mother's house.

R: So you are supporting the family?

F2 son: give my mother a board money, it's not too much but that's what I can. Yes I try and I still do things around the house where I can.

R: Do you feel it's not enough?

F2 son: well something is better than nothing, so if that is what I can get I can give I can try part of it.

R: so you feel you can meet the basic needs

F2 son: Maybe he can answer that, I don't know as I said he doesn't, he doesn't actually open to us.

R: Why does he not open with you?

F2 son: I don't know, I think maybe because he started using drugs. Everything use to be normal and fine but now while the stuff is going on he started doing his own thing, using his drug that he is on it became worse, he started doing his own things, like he come inside when he feels like, there's times when he get angry more and when I don't know he did not get to smoke the stuff and craving is too hard for him he starts doing his own thing, comes maybe inside the house, he starts looking for things he can sell and will take it without even thinking that I know I'm going to get into trouble, or I will have to come back home and the person knows that I have to put up that thing but still do it.

R: What is this doing to the family?

F2 son: it does not make things good, it's like shouting and fighting, maybe he has taken something from my sisters and they will get angry about it as it was maybe bought by someone and he may just come along maybe at the back of your mind you know that it is personal stuff and so much money was paid and it's sold for nothing and when you approach him about he just lies, it's hard and says I didn't know.

R: How does that make you feel?

F2 son: Heart sore, because I think you are my brother why you doing this to me because you know when we grew up things were not easy it was hard, then you should know how

we got here and why should you make someone happy with it for a little bit of this and yet we paid so much of it, just take it like that.

R: Do you talk about the situation?

F2 son: We do in a way and that not everyone will talk about it and that when we here he is never here.

R: As a family do you talk about it?

F2 son: Well I try to talk to my mother but I don't like to over, like talk to her too much because I can see that my mother worries over this too much and more me coming and telling her, she can see not that she doesn't see, she knows that she is trying and, once everything comes right. I don't want to power my mother with more stress, load her with more things.

R: You are aware that your mother does not like the habit?

F2 son: I don't want to stress her because I know she is trying. Oh my mother talks about it to him at night because when we come back from soccer my mother would be up and say this is not right, every night she is telling him about the problem.

R: What is this doing to the family?

F2 son: Miserable, edgy, cross about this thing because she is got this person that's on this thing, we know that its him we know that he is on drugs because if you look at what he was before things would be left for days and months without missing, now if you put something down you have to watch because he is going to take it and don't think just to get the money and buy the drug. he steals things of value from the brother.

R: Do you look forward coming home after work?

F2 son: I do, it's my family, and there is nothing I can do. You know everybody cannot be the same that is the road chose and the friends he chose, that is where he is going to end, we are all willing to help.

R: How does he get the stuff?

F2 son: I know that there are people selling and they are known.

R: What is the community doing about it?

F2 son: From what I know they marched about it, they also attend meetings from the support groups. But if drug addicts can take time to attend these instead of smoking drugs they can play their part.

The family two research participant number 4, is the eldest sister in the family, aged 33, who was born and bred in this community, attained her primary education in the local school but is also a school drop-out, and was employed as a laborer before she left work two years ago to care for and protect her children in this drug ridden community. She was married five months ago. She has two children aged seven and two, she lives in the same household with the husband. She verbalized that she is smoking to relieve stress, because of the brother and a husband who are multiple substance users.

R: What is your experience with drugs?

F2 daughter: It's terrible, because every youngster, the youth, because I know most of them is smoking.

R: Is it the males only?

F2 daughter: No there is a lady who smokes too. Our experience in our home is our brother is on this whoonga, it causes a lot of problem here.

R: When you say it causes a lot of problem here what do you mean?

F2 daughter: Because he steals too much.

R: Steals what?

F2 daughter: Everything, well with me he steals clothes, my takkies, and all my wedding presents, steals our money, he takes everything.

R: So when did you find out that your brother was on drugs?

F2 daughter: well with me and my brother we were very close, we were very close, use to spend most of the time together, we suspected that he is smoking but we did not know

that it's something that he smokes so long because he said he started smoking in Matric and we only found out I think last year. We always talk about it but there is an answer to the problem. There is an attitude because no one can tell him anything.

R: He does not listen?

F2 daughter: He does not listen not even to my mother.

R: How does that make you feel?

F2 daughter: Angry because he does not understand what he is doing, I know because what keeps me and my sister here is we worry about him, my mother, she is not working and he is not working, but he does not understand that he ruins the whole house. She does not get any support anywhere else.

R: So what are the reasons why he is taking drugs?

F2 daughter: I don't know why, my mother didn't grew us up to be like that, we had everything but not everything, but what the child would want, we were able to meet the basic needs, I don't know why he even turns into drugs whether it's out of naughtiness or what I don't know because there is no valid reasons from him going on to smoke. He got over this I think he was in standard five or six when my father passed on, I was twenty years old. He could have done this in the time, but he only started in Matric, only in Matric I don't think there was any problem he is trying to...

R: So how does that make you feel?

F2 daughter: Very, very hurt, because when his father died, my mother was not working, we use to look after him, he use to drink. We wanted to make sure that he finishes his schooling, now he turned out like this... it's sad.

R: So there is no other reason?

F2 daughter: His friends, his company!

R: Is it the neighborhood?

F2 daughter: Yes his company, his friends.

R: Have you talked about this?

F2 daughter: We told him that he must stop if he wants to live, he needs to move away from friends and the streets, you cannot keep company with people that are still doing the same thing, and he flew to go back. At times he comes back at three in the morning and in the night sleeps, and in the period of six to seven hours he is not smoking. As soon as he goes with his friends, they start smoking.

R: You feel the friends have a lot of pressure on him?

F2 daughter: Yes, yeah, and it's not possible to keep him away from them. He is a big person we can't keep him locked up.

R: So when you talk to him about giving his friends or giving up smoking?

F2 daughter: He says nothing, just looks at you.

R: How does he behave when he has not had the stuff?

F2 daughter: Whoa, I'm telling you like the day my mother was going to the centre, he was in and out, was going in and out till after two. You know because I'm not working, I am at home so I was sitting here so I heard a package falling through, so I said what you doing there? He said nothing, I got up and I go and saw my brother's takkies. So I asked the lady downstairs to keep it for my mother. He became aggressive because he still wanted to take them. He is aggressive, very, very aggressive.

R: How do you control aggressiveness?

F2 daughter: That day was the first time because he even open the knife and he threaten my mother with a knife, I took it.

R: What do you think this is doing to the family?

F2 daughter: I'll say we got no peace in our house because my mother says go to the support group meeting on Thursdays and they say they going to teach her how to handle him. But again what they teach her is right, but when we look at it, it's not helping us anyway because they teach only the mother to speak to him in a soft tone of voice and love him. We do that, she does that, and what happen to us as the children because I would think of it as it continues as she is talking nicely to him and she is keeping him here. She is the only person I know who can handle him this much, that smokes that drug and still walks inside as you please and gets inside as you please. Do as like normal life

and no talking because other children, all these three that are not smoking it are not allowed to go to houses, they sit outside and do not get inside the house, and they eat and when finished go outside.

R: Where do they live?

F2 daughter: Some on top, all over, most of the time they spent their time in the streets, most of the time they are on the road, carrying scraps.

R: Where do they find money for drugs?

F2 daughter: Scraps.

R: Tell how this makes you feel?

F2 daughter: Angry, sad, everything it causes a lot of problem because a lot of time my mother and I are got into an argument because of him. You can't say anything to him, because my mother she is only practicing what she is taught, but to us he is part, you understand, I don't know how to put it to you.

R: So you find that there are arguments because

F2 daughter: Only because of him talking about what he is doing, smokes, you see before he left work, I was working at that time, he didn't go to work the whole week and I took three hundred rands and said to him, go to the doctor and explain your problem to the doctor and he will give your letter to go back to work, and he had done that, and I said to him make sure that you come back home with this and we will help you. He worked for three days only and in his lunchtime on the third day he left work and he never went back. I said to him you left work what do you think you gonna survive on? Obviously from there you gonna start stealing here and my words worked. Every time he takes and steals from here.

R: And that makes you feel?

F2 daughter: That is what makes us fight.

R: Your mother, does she express her feelings?

F2 daughter: Whoa, only express minor things acting like this over and over. Whenever we talk it ends up with arguments boiling down to these drugs.

R: So how is life in this house?

F2 daughter: Hey, terrible, we live badly in here. You know before with my friends, you can leave a R100 note even when sitting here but now you can't, I mean you can't live like that hiding, our shoes won't stay in pairs, and one will stay in that room, the other will stay in this room.

R: Because he steals

F2 daughter: Because he steals. If it is a pair on the floor like my takkies, well its stolen because it's easier to take.

R: How are the relationships between you as a family?

F2 daughter: Me I don't really talk to him. I just look at him because it makes me angry, it makes me angry. I put too much on him, so it's hurting.

R: What is it that you want to happen?

F2 daughter: He needs to go to the rehab but at the end of the day even if he goes, must go because he wants to, he won't go because we want him to go or put on a show like to please, you can't, he is a big boy, he is twenty-three, he must do things because he wants to. At the end of the day he will go because he wants. We ourselves are not perfect, we got our own faults, but his problem right now is he is always in the streets, won't even eat, he comes and have one slice and sometimes dish up his food and eat not even half and leave it.

R: So he has no appetite?

F2 daughter: He has no appetite, he is finished, whoa. He is gone very thin hey, I don't think he is aware of the change in him. My mother and I use to fight, jump in between to make him bath. He does not want to eat and bath and has no clothes and you feel as a person that's what even hurts more.

R: If he is given some clothes what do you think he'll do?

F2 daughter: You see when he was working, he didn't have time to smoke, and he only smoked during lunchtime you see. That changed when he left work and things got worse, see how nice he looked here before [a photo was shown from her sister's cellphone, there

is noise made by the children ringing the bell from outside wanting to come inside the room]. He is supposed to be good because children like him and its disappointing when they see him like this because they are not used seeing him like this person. He is not the same person.

R: He has changed.

F2 daughter: He has changed a lot.

R: Where does he get these drugs?

F2 daughter: I wonder if you can see, if you stand here, come see [a drug lord's house is pointed out] and if they want to smoke mandrax they do not mind sitting and smoking.

R: What is the community doing about drugs?

F2 daughter: Mandrax and whoonga all these are in trouble because everywhere grandchildren, my son is at school and is a very intelligent child and by looking at him, even at his father is also a drug addict, we don't even stay together. As if I have my own problem and this, both problem my brother and my husband will sit and smoke this and the child gets in and I will say to my husband, ok with these drugs, my children are looking at you, tomorrow when they smoke drugs you won't be able to control them because they saw you doing it, so when its ok for us do it, you understand what I'm trying to say. You see it's like a joke my husband gets R18, 000 per month. We married now for five months but we can't go on now because of these drugs. I can see now that this is not getting us anywhere because if I 'm working we both live at five fifteen and don't see our children the whole day at least one person must see to the children. But I need to find a job now and I will find a job. He earns R18, 000, the same day I showed you he pays almost R2, 000 a month for drugs, R390 for the shebeen and R1560 for the other girl and R500 I know how he has paid, I do not know about the rest, because he smokes and drinks also said to him you know the experience I have because he takes the money to her. He got the money to pay and he pays for these drugs. I also said to him you know the experience I have because my son is in his first year at school grade 1 and out of all the grade 1 he had an outstanding performance and came first on top of all the grade one, and at school they called me and said they wanted to push him and I said they must leave him, and now because of these drugs the second term he did not come first. The way the father's drugs affected him, you know he is so embarrassed now, and it's not

a good sign, we are not in good terms at all. My children, both of them, the way he speaks they say ma, cant my father leave these buttons everywhere it embarrasses and it's showing that it has an effect on him.

R: when talking to your husband how does he feel?

F2 daughter: He got no money and nobody can tell him nothing that is his attitude.

R: does he become aggressive?

F2 daughter: Yes, yes.

R: Are there fights?

F2 daughter: Yes, fights, there was one where he actually hit me and were still living here by then and were smoking.

R: How did you feel?

F2 daughter: You know I stay angry, very miserable and very angry.

R: Did you get any counselling?

F2 daughter: I don't get any counselling but we are gonna see the pastor now. I don't want him and when I spoke to him about you he said does not even know you. Now I won't allow him to bring my children and me down. I am with him thirteen years and only married to him five months and I know what type of a person he is. Yes he use to smoke drugs, but now it's worse... he is not worried. I even asked him that you are doing this because I am not working, so what must I stay for? Yes he buys food for children but like my basic needs I don't get support, nothing. The Pastor came here last week Thursday, he is meeting us the first thing tomorrow and he is going to see us next week together so I'll know then the outcome then.

R: Is this the end of the road?

F2 daughter: I think it's better for me. I got two sons growing and I don't want to see my children being like my brother and my husband.

R: But you are still living in this area, how are you going to control that?

F2 daughter: I have said to my husband let's go but drugs are all over but it's not exposed like in this area. People do smoke but they don't sit and smoke where children are playing, do you understand, and they do smoke. They come with the police, you see last week Saturday they just came out of jail and they just smoked, the whoonga story, he came here with the police but what are they showing us as the community, the drug lords are working with the law and nothing will be done about it.

R: So you are helpless?

F2 daughter: We are helpless because as soon as the raid starts, the cops will phone and tell them to watch out.

R: How does the community feel?

F2 daughter: Tired of this whoonga business, a lot of people are afraid but no one want to come forward because the man is known that he can get people to kill you.

R: Has he killed people?

F2 daughter: Yes this man got one of our neighbors killed, that time it was for alcohol, it was not for drugs. Hey I just need to go but everyone is trying to avoid this smoking is like normal as I say people smoke but respect, here it's like a routine, I smoke, I smoke, what are you going to do? It's like normal. Mandrax with so much stealing. Whoonga is cheaper but it's more controlling of a person.

R: More dangerous?

F2 daughter: My husband smoke mandrax, he does, he came from Seaview not smoking I stopped him, It's like a normal thing, I can't stop him now, and it's like a normal thing.