SUBSTANCE ABUSE AMONGST PRIMARY SCHOOL LEARNERS IN DURBAN: A CASE STUDY EXAMINING LEARNERS PERCEPTIONS AND EXPERIENCES AT AMAOTI PRIMARY SCHOOL.

BY

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DECLARATION

I, Mafikeni Andries, declare that this dissertation is my own work, and has not been submitted previously for any Degree in any University.

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Date

ABSTRACT

This is a case study examining the children's perceptions and experiences on substance abuse in the Primary School. Interviews were used as a research tool. The research sample of five respondents was drawn using the purposive sampling method. The data was analyzed qualitatively on themes drawn up.

The findings of the study were based on four themes: peer pressure, moral decay, bravado and solace, socio-economic factors and psychological factors

Furthermore recommendations were drawn.

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Finally, to all the respondents, with their views, participation and experiences during the interviews.

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CHAPTER ONE

1.1. Introduction

This study examines substance abuse amongst Primary School learners. Its purpose is to explore the perception and experiences of learners as opposed to the difficulties that teachers and adults have with these children. Certainly the difficulties posed by children who abuse either drugs or alcohol or both will be presented, but the focus will be more on the reasons given by children for their behavior and the day-to-day challenges facing them. The researcher hopes that with this insight, intervention strategies can be developed to assist the children change towards productive ways of tackling daily hardship. The study differs from the dominant focus of research because this is a case study done at Amaoti village. According to Filsted (1990:231), problems of substance abuse have been sources of concern in several parts of the world. Therefore, there is a need to investigate the perceptions and experiences of young children and attempts to explore some of the reasons why substance abuse has become such a major threat to persons of all races, ages and socio-economic levels.

Being hooked is one of the most frustrating, stressful situations and young children are at a disadvantage of being hooked at the different form of situation. Substance abuse and addiction is one of the most challenging aspects for any stakeholders who have an interest in our beloved and valuable children. The challenge to combat substance abuse is intensified by the fact that children seem to develop a particular perception, which the researcher wants to investigate in this study.

1.2. Rationale

The problem of substance abuse is universal and very prevalent in township schools; the researcher's aim is to look at the dynamics around the issue as well as intervention processes at school level. The researcher is a teacher and school counsellor. He has taught for nine years in primary schools and has encountered several young learners who disclosed that they took drugs and alcohol. This has been of great concern to the researcher especially as the readings suggest that this growing problem in primary schools. It is negatively affecting behavior and academic performance of primary school learners.

What constitutes the problem could be the family itself as well as the community because children are easily influenced; they copy from the family as well as the community. The purpose of this study, is to present a new perspective on the problems created by the use of mind-altering substances amongst children. It is troubling to learn that addiction knows no age barriers. The study would benefit teachers, social workers, health professionals, parents of teenagers, other concerned adults, and the Department of Education. As mentioned before, the researcher is a school counsellor and all the interested stakeholders mentioned above will be invited to the school after the study has been concluded and a workshop on substance abuse will be conducted.

The children's views on substance abuse will be focused on in an attempt to understand the phenomenon of substance abuse from the abusers perspective. Such insights will facilitate the implementation of intervention programmes, or recommendations, which will be provided. The other motivation for the study is that there appears to be silence from the Department of Education on matters of substance abuse amongst learners in a way that no intervention strategies are being used in schools, whereas the problem is worsening alarmingly

The researcher's concern also arises from the accessibility of some of the dangerous drugs to learners in schools and in the home environment. Succumbing to drugs will adversely affect the learners in pursuit of academic achievement and their overall well-being. Expelling a child who abuses substances is not the answer because whatever made the learner take drugs has not been dealt with.

1.3. Focus and Critical Questions

1. What reasons do children give for choosing to consume drugs/ alcohol at school (influences at school, home and social environment)?
2. How does substance abuse affect their self-esteem?
3. Given the learner's experiences, what type of intervention could be put in place at school level?

The next chapter will discuss literature review and provide definitions of terminology used in the study.

CHAPTER 2

2.1. LITERATURE REVIEW

Operational Definition of the terms

2.1.1Drugs

Are any substance, vegetable or chemical, which cause psychological change, emotional or behaviourally in a person. (Van den Aardweg, 1989: 45)

The term " Drug" is used in accordance with the definition provided by the World Health Organization, as quoted in the World Drug Report (1997:10) of the United Nations Drug control Programme. It refers to all psychoactive substances, that is " any substance that, when taken into a living organisms, may modify its perception, mood, cognition, behavior or motor function, whether licit (namely alcohol, nicotine, cough mixtures, appetite suppressants, sedatives, tranquillizers) or illicit (for example, cannabis, cocaine, heroine, LSD)"

2.1.2 Substance Abuse

Substance abuse is the abuse of both alcohol and illegal drugs (Bruce: 1990: 6). Any individual who is using a drug when there is no legitimate medical need to do so, or who is drinking in excess of acceptable social standards is said to be abusing that drug or chemical (Schuckit: 1989, World Drug Nexus in Africa: 67)

2.1.3 Tolerance

The World Health Organization (1993:17) explains tolerance to be a reduction in the sensitivity to a drug following its repeated administration, in which decreased doses are required to produce the same magnitude of effect previously produced by smaller doses.

People who consume alcohol and take drugs on a regular basis become tolerant to many of the unpleasant effects of it and thus are able to drink more before suffering these effects. However, even with increased consumption many such drinkers do not appear intoxicated. Since they continue to work and socialize reasonably well, their deteriorating physical condition

may go unrecognized by others until severe damage develops, or until they are hospitalized for other reasons and suddenly experience alcohol withdrawal symptoms (Addiction Research Foundations, 1991:I0)

2.1.4 The Alcohol Withdrawal Syndrome

The alcohol withdrawal syndrome is a combination of various symptoms observed in persons who stop drinking alcohol following continuous and heavy consumption. If used for a long enough time, each drug abused will bring about a characteristic withdrawal syndrome which depend on factors such as the class of the substance, the period of time it has been used and the individuals state of health (Doweiko, 1996: 246)

Seizures and hallucinations are milder forms of the syndrome, which typically occur within 60-48 hours after the last drink. Delirium tremors (DTs) are a more serious syndrome, which occurs between 48 and 96 hours after the last drink. This involves confusion, hallucinations and severe autonomic nervous over activity (Victor, 1983 :198)

2.1.5 Alcohol Abuse

Alcohol abuse is "repeated or episodic self administration of alcohol to the extent of experiencing harm from its effects, or from the social or economic consequences of its use" (International Labour Organization, 1994).

Albertyn & McCann (1993) define alcohol abuse as the "consumption of alcohol which interfere with people's work, or which affects their performance or ability to function well". The American Psychiatric Association (1980) and the National Institute of alcohol abuse and alcoholism (1996) declare the following criteria for alcohol abuse:

- Impairment in social or occupational functioning due to alcohol use
- Pattern of Pathological alcohol use
- Drinking in situations which are physically dangerous, such as driving a car or operating machinery

- Recurring alcohol-related legal problems, such as being arrested for driving under the influence of alcohol or for physically hurting someone while drunk.

2.1.6 Psychological Dependence

A model of drug dependence based on the idea that the drug abuser is motivated by a craving for the pleasurable effects of the drug (Doweiko, 1990:176).

2.1.7 Physical Dependence

A model of drug dependence is based on the idea that the drug abuser continues the drug taking behavior in order to avoid the consequences of physical withdrawal symptoms (Lawson, 1999:104)

2.1.8. Substance Dependence

A diagnostic term used in clinical psychiatry and psychiatric that identifies an individual with significant signs of a dependent relationship upon a psychoactive drug (Lawson, 1999:104)

2.1.9 The Recreationist

A young person uses drugs to share pleasurable experiences with friends not to achieve a mood or mental effect from the substance (World Book Encyclopedia,1992: 145)

2.1.10 Trip

It refers to the feelings, thoughts and perceptions one experiences while under the influence of a hallucinogenic (World Book Encyclopedia, 1992: 145).

2.1.11 The Seeker

The teenager or adolescent seeks an altered state and uses drugs and or alcohol regularly to achieve a sedative or intoxicant effect (McBride & McCoy, 1993: 10).

2.1.12 Alcoholic

An alcoholic is a person who cannot drink in moderation consistently, and whose pattern of drinking is uncontrollable and usually compulsive. He or she may develop physical dependence and require hospital care to safely quit drinking (Tommasello, Tschirgi, Clinton & Wood, 1991: 32)

2.1.13 Alcohol Dependence

Alcohol dependence is " the habitual reliance upon or addiction to the consumption of excessive quantities of alcohol, or an inability to limit alcohol consumption to within reasonable limits (Campbell & Langford, 1995:79)

2.1.14 Alcohol

The International Labour Organization (1994: 78) defines the term alcohol as a primary and continuous depressant of the central nervous system whose effect is analogous to a general Anaesthetic, absolute alcohol is a pure amount of alcohol, free from water and other substances, in beverages such as beer, wine and distilled spirits".

Campbell and Langford (1995: 17) explain alcohol to be any of a family of organic compounds possessing a hydroxyl group attached to a carbon atom. Ethyl alcohol (ethanol) is one of these compounds, which is most commonly used.

2.1.15 Alcoholism

"Alcoholism is a primary, chronic disease with genetic, psychological, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by continuous or periodic use of the drug alcohol, despite adverse consequences and distortions in thinking, most notably denial"

2.1.16 Approaches to Alcoholism

Denenberg & Deneberg (1991:167) distinguish between two approaches to alcoholism, namely the physical and the psychological approaches.

2.1.17 Primary

" Primary" refers to the nature of alcoholism as a disease entity in addition to and separate from other path physiologic states which may be associated with it (Morse & Flavin, 1992:135)

2.1.18 Disease

" Disease" means an involuntary disability. It represents the sum of the abnormal phenomena displayed by a group of individuals. These phenomena are associated with a specified common set of characteristics by which these individuals differ from the norm, and which places them at a disadvantage (Conner, 1994:35)

2.2. CAUSES OF SUBSTANCE ABUSE

Theories that view early adolescent drug use as a function of social learning and influence may have the most explanatory merit. According to Jessor & Jessor (1980:234) and his colleagues view early adolescent drug use as an interaction between personality, environment and behaviour that leads to "problem behaviour proneness" a characteristics that adumbrates later drug use. Among the environmental variables are those major socialization links that connect a youth to society and to society's values.

The major socialization systems that are likely to influence youths include the neighbourhood, the family, religion, school and peers. Although it is hard to isolate the effects of these socialization characteristics from each other, there is enough evidence to indicate that each is important. There are census tracts; neighborhoods that have negative characteristics and that have high levels of drug use (Nurco, Shaffer & Cisin, 1984:302)

Family problems can also be important factors in increasing the chances of early adolescent drug use. Drug use is higher when the family is not intact as was mentioned in the family system theory, when the youth were away from parents, when there is drug and alcohol abuse within the family, when family relationships are poor, and particularly when the family does not have strong sanctions against drug use (Adler & Lotecka, 1989:163).

When school adjustment is poor, chances of drug use are much greater (Annis & Watson, 1989: 34). The most important socialization link for youths however, is peers. Drug use is highly related to whether or not friends use drugs, and whether youths believe their friends would discourage their use of drugs (Oetting & Beauvais, 1989:245).

Peer cluster theory strongly emphasizes the role of peers, stating, that although there are a number of underlying psychosocial factors that create the potential for drug involvement, actual drug use is dominated by the effect of the peer cluster. Peer clusters are dyads, such as best friends and small groups of close friends. When drugs are used, it is almost always with members of a peer cluster. Members of peer clusters communicate often and share ideas with each other, and overtime establish attitudes and beliefs about drugs.
This theory is all about the group of peers (children) being together, influencing each other on substance abuse. They learn and teach each other about drugs. (Oetting & Beauvais, 1989:246).

Peer clusters favorable toward use provide drugs and opportunities for use, and they are a critical factor in both initiation and maintenance of drug involvement. Peer Cluster theory suggests that whatever effects other socialization links exert on drug use are indirect. Although they can increase the chances that a youth will build associations with other youths who have a high potential for drug use, actual drug use will be linked directly to peer drug involvement. A path model of socialization and drug use was developed based on this principle and was tested in article the (Oetting & Beauvais, 1989:246).

There were five socialization variables namely, family strength, family sanctions against drug use, religious identification, school adjustment and peer drug associations examined these and it was found that the peer variable mediated the effect of all other socialization variables.

The definition of drugs is in line with local and international evidence that various patterns of drug use- whether licit or illicit are interconnected. Hence the traditional tendency in the social sciences to investigate the use of a particular group of substance(s) in isolation from that of other obscures the dynamics of drug use, (Anderson, 1994: 150). Drug use is also viewed as neither a random nor a static activity, but socially regulated, complex and dynamic (World Drug Report; 1997). Human consumption of drugs and other psychoactive substances, or drug use, is regarded as an established phenomenon. Drug is also associated with the harm and with the benefits, all of which differ across the type of drug, drug user, and manner of drug use and socio-cultural and physical context of drug use, apart from varying over time.

Furthermore, efforts at preventing or minimizing harm related to the human consumption of drugs tend to exist alongside measures to facilitate the production, distribution and consumption of drugs. The latter measures also vary over time and space but are not necessarily integrated with the former measures. The prevention or minimization of harm and efforts at promoting consumption are also not necessarily evenly balanced within and across nations (Olivier, 1990: 79)

Nevertheless, association between the use of licit drugs, such as alcohol and tobacco, and between these and illicit drugs, such as cannabis, is strong. Such associations were in fact evidence in two studies in the early 1990's among South African young people (Rocha-Silva, 1992: 40) various studies abroad (e.g. Brunswick 1980, Kandel 1989) have also shown that illicit drug use, particularly long-term or continued illicit drug-use, tends to manifest within a drug-taking lifestyles in which the use of licit and illicit drugs is closely intertwined.

Most previous studies have only concentrated on late adolescents, not on early adolescents. There is a clearly defined social process by which individuals in this study become involved with drugs and ultimately addicted. Exposure to stimulus occurred early in their lives and continues for as long as they resided in the area of their addiction. Roughly one-third to one-half of the boys by age ten engaged in glue sniffing. Most studies show that boys are more anxious than girls. Other studies have shown that boys who experience high anxiety tend to perform poorly academically (Mwamwenda, 1994: 228). At this stage 10-11 years old, there is also use of pills, particularly barbiturates and marijuana. The reason being they are easily available in the neighbourhood.

(Lander, 1998:89) emphasized that the drug process assumes a more formed and involved pattern. Drug use, or most, becomes intimately tied to sexual and educational patterns around the age eleven (Ernest, 1998:98).

In An article titled "The effects of Drugs on Adolescents", it is stated that young marijuana smoking children consistently showed very poor social judgment, poor attention span, poor concentration, depression, slowed speech and a regression to a more infantile state (Landman, 1997: 189)

In 1965 the World Health Organization (1994:130) adopted the term drug dependence is defined as a state of psychic and sometimes also physical dependence resulting from the interaction between a living organism and a drug, characterized by behavioral and other responses that always include a compulsion to take the drug on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomfort of its absence.

As with adults, accurate measuring of how much young people drink is subject to possible bias in self-reporting. Children are aware of alcohol very early in life. There have been several recent studies of young children drinking indicating that drinking begins at ages 8-12 years, with the majority of 12-14 year olds having some experience of drinking. They also found that 74% of 11 year-olds had tasted an alcoholic drink, this proportion increased with age, from 89% of 13-14 year to virtually 96% of 15 year olds.

2.3 SUBSTANCE-RELATED DISORDERS

The misuse of psychoactive substances is the nation's foremost public health challenge. The use and abuse of alcohol, cigarettes, illicit drugs (heroin, cocaine, and marijuana), and licit drugs (sedatives and tranquilizers) are by for the largest cause of preventable and premature illness, disability, and death in our society.
(Committee on Drug Abuse of the Council on Psychiatric Service, 1987: 698)

Through history, people have swallowed, sniffed, smoked, or otherwise taken into their bodies a variety of chemical substances for the purpose of altering their moods, levels of consciousness, or behaviours.

The widespread use of drugs in our society today is readily apparent in our vast consumption of alcohol, cigarettes and illegal drugs. Our society is generally permissive with regard to the use of these substances.

People and representatives of public institutions become concerned when the ingestion of drugs results in:

- The impairment of a person's social or occupational functioning;
- An inability to abstain from using the drug despite its harmful effects on the body
- The user becoming a danger to others, or
- Criminal activities, such as the sale of illegal drugs or robbery, to support a drug habit (Albertyn & Mcann, 1993:202)

The first two of these problems are directly involved in substance related disorders i.e. altering one's psychological state or mal-adaptive behaviour associated with the pathological use of a substance. The other problems arise as a concomitant of such use. Yet another problem is that use of one substance may lead to use of other substances.

In a longitudinal study of drug use among youths, Ellickson, Hays and Bell (1992) found that involvement with "legal" drugs such as alcohol and cigarettes tended to precede the use of illicit drugs such as marijuana and "hard" drugs.

The researcher supports Ellickson (1992:30) because in this study most of the participants started by taking cigarette and later resorted to hard drugs.

Substance related disorders refers to the mal-adaptive behaviour associated with substance use and substance induced cognitive disorder describes the direct acute or chronic effects of such substances on the central nervous system (Morse & Flavin, 1992:131)

2.4. ALCOHOL ABUSE

Alcohol prevails as one of the most addictive chemicals available. It is probably the oldest and most widely used drug. An immoderate use of alcohol may impair or diminish an individual's social, physical and emotional health and result in negative consequences for the individual. It is capable of causing extreme damage to the central nervous system, the circulatory system, as well as to the kidneys, liver, vision and breathing (Florenzano, 1990: 117)

Alcohol abuse has become an epidemic in our society and it should be treated as an illness. The use and abuse of alcohol and other forms of substance abused by young children represents urgent societal crisis. The Department of Education must shoulder some responsibility for the problems caused by alcohol and substance abuse. Children as well as adults should therefore assess ways to both detect and prevent these problems in their lives (Florenzano, 1990: 117)

2.4.1. Alcohol Consumption

Society has now been forced to develop rules that govern the time and manner in which its members can use mood-altering substances. The rules evolving from different societies vary significantly e.g. In the Middle East, dagga use is tolerated but strong religious sanctions exist against the use of alcohol, whilst in the United States the reverse is true (Doweiko, 1996:257)

Alcohol in not often thought of as a drug since it can be legally purchased in the most countries and it is commonly used for both religious and social purposes in most parts of the world. It is a drug however and compulsive drinking has become one of the modern society's problems. (Addiction Research Foundation, 1991:215)

The National Household survey on drug abuse reported that in 1998 over 100 million Americans aged twelve years and older reported that they consumed alcohol at least once during thirty days prior to the interview, approximately thirty-three million of this groups engaged in binge drinking, meaning they drank five or more drinks on one occasion during that thirty day period. Heavy drinkers constituted twelve million of this group. The percentage of the population falling into these different groups has not changed since 1988 (Drug Nexus)

Main patterns and trends:

- Drinking is mainly a male phenomenon, with females increasingly becoming consumers.
- The prevalence of drinking increases with age apart from tending to be more common among historically advantaged than disadvantaged youngsters.

- Comparatively, heavy drinking, who used to be largely an urban phenomenon, has increasingly spread to rural areas.
- Historical differences in the proportions of young people using various alcoholic beverages are equalizing.
- Enjoyment or fun, mood-change and coping are particularly common reasons for drinking.
- Youthful drinking tends to be associated with participation in festivities.
- In poor communities youthful drinking mainly takes place in public places, such as shebeens or taverns and bottle stores.
- A high level of absolute alcohol intake (7 cl AA-absolute or raw alcohol-on average per day) as well as morning drinking are fairly common among especially older males (18-20 years) who live in informal settlements and who are married
- Youngsters commonly experience direct pressure to drink (Grinspoon &Balakar, 1997:330).

2.4.2. Characteristics of Alcoholics

According to Rogers and MacMillan (1988: 173) "Some people think and believe that alcoholism can only develop if a person drinks a lot over extended periods, alcoholics are basically weak willed or they will be able to control their drinking, alcoholics have underlying psychological problems that cause them to drink excessively, the roots of alcohol drinking are in an alcoholics relationship with parents and treatment is useless unless an alcoholic wants to change and quit drinking".

Rix and Rix (1983:542) agree with Rogers and McMillan and in that alcoholics are clients who suffer from a chronic disease characterized by repetitive and compulsive drinking that produces injury to the drinkers health and other aspects of life.

According to the South African National Council on Alcoholism and Drug Dependence, (SANCAD 1995, P 11) most alcoholics lose control over drinking in amount, time and place. An alcoholic drinks more than he intends to, one drink instead of satisfying him seems to increase his desire for more. Drinking slips outside boundaries an alcoholic has set for it. The ability to confine drinking to certain times and places is sabotaged by the disease.

2.4.3. Alcoholism

Alcohol dependence or alcoholism is a chronic. Oppressive disease characterized by significant impairment that is directly associated with persistent and excessive alcohol consumption. Impairment may involve psychological, social and physiological function (Chein 1989: 113) similarly, Morse and Flavin (1992:109) explains the concept of alcoholism to be a primary, chronic disease with genetic, psychosocial and environmental factors, which influence its development and manifestations. The disease is often progressive and fatal. It is characterized by impaired control over drinking preoccupation with drug abuse and the use of alcohol despite adverse consequences and distortions in thinking.

Alcoholism is characterized by the following elements, as defined by the National Institute on Alcohol Abuse and Addiction (NIAAA 1996:115)

- Craving: a strong need, or compulsion, to drink.
- Loss of control: The frequent inability to stop drinking once a person has begun.
- Physical dependence: The occurrence of withdrawal symptoms, such as nausea, sweating, shakiness and anxiety, when alcohol use is stopped after a period of heavy drinking.
- Tolerance: The need for increasing amounts of alcohol in order to get "a high" (Conner, 1994:45)

There are two types of alcoholism.

TYPE 1: Alcoholism is noticed in both sexes and is associated with recurrent alcohol abuse (Conner, 1994: 46)

TYPE 2: Alcoholism is seen predominantly among males, has an early onset and is frequently associated with violent and antisocial behavior. In addiction, it may cause an individual to over-react to a wide range of stimuli, resulting in a cluster of behavioral problems (Conner 1994: 46).

2.4.4. Components of Alcohol Dependence

The World Health Organization (1993:79) distinguish between three components of alcohol dependence:

- **Psychological**: This may occur with regular use of even relatively moderate daily amounts of alcohol. It may also occur in people who consume alcohol only under certain conditions, such as before and during social occasions. This form of dependence refers to a craving for alcohol's Psychological effects, although not necessarily in amounts that produce serious intoxication. The users may not only experience withdrawal symptoms upon cessation of alcohol use, but they believe they cannot function without it, and tend to get anxious (Drug Nexus).

- **Physical:** The users body has become so accustomed to the presence of alcohol, that when it is no longer used, withdrawal symptoms occur. Such symptoms may be mild, such as sneezing, to very severe, such as potentially fatal convulsions. The seventy of withdrawal increases with the amount of alcohol consumed and the duration of abuse.

- **Addiction:** It is synonymous with physical dependence and withdrawal symptoms, and is also wildly known as "dependency".

2.5. TEENS: ALCOHOL AND OTHER DRUGS

Teenagers may be involved with alcohol and legal or illegal drugs in various ways. Experimentation with alcohol and drugs during adolescence is common. Unfortunately teenagers often do not see the link between their actions today and the consequences tomorrow. Using alcohol and tobacco at a young age increases the risk of using other drugs later. Some teens will experiment and stop, or continue to use occasionally, without significant problems. Others will develop a dependency, moving on to more dangerous drugs and causing significant harm to themselves and possibly others (Weber & McCormick, 1992:270).

Teenagers at risk for developing serious alcohol and drug problems include those:

- With a family history of substance abuse
- Who are depressed
- Who have low self-esteem, and
- Who feel like they do not fit in, or are out of the mainstream

Children from alcoholic and drug abusive families are four to six times more likely to become alcoholic than in children raised in non-alcoholic and drug abusive homes (Weber & McCormick, 1992:276)

Drug use is associated with a variety of negative consequences, including increased risk of serious drug use later in life, school failure and poor judgment, which may put teens at risk for accidents, violence, unplanned and unsafe sex and suicide (Webber 1984: 120)

2.6 EFFECTS OF ALCOHOL ABUSE ON THE FAMILY INCLUDE:

- Family organization.
- Family head may be lost, blurring of roles between father and mother, and children in the family.
- Relationship between families may become unstable.
- Family stability offered by the parents to their children and to other members of the family is lost, and conflict, violence, lack of respect may occur.
- Single parenthood
- Poverty to the rest of the family
- Decreased parental control over children, children do not attend school, which leads to poor performance of school goers, and failure in grades, which results in early drop out from school.

2.7. WARNING SIGNS: OF TEENAGE ALCOHOL AND DRUG ABUSE:

The following are source of common warning signs of alcoholic abuse: -

Physical – Fatigue, repeated health complaints, red and glazed eyes, and a lasting cough

Emotional: Personality change, sudden mood changes, irritability, irresponsible behavior, low self-esteem, poor judgment, depression and a general lack of interest.

Family: Starting arguments, breaking rules, or withdrawing from the family.

School- Decreased interest, negative attitude, dropped grades, truancy and discipline problems.Social- New friends who are less interested in standard home and school activities.Problems-Problems with the law, and changes to less conventional styles in dress and music (McBride & McCoy, 1993: 273).

2.8. PERSONALITY CHARACTERISTICS

Adolescents who display personality characteristics seem to be more prone to developing substance abuse problems. According to Shelder and Block (1990: 11) these include

- Impulsivity
- Depression
- Anger
- Achievement Problems.

Psychoactive substance dependence is defined as the presence of at least three of the following symptoms for at least once a month (Shelder & Block, 1990: 127)

- The person uses more of the substance or uses it for a longer time that intended
- The person recognizes excessive use of the substance and may have tried to reduce it but has been unable to do so.
- Much of the person's time is spent in efforts to obtain the substance or recover from its effects.
- The person is intoxicated or suffering from withdrawal symptoms at times when responsibilities need to be fulfilled, at school or work.
- Many activities are given up or reduced in frequency because of the use of the substance
- Problems in health, social relationships, and psychological functioning occur.
- Tolerance develops, requiring larger doses (at least a 50 % increase) of the substance to produce the desired effect.
- Withdrawal symptoms develop when the person stops ingesting substances or reduces the amount.
- The person uses the substance to relieve withdrawal symptoms. For example, one may drink alcohol early in the morning because one feels withdrawal symptoms coming on.
- Tracks or needle marks (usually on arms, hands and neck)
- Excessive use of breath mints (masks the smell of drugs)
- Unwarranted laughter (associated with marijuana)
- Bad attitude in the morning

- Gradual disappearance of valuables
- Burns on fingers
- Yawning (withdrawal symptom) (http: www.addictions_net/warning.html)

2.9. THE FAMILY AND TEENAGERS DRUG AND ALCOHOL USE

The family plays an important role in the development of children's attitudes and behaviors. Family influences are strongly associated with drug and alcohol use in young children (Zigler. E.R. 1996: 114).

Children who abuse drugs and alcohol tend to have parents who are extremely permissive, meaning that they place very few demands on their child and give them a lot of freedom. Parents that are neglectful or uninvolved are also putting their children at risk for drug and alcohol use (Baumrind, 1991:114). There are two other factors that could put children at risk of substance abuse, one is that many of these children with substance abuse problems come from families in which one parent or both use drugs. In this way, the children are exposed to the drug use and made to think that it is okay. Second, the parents may not object to their children's using drugs and therefore send a message that is okay to use drugs and alcohol.

2.9.1. Parental Influence

Children learn their drinking behaviors from watching and imitating their parents. Parents who use drugs and alcohol are more likely to have children who use drugs (Prusoff, 1989: 130). Adolescents who reported that their parents drank heavily had higher alcohol use in early adolescence than those who had parents who did not drink heavily (Weinberg, Dielman, Mandell & Shope, 1994:230)

2.9.2. Parental Attitudes and Norms Influence

When parents view drug and alcohol use as normal in their own lives there is higher rate of initiation, escalation, and continued use in those adolescents. Also parents who are lenient about adolescents that are more likely to be users.

Parental norms can be communicated indirectly to adolescents through how parents involve their children in their own substance use. For example, letting them pour or serve alcoholic drinks has been found to contribute to adolescent alcohol use (Prusoff, 1989:138).

Adolescents who had never smoked marijuana reported that their parents would strongly disapprove if they used marijuana. Those who did not smoke marijuana were less likely to report their parents would disapprove of their marijuana use (Dielman, 1995:243)

2.9.3. The Parenting Style Influence

The relationship between parents and children also influences drug and alcohol use. The quality of parental socialization is an important factor since parental closeness and open communication has been found to discourage substance abuse (Prusoff, 1989: 138)

Parenting style factors associated with high drug and alcohol use in teenagers includes (Prusoff, 1989: 142).

- Few or inconsistent reward for positive behavior
- Unclear expectations for behavior
- Inconsistent punishment
- Poor monitoring of behavior
- Low perceived parental love

It is important for parents to discuss the negative aspects of drug and alcohol use with their children. Also parents should express their own views on drug and alcohol use and explain what they expect from adolescents in regard to if they use or not (Prusoff, 1989: 145).

2.10 THE USE OF OTHER DRUGS

A number of studies pointed to cannabis as the most commonly used drug among young people besides alcohol, over the counter medicine and tobacco, apart from being particularly prevalent among males (Van der Burgh, 1975:20)

Except for the 1994 survey, limited information has been accumulated on the context of drug use, e.g. on the place of use, time of use and type of company when drugs are used. The 1994 survey (Rocha-Silva. 1992:103) pointed out that licit drug use (alcohol and cigarettes) took place in company, the opposite applied to illicit drugs and inhalants.

A comprehensive review as prescribed in a paper read by Lombard at the 9th International Conference on alcohol, Liverpool UK, of research projects conducted between 1962 and 1996 and pertaining to alcohol and drug use in South Africa, highlighted the following points:

- Licit and illicit drug use tend to intertwine
- Young people tend to copy the drug use patterns of adults
- Drug use patterns tend to be associated with broader socioeconomic conditions, such as level of educational/ employment opportunities and the distribution of health and welfare services (Wonga, 2000:79)

2.11. THE RISE IN THE GENERAL LEVEL OF DRUG-USE

International and Regional calls for preventive action and particularly for comprehensive and integrated measure against the harmful results of alcohol, tobacco and other drug use have progressively intensified (World Drug Report, 1997, Declaration and Plan of Action on Drug Abuse and Illicit Trafficking Control on Africa, 1996, World Health Organization). For example, at a special session in 1998 the General Assembly of the United Nations committed itself to strengthening efforts at countering socio-economic and health problems related to the production and use of illicit drugs throughout the world.

Also contributing to the calls for comprehensive action against drug-related harm are indications that since at least the beginning of the 1990's, a progressive global rise in the general level of alcohol, tobacco and other drug use has been evolving, across region and group (The Drug Nexus Africa, 1999:147).

The concern about the global rise in the prevalence of drug use especially relates to substantial evidence that the overall level of drug use (prevalence, frequency, quantity of use and number of drugs used) in a community tends to correlate with the level of various harm in that community (World Drug Report, 1997).

The general level of drug use has also increased on the African Continent and it calls for preventive action. (Drug Abuse and Illicit Trafficking Control in Africa, 1999: 109). The rise in drug use on the African continent has been evidenced by a number of studies. For example, a recent comprehensive study of the United Nations drug Control Programmed (UNDCP) in ten sub-Saharan countries points to a broadening and an intensifying use of psychoactive drugs in these countries.

The types of drugs used, patterns of use and the categories of users are widening (The Drug Nexus in Africa, 1999). Apart from drugs that have been traditionally used (namely, alcohol, tobacco, cannabis and indigenous plant based substances such as Khat, Iboga and Narcotics), pharmaceutical depressants and stimulants, severe pain relivers and solvents have emerged within the non- medical consumer market. The emergence of the "new" Drugs has been selective across regions and socio-economic and demographic groups. For example, the use of solvents is particularly common among urban street children (The Drug Nexus in Africa, 1999:312).

Socially acceptable drugs, historically used by selective regions, groups and settings have come to be used more widely. For example, the UNDCP study found that although historically cannabis consumption has been a male practice, this is starting to change with consumption (Holder, 1995:111).

It is now increasingly into different gender, age and religious groups (e.g. Rastafarians), young people from high-income families and university students (The Drug Nexus in Africa, 1999:135).

Desjarlais (1995:100) notes in this respect that prostitution; theft and exploitation are directly correlated to drug use, leading to decay in the cultural and moral fabric of a community.

2.12. CATEGORIES OF DRUGS

2.12.1. Narcotics / Opiates

Narcotics are drugs obtained from opium and their function is that of relieving pain. Some of the drugs in this category are known as morphine. If these drugs are used in large doses, they make the user experience euphoria, that is a sense of well-being which is associated with relaxation and apathy. Heroin's dominant effect is a feeling of well-being, which is part of the lure that attracts people to this highly addictive and very dangerous drug (Rathus, 1990:211)

2.12.2. Sedatives

Sedatives are also known as downers and are drugs capable of inducing sleep, and as such they down the central nervous system's activation and behavioral activity. They are known as barbiturates and are derived from barbituric acid. As a result of using a large dose, the user is under the same influence as an alcohol abuser and therefore experiences a sense of euphoria. However, overuse of barbiturates can cause difficulty in walking or talking, unconsciousness, coma and death (Sridhar, 1994: 109)

2.12.3. Stimulants

Stimulants are intended to increase central nervous system activation and behavioral activity. Some of these drugs are caffeine and nicotine, which are relatively mild, whereas cocaine is a very strong stimulant. Both amphetamines and cocaine can cause behaviors that are indistinguishable from certain kinds of mental illness" (Harrison, 1996:33).

Caffeine is associated with tremors, increase in heart rate and restlessness, amphetamines lead to an increase in blood pressure and breath rate; depress appetite, cause rapid and irregular heartbeats and cause dryness in the mouth. Use of cocaine is followed by dizziness, low blood pressure and convulsions. Excessive use of cocaine could lead to mental disorder, hallucinations, difficulty in controlling ones thoughts and confusion in ones thoughts. A person may feel paranoia and believe that someone is after him (Sridhar, 1994: 111)

2.13 MARIJUANA

Marijuana (grass, pot, weed) is the common name for a crude drug made from the plant Cannabis sativa. The main mind-altering (psychoactive) ingredient in marijuana is THC (delta – 9- tertrahydrocannabinol), but more than 400 other chemicals also are in the plant. Marijuana " joint" (cigarette) is made from the dried particles of the plant. The amount of THC in the marijuana determines how strong its effects will be. The type of plant, the weather, the soil, the time of harvest, and other factors determine the strength of marijuana. The strength of today's marijuana is as much as ten times greater than the marijuana used in the early 1970's (Paria, 1996: 77)

2.13.1. Effects of Marijuana

Some immediate physical effects of marijuana include a faster heartbeat and pulse rate, bloodshot eyes, and a dry mouth and throat. No scientific evidence indicates that marijuana improves hearing, eyesight, and skin sensitivity. Studies of marijuana's mental effects show that the drug can impair or reduce short-term memory, alter sense of time, and reduce ability to do things which require concentration, swift reactions, and coordination, such as driving a car or operating machinery. A common reaction to marijuana is the "acute panic reaction". People describe this reaction as an extreme fear of "losing control," which causes panic. The symptoms usually disappear in a few hours (Paria, 1996: 79)

Physiological Effects

- Serious damage to lungs
- Increased heart rate
- Interferes with sexual performance
- Alters mood, memory and coordination and reproduction

Behavioral Effects

- The ability to perform complex tasks is strongly impaired
- Feelings of paranoia
- Feelings of euphoria

Psychological Effects

- Poorer physical and mental health
- Rebellion and tolerance of deviance
- Lower academic achievement
- More involved in other delinquent behavior

Some studies have linked marijuana use to lung-cancer (Sridhar, 1994:125). One joint is approximately equivalent to five tobacco cigarettes in terms of carbon monoxide intake, four cigarettes in terms of tar intake, and ten cigarettes in terms of damage to cell linings in the lungs (Sridhar, 1994: 127).

Marijuana has been linked to reduce effectiveness of the immune system (Sridhar, 1994:132), and Cannabinoids receptors have been found on the cells of the immune system (Sridhar 1994:134). However, most evidence suggests that this reduction is temporary and might not be of medical concern. Smoking marijuana during pregnancy has been linked to low birth weight and prematurely, and fetal exposure has been associated with later problems in thinking and attention (Hatch & Bracken 1986:109). Furthermore receptors for anandamide have been found in the cells of the uterus of mice and rats (Paria, Deutcsh & Day, 1996:200).

High doses can produce a toxic delirium or psychosis, the symptoms of which include confusion, agitation, disorientation and even hallucinations (Grinspon & Bakalar, 1999:24).

2.13.2. Psychological Dependence on Marijuana

Long-term regular users of marijuana may become psychologically dependent. They may have a hard time limiting their use, they may need more of the drug to get the same effect, and they may develop problems with their jobs and personal relationships. The drug can become the most important aspect of their lives.
One major concern about marijuana is its possible effects on young people as they grow up (Paria, 1996: 82)

Research shows that the earlier people start using drugs, the more likely they are going to experiment with other drugs.

In addition, when young people start using marijuana regularly, they often lose interest and are not motivated to do their schoolwork. The effects of marijuana can interfere with learning by impairing thinking reading comprehension, and verbal and mathematical skills. Research shows that students do not remember what they have learned when they are "high" (Paria, 1996: 85)

How are people usually introduced to marijuana?

Many young people are introduced to marijuana by their peers- usually acquaintances, friends, sisters and brothers. People often try drugs such as marijuana because they feel pressured by peers to be part of the group. Children must be taught how to say no to peer pressure to try drugs. Parents can get involved by becoming informed about marijuana and by talking to their children about drug use (Paria, 1996: 90)

What is marijuana "burnout "?

"Burnout" is a term first used by marijuana smokers themselves to describe the effects of prolonged use. Young people who smoke marijuana heavily over long periods of time can become dull, slow moving, and inattentive. These "burned-out" users are sometimes so unaware of their surroundings that they do not respond when friends call them (Paria, 1996:92)

2.13.3. How to Recognise Marijuana Abuse

The dagga-abusing youngster generally changes gradually following his introduction to dagga. Some signs to look out for include the following:

- Giggling
- Short attention span and inability to concentrate
- Distorted perception of time, distance, body image
- A gradual loss of drive and motivation, a loss of interest in all normal activities and a don't care attitude towards everyone and everything

- A deterioration in school work, giving up of sport, a change of friends to an equally "don't-care" group, dreamy withdrawal from family interests and activities
- Dark yellow stains on the hands
- Frequent coughing and bronchitis
- Bloodshot eyes or the persistent use decongestant eye drops and glasses to hide red eyes (Roper; 1991).

2.14. SUBSTANCE ABUSE AND BEHAVIOUR

Kandel (1975: 113) who wrote of Delinquent boys, believed that there was a correlation between delinquent behavior and drug use as well as drug abuse, primarily in lower-class peer groups (Hanson, 1995:245). Drug use can be associated with crime.

Drugs may activate criminal behaviour, especially if they are taken to help the person commit the crime. For instance, money to buy drugs may be gained through crime. For example (Post July, 2003) it was said that there was an Indian man who was robbed on his way home work by youngsters who wanted money to buy drugs, but they only found as little as R5 in his pocket. Drugs have been associated with gang organization and other such related activities. Some gangs deal in drugs and use this money to support their activities.

The attitude toward drug taking behaviour at the close of the twentieth century is quite different from the attitude that prevailed even as recently as a few years ago. There is a far greater awareness that a wide range of psychoactive drugs, whether they illicit or licit, all qualify as substances with varying levels of potential for abuse (Edwards & Gross, 1976: 129)

2.15. CAUSES OF ALCOHOL AND DRUG ADDICTION.

There is no single cause of alcohol and drug addiction. Research certainly shows that a genetic predisposition to alcoholism can be inherited (Weber & McCormick, 1992:24). However most researchers seem to be in agreement that the environment has the largest effect on whether or not a teenager will become addicted.

Other contributing factors are lack of effective parenting whether or not their friends use drugs, whether they smoke or already use other substances in moderation, and if they have other psychosocial problems. The need to give special attention to multiple drug use and injecting drug use relates to the following factors (World Drug Report, 1999:56).

Factors relating to the need to multiple drug use:

- The comparatively high prevalence of sexually transmitted diseases on the African continent,
- The severe burden that these diseases impose on health care systems,
- Multiple drug use and injecting drugs increase the chances of involvement in risky practices (e.g. indiscriminate sexual activity).
- The use of heroine is spreading in Africa
- Heroine users tend to inject this drug, especially when the drug is comparatively expensive and difficult to obtain.

McLatchie and Lamp (1988:265) states that loneliness, boredom, depression, disappointment and any kind of stress precipitate alcohol drinking and alcohol related problems.

Exposure of the youth to alcohol is an important etiological factor that influences the already existing prevalence of alcoholism in a community on the youth. In children exposed to abuse of alcohol in the home, especially in communities where it carries no social disapproval, the example of parents and their friends exert a powerful effect on the lifestyle of the growing child. Alcohol may become a way of life perpetuated from one generation to another (World Book, 1992:62)

Rix and Rix (1983:135) and the World Book (1992:67) agree that genetic influences play a part in causing alcohol problems. Dorris and Lindley (1968) add that superimposed upon the medical and physical difficulties involved there are emotional, legal social and political implications which have generated further complications for alcoholics Florenzano (1990:137) also agrees that genetic influences predispose some people to develop alcoholism.

Kwakman, Zulker Schippers and Wuffel, (1998:230) state that parents influence their children in a myriad of ways, these parents may displays drinking patterns problems, which could be imitated by their children when they began to drink.

Wiggins and Wiggins, (1992:201) state that college drinking is a social activity, which occurs and may be influenced by peers. According to Fisher (1994:17) difficulty in establishing a healthy self concept and strong feelings of personal identity in family, job and community predispose one to alcohol-related problems e.g. rural youngsters moving to cities are particularly vulnerable in this respect.

2.16. WHY PEOPLE USE DRUGS

Different people use different drugs for different reasons. While one person will use alcohol to facilitate group interaction at a party, another may smoke Marijuana as a political statement. The reasons individuals use psychoactive substances vary as much as the individuals themselves:

- To seek mood fluctuation
- To enhance athletic performance
- To supplement behavior in bar settings
- To fight boredom
- Out of curiosity
- To be "in" as opposed to being "left out".
- As a protest (Wovacek, J. Raskin & Hogan, 1991:132)

The many reasons for psychoactive substance use are similar to those mentioned in above but they can be broken down into 2 major cluster groups:

- Psychological, and
- Sociological (environment)

Some people use drugs to gain spiritual enlightenment and to enhance religious ceremonies. Medical studies have determined that psychoactive substances can produce profound perception changes that can enhance and facilitate spiritual experiences. The Native American Indian Church of the American Southwest and the Tarahumara and Huichol Indians of Mexico utilize the Peyote Cactus, whose plant buttons contain Mescaline.

Buddhist religious rites call for the use of marijuana (ganja), a rich potent tea made from cannabis (dagga) (Wovacek, Raskin & Hogan, 1991:137)

"To the Hindu, the hemp plant is holy. A guardian lives in 'bhang' (usually known as dagga), which is the joy-giver, the sky-flier, the heavenly guide, the poor man's heaven, the soother of grief. No god of man is as good as the religious drinking of bhang. The students of the scriptures of Banares are given bhang before they sit to study." (Wovacek, Raskin & Hogan, 1991:139)

When used in a religious setting- be it a temple or the desert alcohol-cannabis (dagga) and psychedelic drugs can elevate the emotional intensity of a persons perception.

2.17. SOCIAL FACTORS INFLUENCING SUBSTANCE ABUSE

Peer group pressure influences our activity phenomenally. Peers copy the activities and behavior of other peers as a way of learning social behaviour and as a way of acceptance. Behavior acquired through environmental influence is visible in the young of many species as they learn survival techniques. In humans, drug consumption is often a group entrance requirement. In the process of gaining entrance to a group, people prove themselves to the group (Van der Burgh, 1975:145).

The family also affects attitudes toward drug use although its effect, more pronounced in a child's earlier years, diminishes as peer influence increases Parent figures are powerful models that cue the behavior of their progeny. Young children model the behavior of their parent in much the same way individuals seeking group entrance do. For example, children born into alcoholic families are more likely to become alcohol abusive or dependent than those youth growing up in families in which use levels are Non existent to moderate (Van der Burgh, 1975:149)

2.18. PEER RELATIONS

Adolescents who use drugs are much more likely to have friends that also use drugs. There are two reasons for this:

- The adolescent may be influenced by those friends to try alcohol and drugs and to continue to use them.
- The adolescent may be drawn to these friends because of their common drug use (Sternberg, 1995:245).

Some take drugs to alter their mood or state of mind in a pleasurable way that signifies a movement toward adulthood.

2.18.1 Attachment

The past research suggested that it is parents own attachment style, which has the greatest impact on the attachment style of their children (Billar, 1974:149)

Parents are the most important attachment figures for their children; therefore any intervention, which aims to help children, should start within the family (McKay, 2001: 31). She mentioned a number of reasons why the parents may not have been able to give their children a secure base. She further mentioned that, if there is a lack of social security, children tend to take drugs

2.18.2. Some social and political factors are:

- The legacy of the apartheid laws, such as domestic labour, migrant labour and the pass system, which forcibly separated black parents from their children.
- Poverty, which might mean that parents have to work wherever they can find a job, even if it means leaving the children alone or with others for long periods of time(Ramphele, 1994:135)
- Poverty also puts stress on the home, basic necessities are in short supply, parents are tense about being able to provide, and money worries can make them irritable and easily angry.
- Alcohol and drug abuse in parents: intoxicated parents often do not have the mental space, and alertness to be sensitive to their children's feelings
- Marital disharmony: parents who are so busy quarreling with each other or feeling hurt that they cannot pay attention to the impact this has on their children

- Lack of Social support: loneliness and isolation, which leads to mothers feeling persecuted by the emotional demands of their children
- Post Traumatic stress disorder: a frequent consequence for survivors of political, criminal and domestic violence, including sexual abuse, leaves parents pre occupied with the mental pain and fear. They can also be triggered into flashbacks to the traumatizing situation, which may make them treat their children in bizarre ways.

- Depression or mental health difficulties in the parents, which leave them too preoccupied with their own pain to focus on their children (Ramphele, 1994:152)

2.18.3 Poverty and substance abuse.

Jaffe (1999:201) who researches social issues found out exactly what it is about poverty that seems to lead to an increase in drugs in young children. In his findings he found that: low income for families causes depression in parents and most importantly, in mothers, and depressed mothers bring up depressed and angry children. What the researcher thought was most important about his research was that it showed how poverty created the conditions for drug abuse. The link is psychological as well as social and economic. It is how poverty makes people feel about themselves, and others, that drugs become a way of getting rid of these painful and unmanageable emotions

McKay and Adlam (2001:130) show that drugs are associated with being male, young and from low-income families. Women from the same type of families tend to be depressed, may misuse drugs/ alcohol, or otherwise take out violent feelings on themselves. The difference between the families of violent and non-violent males from low-income families is explained by the presence of parental abuse, parents arguing and parents being constantly irritable. This irritability and disharmony means that children get very little positive loving attention.

2.19 Psychological Factors Influencing Substance Abuse

Self-esteem is the positive or negative way in which you judge yourself .It is also the extent to which you view yourself as a competent worthwhile and likeable person.

The way you feel about yourself influences everything you do in life. It influences how you experience the world around you, also how others respond and react to you (Van den Aardweg, 1999:179)

Self-esteem is the foundation of emotional well-being. A person with strong self-esteem is able to relate to other people, feel comfortable with him or herself, cope with disappointments and stress, solve problems, make decisions, celebrate success, enthusiasm for life.

People with low self-esteem often find themselves unable to take the action that they should. An example would be when a teenager is unable to say "no" to drugs even if he knows that it not what he wants.

2.20. DRUG ABUSE AMONG HOMELESS PEOPLE AND STREET CHILDREN

Considering that young people, like women, are " over represented" among the very poor, that homeless/street children are increasing, and that the level of drug use and involvement in illicit drug trafficking are rising among children and young people, preventive programmes need to give special attention to this group and in particular to the homeless or among them. Consideration of the following seems appropriate". Due to the multiple health problems that homeless youth experience, their drug use adds a further immense burden. They experience the direct effects of their drug use: the brain damage from solvents and petrol; the psychosis from cannabis, amphetamines and hallucinogens and the risk of AIDS and hepatitis B. They also experience the consequences of a lifestyle which surrounds drug use-the violence; the sexual exploitation; the crime; the scarce educational, recreational and vocational opportunities; the isolation and dislocation from their peers and families, and the lack of shelter and security for many, the drug culture and economy becomes an integral part of their lives" (World Drug Report, 1999: 84).

CHAPTER THREE

3. THEORETICAL FRAMEWORK

3.1. PREAMBLE

The theoretical framework guiding this study includes systems theory, the humanistic model, behavioural theory and biopsychosocial theory.

3.2. SYSTEMS THEORY AND SUBSTANCE ABUSE

A system is a whole, made up of mutually independent parts. "Systems Theory states that in any system change in one part has an impact on others," (Berger, Federico & McBreen, 1991:87).

A system is seen as a number of inter-connected elements, and they continually influence each other. By adopting systems theory, a holistic approach can be adopted in understanding the problem of substance abuse in primary school. This approach enables service provides to view substance abuse to be viewed as being more than a hobby or habit (Berger, Federico & McBreen, 1994:87).

All members of a family are enmeshed in a network of interdependent role status, values and norms. What one member does directly affects the entire family system. People typically behave in ways that reflect family influences. This theory concentrates on the family's influence on individual behavior (Hartman & Laid, 1983: 83).

Family systems theories are also called bridging theories because they highlight the connections among the life domains of the individual, namely, the biological, social, psychological and connections among the individual, the family, and the larger environment. Bridging theories imply a positive view of human potential and the interactions that take place between these interdependent systems. An underlying assumption is that families do the best they can even when substance abuse and other problems exist (Hartman & Laid 1983:84).

There are a number of additional assumptions related to general systems theory and family systems approaches include the following (Hartman & Laid, 1983: 79).

- Systems seek to maintain a steady state or the status quo even if the current circumstances are dysfunctional and painful (as when a family has an addicted member)
- Transitions and milestones represent opportunities for growth and for crisis
- Change related to systems is circular rather than linear (addiction and other problems are both responses to and influences on the family system).
- A system's health so based on its ability to initiate change as needed (to give indications of the need for help in resolving the addiction, and other problems, to seek and use help, to use internal and external resources to maintain the necessary changes).
- Problems develop in boundary areas within and between systems (within the family and between the family and other systems).
- Problems such as addiction manifest themselves as symptoms that are a response to the system's needs for survival, although they may be contradictory to the member's individual needs.
- A lack of differentiation occurs in families that are too inflexible, hypersensitive to feelings, and unable to tolerate emotional closeness without anxiety (addicted and other dysfunctional families become fused in their mutual efforts to maintain the system).
- A lack of differentiation, unresolved family issues, dysfunctional patterns such as addiction, and losses are passed to future generations, often manifested as problems on anniversary dates or stages of the life cycle (Hartman & Laid, 1983:82).

The integral part of the structure and daily fabric of the family, the impact of the addiction goes far beyond the effects on individual members. Internally the units and the members needs become secondary to the addicted member's compulsion for alcohol and other drugs and the system's maintenance (Prusoff, 1999:70)

Personality development is ruled largely by the attributes of the family; especially the way parents behave around their children. Abnormal behavior in the individual is usually a reflection or "symptoms" of unhealthy family dynamics, more specifically of poor communication among family members. According to this theory disorders are not seen to reside within the individual, but within the family system (Prusoff, 1999:72)

Ellickson, Hays and Bell (1992:109) also stressed the child-parent relationship. He said that parental love and attention are important for the child to develop a sense of trust.

We all need a few people on whom we can rely and in whom we can confide with confidence. Without this trust relationships are hostile and threatening. As a result we may shun close personal relationships and even avoid causal social interactions. How trust develops in a child depends very much on the parents. This means day-to-day operations of the family system, including communicating among its members. Inconsistent communication or a distorted pattern of operations can cause children to develop a misconception of reality. Communication mostly occurs at two levels, verbal and non-verbal. The verbal content of a message can be enhanced by its non-verbal content.

3.3. THE HUMANISTIC MODEL

This model suggests that people are basically rational, and that abnormal behavior results from inability to fulfill human needs and capabilities. The humanistic model of abnormality concentrates unequivocally human, viewing people as basically rational, oriented toward a social world, and motivated to get along with others. (Rogers, 1980:554). Although diverse in many ways, all humanistic approaches to abnormal behaviour focus on the relationship of the individual to the world, on the ways in which people view themselves in relation to others and see their place in the world in philosophical sense. People have an awareness of life and of themselves that leads them to search for meaning and self-worth. Humanistic theorists view abnormal behavior as an understandable reaction to circumstances arising in the person's daily life. Moreover, the humanistic model suggests that people have a relatively high degree of control over their lives and can make informed and rational choices to overcome their difficulties (Hollingshead & Redich, 1991:554).

The humanistic model is not without its detractors. It has been criticized for its use of unscientific, unverifiable information, as well as for its vague, almost philosophical formulation related to such concept as " human striving" and fulfillment of human needs. Despite these criticisms, the humanistic model offers a view of abnormal behavior that stresses the unique aspects of being human and provides a number of important suggestions for helping those with psychological problems(Regier & Redich, 1991: 452).

3.4. BIOPSYCHOSOCIAL APPROACH ASSESSMENT OF PERSONALITY

Persons who favour the biological approach warn that "Any theory that ignores the evidence for the biological underpinnings of human behavior is bound to be an incomplete one" (Kenrick and Dantchik, 1983: 302). Ancient and modern thinkers alike have recognized the biological basis of personality.

The Texas Adoption Project found that, in regard to personality, children tend to resemble their biological parents more than their adoptive parents (Loehlin, Willerman &Horn, 1990: 540) Findings such as these indicate that parent-child personality similarity is influenced more by common heredity than common life experiences.

Research has failed to find the strong relationship between somatotype and personality. Putting aside the question of the relationship between physique and personality, how heritable is personality? The heritability of personality is the extent to which the variability in personality in the population is caused by heredity. Estimates of the heritability of personality vary from about 25 percent (Webber 1984:505) indicating that environment is more important than heredity, to about 60% (Tellegen, 1988:702), indicating that heredity is more important than the environment.

One's personality is unique, relatively consisted pattern of thoughts, feelings, and behaviours. Closely related to personality is temperament, a person's most characteristic emotional state. Sheldon's constitutional theory holds that different temperaments are associated with different physiques or somatotypes. Research in behavioural geneties has found evidence of the heriditary basis of temperament and other aspects of personality (Lander, 1998:138)

There are no 'typical substance-abusing children, no specific personality type, family history, socio-economic situation, or stressful experience that has been found to predict categorically the development of teenage substance abuse.
Various physiologies, psychological and sociological factors have been associated with substance abuse (Lander, 1998: 138)

PHYSIOLOGICAL FACTORS

If there is a history of alcoholism or substance abuse in the parents or grandparent, an adolescent may have a physical predisposition to addiction.
There is little or nothing of a physical nature that can be done to reduce this predisposition, but it is useful for the adolescent to be aware of it so he can take precautions to avoid undue risks or psychological and sociological pressures that may lead to substance abuse (Lander, 1998:142)

PSYCHOLOGICAL FACTORS

Among the major psychological factors involved in substance abuse are emotions and personality. Psychological factors are often directly related to sociological factors. For example, a child who grows up in a family where there is a great deal of stress may develop certain methods of coping with stress or learn to withdraw from stress altogether. On the other hand, a child who grows up where there is little stress may not handle stress well at all in later life.
Psychological factors that affect substance abuse include mental obsessions, emotional compulsions, a low self-image, negative attitudes, rigid defense systems and delusions (Lander, 1998:150)

SOCIOLOGICAL FACTORS

The interactions between the adolescent and those around him or her, including family processes with the family of origin, nuclear family and extended family members, affect an adolescent's substance abuse. The education process or involvement with school is often important to an individual's self-image (Lander, 1998:155)

3.5.THEORIES OF ALCOHOL AND ALCOHOL DEPENDANCE

No theory has been found to define alcoholism or problem drinking. It is not a disease state such as Tuberculosis, which has a clear diagnosis. Hore (1990:25) states, " Alcoholism is best regarded as more than a uni-dimensional illness involving more than a single factor".

3.5.1. The Moral Theory

Historically, the moral theory has been the most dominant. In Eighteenth Century Britain, an act for repressing "the odious and loathsome sin of drunkenness" was passed.
Hogarth depicted this moralistic view in his cartoon "Gin Lane", which shows all the ramifications of alcohol excess, and includes drunkenness, child neglect and starvation.
The Moral Theory exerts a powerful influence on contemporary attitudes toward alcohol problems. Even though alcohol abuse is labeled as an "illness", many who have value, self – control, self –restraint and respectability believe, at root, that it stems from a moral failing (Jaffe, 1998:551).

3.5.2 The Genetic Theory

The genetic theory contends that certain individuals, who are born with a susceptibility to alcohol dependence due to a possible lack of certain unknown metabolic factors, are inevitably alcohol dependent. Thus the theory goes together with medical theory (Holder, 1995:131)

3.5.3 The Physical View

Dr. E.M. Jellinek, which he referred to as the "Disease Concept of Alcoholism", originally formulated this view; it explains that people who become alcoholics are born with a specific physical vulnerability to the physiological effects of alcohol. Due to this vulnerability, their reactions to alcohol differ from others. This need becomes an obsession and eventually an addiction.

3.5.4. The Medical Theory

The medical or disease theory, based on the concept of an illness or disease, gradually succeeded the original moral theory. It originated and gained acceptance in the USA, owing its origin largely to the development of the Alcoholics Anonymous (AA) movement and then the research of Dr E .M. Jellinek.

Dr Jellinek is perhaps the most quoted scientist who has researched alcohol problems and it is due to his work that both the medical profession in the United States and the World Health

Organization (WHO) came to accept alcoholism as a disease. Too often Jellinek's work has been oversimplified in interpretation. He attempted to give an unbiased and factual description of a subject, which had been treated subjectively. He was able to dissociate himself from an American cultural bias and to look at the problem form the viewpoint of other cultures and ethnic groups in the world. He did not intend to produce a rigid narrow model or theory (Pattison, Sobell & Sobell, 1991:137).

According to the theory the individual suffering from alcohol dependence has an incurable disease and his only salvation is to abstain from alcohol. The classical Alcohol Anonymous (AA) approach states that he is suffering from an "allergy to alcohol", that he is and always will be an alcoholic in terms of this, he must seek the intercession of a spiritual or divine power.

The classical theory was defined in terms of tolerance to alcohol, withdrawal symptoms, craving, loss of control and inability to abstain (Glatt, 1998: 104). It is argued that the term "alcoholic" is outdated and imprecise, yet it is still likely to be used by the general public for some time. When Jellinek used the term, however, it was to describe the five different types of "alcoholics"; alpha, beta, gamma and delta. A heavy or excessive drinker (or inappropriate drinker) needs to be a dependent drinker, but he could still be affected by the impact of alcohol abuses as regards alcohol-related diseases, social problem, poor productivity and accidents.

The distinction between an alcohol abuser or problem drinker and dependent drinker is important as regards handling the individual in the occupational setting, though management tends to be primarily concerned with alcohol abuse (Albertyn & McCann, 1993: 172). However, in recent years has been a backlash against the concept of alcoholism as a disease and against the medical theory. Critics state the disease concept implies the affected individual is the helpless victim of biographical predestination and is powerless to correct his or her behavior. This leads to an unnecessary erosion of personal responsibility (Denenberg & Denenberg, 1991:204).

3.5.5. The Behavioural Theory

The behavioural theory offers an alternative view to the medical theory, stressing as it does that drinking is a learned behaviour and that problematic or inappropriate behavior coupled with external influences is the prime consideration in developing an abnormal drinking state.

Alcohol abuse is considered a reflection of an individual's poorly developed ego. According to the theory, if the behavior problem can be solved, or empowerment developed, then the individual can be cured. Changing the environment and the behavior of the problem drinker is regarded as significant in altering his drinking pattern (Albertyn & McCann, 1993:213).

B.F. Skinner's operant conditioning theory assumes that what we call personality is simply a erson's unique pattern of behaviour. Behavioural assessment is accomplished through behavioural observation, the situational interview, and the experience-sampling method.

COGNITIVE THEORY

Albert Bandura's Social-Cognitive theory argues that cognitive process influence behaviour. His concept of reciprocal determinism points out the mutual influence of personality characteristics, overt behaviour, and environmental factors. One of the most important personality characteristics is self-efficacy, the extent to which a person believes that he or she can perform behaviours that are necessary to bring about a desired outcome.

3.5.6. The Alcohol Dependence Syndrome Theory

The alcohol dependence syndrome proposed by Edwards & Gross (1976:112) actually fall under the heading of the medical theory. It described a syndrome and therefore a disease or state of illness, but Edwards argues against placing drinking problems into pigeonholes. He feels to do so is to over-simplify a complex and varied problem. The task is to identify each individuals drinking pattern as it exist and only then try to identify -the influences that shape this pattern. The World Health Organization (WHO) distinguished between problem drinking and dependency.

It no longer uses the term "alcoholic", preferring the term "alcohol dependent" or person suffering from the alcohol dependency syndrome instead, a narrowing of the dependant's repertoire in type of drink, timing and frequency of drinking. There is a tendency to drink a set times of the week or weekends, irrespective of a change in social restrains (Deneberg & Deneberg, 1991:209)

Drinking alcohol becomes of prime importance to the individual, who begins to neglect other interests. Tolerance to alcohol increases, so that sufferers can consume excessive amounts of alcohol without showing signs of intoxication, later, when liver failure ensues, this tolerance is lost. Repeated withdrawal symptoms occur, causing tremor, nausea, sweating and disturbances of mood. Withdrawals are avoided or relieved by continued drinking or "topping up", not necessarily in the morning before work, but throughout the day. The sufferer knows he is unable to stop drinking once he has started. This loss of control is variable and not yet necessarily consistent. (Deneberg & Deneberg, 1991:211)

3.6. THE PSYCHOLOGICAL VIEW / APPROACH

This view states that people who became alcoholics are alcohol-prone. This is not due to a physical disability, but rather to psychological disabilities. Such people go through disturbing emotional experiences such as rejection by parents, parental cruelty, inability to make friends, lack of success in schools, constant parental conflict, alcoholism in the family, a broken home and other such difficulties in their childhood (Lander, 1998:148).

Therefore these children developed feelings of anxiety, insecurity, depression, loneliness, repressed anger and low self-esteem hence they carry these feelings into their adolescence and adult life. Deneberg and Denenberg (1991:223) further explain that such individuals have an urgent need for relief from emotional stress, an instant, easy source of pleasure, gratification and self-esteem, and a way to deal with a reality they cannot handle. Alcohol provides all of these. It anaesthetizes emotional pain, produces euphoria, inflated the deflated ego and modifies reality so the drinker does not have the deal with it.

Psychological theories of the origin of drug addiction usually emphasize reduction of distress and the pleasant feeling and euphoric state that the drug produces. Psychological theories also attempt to explain why particular kinds of people seem to 'need' these effects. Longitudinal data on personality variables such as those that were collected by Jones on alcoholism are not available on narcotics addiction (Doweiko, 1996:176)

Some similarities in family background have been identified in the life histories of drug addicts (Chein, 1989:346). In many cases the father is absent from the home of the future addict. If the father is present, he tends to be a shadowy figure or to be overtly hostile and distant.

If present he may also serve as a model for criminal behaviour, and the relations between the mother and father are likely to be stormy. Chein and his colleagues therefore proposed that the personality defects of the drug addict, whatever they are, were developed through family background.

Most addicts found to have been introduced knowingly to the drugs, not by an adult but rather by a member of their peer group, suggesting the importance of peer pressure and curiosity. Boredom and aggravation are probably contributing factors. In ghettos where narcotics are readily available, and the culture of the streets prevails, the incidence of drug use is especially high (Annis & Watson, 1989:90)

There is little evidence available concerning the origins of drug addiction. Personality characteristics, peer pressure, family background, the ease with which the drug can be acquired, and the frequency with which it is used in a particular culture are all possible factors, but as yet the role of any of them has been only vaguely specified (Doweiko, 1996:153)

3.7. OVERALL THEORIES OF THE ADDICTION PROCESS.

Solomon (1979:110) argued that the conditions that cause a person to try a drug have not been identified. The best predictor of drug sampling is drug availability, but drug use is too widespread and drug addiction too rare for the mere sampling of a drug to be a major cause of subsequent addiction.

The user now must cope with drug craving, a fear of withdrawal, and other acquired motivations. The addicts desire to maintain social relationships and a certain lifestyle may also be a motivating factor (Annis & Watson, 1989: 230)

Solomon (1979:115) proposed the opponent process theory of acquired motivation. Consider first the person who has used a drug only a few times. Before taking the drug again, that person, who is not yet addicted, is in a resting state. Then, while ingesting the drug the person experiences a peak state (the rush) and euphoria, in other words, the psychopharmacological properties of the drug make the user feel " high" after the effects subside, there may be mild discomfort ("coming down" from the drug).

The person may start to crave the drug to combat the discomfort, but the discomfort soon subsides and the person returns to a resting state.

The motivation for use is to achieve the high and to avoid the aversiveness of the craving (Doweiko, 1996:181)

CHAPTER FOUR

4. METHODOLOGY

4.1. PREAMBLE

The methodology closely follows the researcher's rationale. The research methodology employed in this study is rooted in a qualitative research tradition, which has been developed across several disciplines over the past few years. Qualitative methodology makes it possible to get closer to the data, thus allowing the data to produce certain levels of explanation, instead of the researcher imposing his own categories and meanings on what is observed as it generally is the case with the positivist tradition of research (Mcmillan & Schumacer, 1997: 210)

The purpose of this study is not to know how many children are affected by substance abuse at schools, but to understand what causes this kind of behaviour. The researcher wants to record the children's thoughts about their experiences and not gather impersonal statistics and make recommendations as to how this social issue could be addressed.

4.2. TYPE OF STUDY: CASE STUDY APPROACH

A case study is an in-depth intensive investigation of an individual in order to understand that individual better and to make inferences about people in general. (Roberts & Fieldman, 1993: 37)

Yin (1993:112) defines "case study methodology as a strategy for doing research which involves an empirical investigation of a particular contemporary phenomenon in its real life context using multiple sources of evidence". It is a research strategy based in empirical research, which focuses on the particular, in context and, like action research, involves using a variety of methods of data collection.

The logic of the case study is to demonstrate a causal argument about how general social forces shape and produce results in particular settings. Case study research raises questions about the boundaries and defining characteristics of a case. Such questions help in the

generation of new thinking and theory. "Case studies are likely to produce the best theory (Yin, 1993:109).

The case study was chosen by the researcher so as to be able to get below the surface, "unlike the experimenter who manipulates variables to determine their casual significance or the surveyor who asks staged questions of large representative samples of individuals, the case study researcher typically observes the characteristics of an individuals unit, a school or a community. The purpose of such observation is to probe deeply and to analyse intensively the multifarious phenomenon that constitute the life cycle of the unit with a view to establishing generalizations about the wider population to which that unit belongs" (Cohen, 1994:111).

Another factor that the researcher considered was the fact that since education belongs to the social sciences it would be appropriate to use a case study. Yin (1993:114) argues: " case study research continues to be an essential form of social science inquiry". Apart from being essential in social sciences research, the case study has many advantages. Cohen (1994; 123): summarize the advantages as follows:
"Case study data paradoxically is strong in reality but difficult to organize. In contrast, other research data is often weak in reality but susceptible to ready organisation. This strength in reality is because case studies are down to earth and attention holding in harmony with the reader's own experience and thus provide a natural basis for generalization".

Case studies allow generalization either about an instance or from an instance to a class. Their peculiar strength lies in the case study's attention to the subtlety and complexity of the case in its own right (Yin, 1993: 117)

Case studies are considered as products, may form an archive of descriptive material sufficiently rich to admit subsequent reinterpretation. Given the variety and complexity of educational purposes and environment, there is an obvious value in having a data source for researchers and users whose purpose may be different from our own (Yin, 1993:119).

Case studies are a step to action. They begin in a world of action and contribute to it. Their insights may be directly interpreted and put to use, for staff or individual self development, for intra-institutional feedback for formative evaluation and educational policy making" (Yin, 1993:120)

The case study approach is particularly appropriate for individual researchers because it gives an opportunity for one aspect of a problem to be carried out in some depth within a limited time scale (Bell, 1997 : 37).

Stenhouse, (1988: 112) defines the case study as the collection and recording of data about a case or cases and the preparation of a report or a presentation of the case. The collection of data on site in termed "field work" and it generally involves participant or non-participant observation and interviewing and descriptive statistics and the administration of tests and questionnaires. The case study was also selected because it is suitable for research that has to be carried out in a limited time period by an individual researcher.

Finally the case study was selected for this study because the research site is easily accessible to the researcher, as he is an educator at the same school.
"In a natural setting it is difficult for the researcher who wishes to be covert not to act as a participant. If the researcher does not participate there is little to explain his presence, as he is very obvious to the actual participants (Cohen, 1994:160)

4.3. SITE AND BACKGROUND OF THE STUDY

The school is located at Amaoti; a predominantly African settlement outside Durban which is characterized by poverty, violence, crime, malnutrition, unemployment, illiteracy, high levels of immorality and a poorest of infrastructure. The school is prefab with no tuck-shop or sports field. A gravel road takes one to the school. It is surrounded by an informal settlement of corrugated shacks. There are no entertainment facilities for the youth

Subsequent to these adverse conditions, some learners have become victims of HIV/AIDS, murder, engage in pre-marital sex, and have lost interest in schooling. Some of these learners suffer from domestic and sexual abuse, which pushes them into drug abuse as a way of trying to immaturely deal with issues.

This is the kind of learners in this school and in the classrooms. The learners shoulder all of these while they are supposed to be ready and prepared for learning. They may be conveniently confined in a stable class for seven lawful hours, but after school, they become

subjected to these conditions. It thus becomes a vicious circle until they are in the high school to be able to gain relative control of their situation and fate.

Living in a shack that leaks during rainy days, a shack that is easily destroyed to ruins by a heavy storm, a shack that is too small for privacy even on matters of sex become terrible. What kind of a learner is brewed here?

The school is located near Phoenix residential area, which is an urban area, populated by middle-income groups. Learners from Amaoti Primary School constantly compare themselves to the Indians and become envious, jealousy and generally dislike them.

There are twenty-nine educators at Amaoti School, including the principal. There are more than one thousand two hundred learners in the school. The teaching staff is 83% female and 17% male. There are four buildings, two for intermediate phase and two for senior phase including the administration block.

4.4. RESEARCH INSTRUMENTS

4.4.1. Semi-Structured Interviews

According to Marlow (1983:321) in a semi-structured interview, the interviewer has more freedom to pursue hunches and can improvise with the questions. The semi-structured interviews consist of general types of questions, but they are not in a questionnaire format. Bailey (1991:12) added that the semi-structured interviews provide flexibility and allows the researcher to probe the interviewee. They allow for the researcher and participants to clarify misunderstandings and allow participants to provide detailed explanation about certain issues.

This method of data collection enables the respondents to explain their experiences and perceptions regarding substance abuse. The semi-structured interview used in this research began with general questions and moved towards the teenager's specific experience and perception of substance abuse.

The respondents were interviewed for half-an hour each because they had a short span of concentration. They were interviewed twice a day, once before lunch and once after lunch. As it was mentioned earlier, the researcher has used semi-structured interviews for data collection. The researcher set up these interviews. The other method that was used was

observation method, where the researcher concentrated on behaviour and appearance during and after the interviews. Observation was relevant so as to ascertain if the respondents were under the influence of drugs or alcohol.

The interviews were tape-recorded and the researcher took notes, the permission to do so was granted to the researcher by the respondents. The parents or guardians were also interviewed only once for an hour to get more information on the family background of their children as well as birth history and financial status and the behaviour of their children at home. Interviews with parents were conducted at the school and were tape-recorded for data analysis purposes.

4.5.CONFIDENTIALITY

Clients or respondents were reassured of confidentiality. The interviews were tape -recorded and pseudonyms were used to protect their identity and tapes transcribed after which they were destroyed.

4.5.1. Tape Recorder

When conducting interviews, an interviewer must pay attention to multiple situations hence a tape recorder was used. Tape recording allows a fuller record than notes when taken during the interviews. According to Stenhouse (1988:179) knowing that recording can be intimidating to participants, and that participants may not feel comfortable, permission was sought before and the importance of recording explained. Also, because this is a qualitative study, tape recording allowed for the reproduction of data in the form of transcripts. This in turn facilitated perceptions, behaviour, attitudes and actions of the substance abusers, with regard to coping strategies.

Using a tape recorder allowed for a complete and accurate recording of the respondents exact words. Tape recording provided time for important aspects in an interview like the non-verbal behaviors, for example, gestures, and facial expressions observed to be noted.

Ary (1996:86) summarizes the advantages of tape recording by saying that tape recording has an obvious advantage of recording the subjects responses verbatim, along with the added

advantage of freeing the interviewer to participate in the dialogue rather than having a concentrate on note taking.

4.5.2. Transcripts

It was necessary to make transcripts from the audiotape. The transcripts were needed for repeated readings. Reading and writing the transcripts was helpful as it familiarized the transcriber with the data as one goes over and over reading and writing.

Knowing that transcripts are expensive to develop but an important commodity, they were written clearly and the sentences were in double line spacing on a page (Burma & Parker, 1993:246). It is better to have the interviews recorded because when reading the transcripts one could be confused by the words and when there is conflict one could always go back and listen to what the participant may have said (Ary, 1996:89).

4.6. SAMPLING METHOD

Because of the difficulties of locating Primary school learners who abuse substances, the researcher decided to do an in-depth research with the five children who have displayed unwanted behaviour at the school where the researcher is employed. So, purposeful sampling was used.

For the purpose of this study, the researcher used a purposive sampling by targeting five children in the researcher's school. The reason for using purposive sampling was that, it increased the utility of information obtained and that the sample chosen was likely to be knowledgeable and informative about the phenomenon investigated, and it might yield much insight about the topic, Therefore, purposeful sampling requires that information be obtained about variations amongst the subunits before the sample is chosen. Some qualitative researchers view sampling process as dynamic, ad hoc, rather than static. (Patton, 1990:216) also highlighted that purposive sampling in contrast to probability sampling, is selecting information-rich cases for study in depth, when one wants to understand something about those cases without needing to generalize for all such cases.

The reason why he chose five learners was because they would be manageable. Also, his colleagues referred these learners to the researcher. They were all males, on different grades, ranging from ten to fourteen years of age. Also, and equally important has used these respondents because they trusted him.

The choice of the researcher's school rather than any other in Inanda was also determined by the difficulty involved in gaining the trust of children around the highly sensitive issue of substance abuse. The questions of the researcher's dual role as the teacher-counsellor and researcher would be addressed in the study when reflecting upon researcher's own perception and assumptions about substance abuse and its effects on the children or under limitations of the study. The researcher was hoping that the insight gained into the lives of the affected children will lead to greater compassion on the researcher's part rather than to prejudice those affected.

For each and every respondent, the researcher gathered the following information:

- Biographical details
- Family history
- Academic history
- Social history
- Financial history
- Medical history

SAMPLING CHARACTERISTICS

The respondents were all from one school (Primary). They were all indigenous black South Africans. Their grade levels range from grade four to grade seven. One in grade four aged ten, two in grade six both fourteen years and two in grade seven twelve and thirteen years.

4.7. THE BIOGRAPHICAL INFORMATION OF THE RESPONDENTS

Zolisile

He is fourteen years old and a very shy boy. He is almost 1.72m tall. He is doing grade six.

The family history: He stays with his 28-year-old unmarried sister and her boy friend. Originally they were from the Eastern Cape. His mother is residing in Eastern Cape and she is unemployed hence, she cannot provide for him. He is the last but one in the family. The last born in the family is ten years old. His sister has three boys.

He shares his problem with his sister, as she is the only one he trusts and believes in.

Social history: He is a friend with older boys who are not at school. They are all working. All of his friends take drugs. All of his friends left school while they were in grade five. When they are together they talk about girlfriends. He was once arrested for carrying a dangerous weapon on the beach with his friends, later his charges were dropped. Academic History, his work is very bad. He often bunks school. He says his friends always pick him up from his home so he cannot find time to do his homework. His scholastic performance is very poor.

Lifa

He is twelve years old; he lives with his father and his stepmother. He is in grade seven. His biological mother does not live with him. His father has three wives and his mother was the second wife. He is the only son and all his aunts have girls. His mother has two girls out of marriage.

All of these women are not married to his father legally. His parents broke up two years ago that is why he is living with his stepmother. He is the only child currently living in the family. His father is a truck driver and he is always away and seldom he comes home.

Social interaction: He has friends, aged from fifteen to seventeen. Before he came to Amaoti he was living with his half-brother who was taking drugs and selling them. Unfortunately that brother passed away, unknown people stabbed him and Lifa was on the scene. He witnessed the whole incident, which traumatized him for sometime.

He is always with his friends after school and they usually lock themselves in the room in his friend's place and start taking drugs.

Financially: His father is not struggling to bring him up. He has everything even a bicycle that he always rides to school.

Academically: his scholastic performance is not that bad, he struggles in Maths and Geography. He is a very good soccer player and aspires to play soccer professionally.
He is from a multi-racial school. His father removed him because he was playing truant; his father said his mother is a very permissive mother. At present, Lifa and his stepmother do not get along with each other at all.

Thabo

He is a shy little boy. His clothes are torn; he comes to school looking very dirty. He comes from a very poor family. He is malnourished. He is ten years old and in grade four. He lives with his parents who are alcoholics and two other siblings. Thabo's sister is sixteen years and his younger brother is three years. His parents are both working for the same company, doing odd jobs.

His sister is not living with them; she lives with her aunt in Clermont. Thabo's mother drinks and smokes and his father smokes dagga.

His uncle lives in the neighbourhood, he also drinks. His uncle sends him to buy liquor every Friday (his payday). The uncle drinks with him. His parents are always drunk on Fridays. He has the duty everyday of taking his younger brother to the neighbour's house where he is looked after until after school.

Social interaction: Thabo has four friends, their age's range from thirteen to seventeenth years. His friends always come in the afternoon to pick him up. They beg for money on the street corners in Phoenix. The money they get is used to buy drugs. His parents are aware of this behaviour.

Academic history: He has never repeated any grade. His work is very poor and his school attendance is irregular, he comes to school three times per week. Most of his time is spent with friends. Three of his friends are not at school.

Gideon

He is in Grade Six. He is fourteen years old. He started school very late. He spent most of his childhood in Transkei as a herd-boy looking after sheep. He is an orphan. He lives with his grandparents who had three boys but they all passed away. His mother was an alcoholic; the grandfather at the interview mentioned this.

Social interaction: He has friends who are known for their bad behaviour in the community. In 1999 he was out of school doing odd jobs with his friends in Phoenix, in the construction business and that is where he met his friends. The two of his friends are nineteen years old. His friends are not living with their parents either. When he is with friends they smoke drugs and when broke they sell sugar cane to make money.

Academically: He is not bad at all. His scholastic performance is good. The only problem is that he started school at a very late age. His grandparents are pensioners. He is an average child.

Siyabonga

He is a little boy with red eyes and a black mouth. He coughed all the time during the interview. He is a short and very short-tempered boy in class. He always quarreled and fought with other children in class. He is thirteen years old. He has both parents but at present they are not living together. He is living with his mother and a stepfather and seven half siblings. His mother is a domestic worker who comes home every month-end.

Social history: He has many friends in the neighbourhood. Their ages range from fourteen to seventeen years. He likes kwaito music and slow jam. When they do drugs they lock themselves in a room of which they call "office". His scholastic performance is very poor. He struggles in all subjects. Financially, they struggle at his home as his mother is the only one who is working and his older sisters are looking after their children. His real father is not responsible at all as he does not pay maintenance.

CHAPTER FIVE

5. DATA ANALYSIS AND DISCUSSION

5.1. PREAMBLE

The sensitive nature of the study meant that only the affected learners and their parents or guardians were interviewed. From the respondents five themes were principal contributing factors towards their substance abuse. Those were socio-economic factors, peer pressure, family composition, moral decay and psychological causes. These may not be the only causal factors but they certainly stood out from the responses received from the learners and their parents or guardians. It is important to bear in mind that these themes do not exist in the data on their own but within the context of each other, the separate themes merely provide a way of unpacking the complex dynamics inherent in each of them.

Literature on substance abuse reveals that drugs are a serious problem, which needs to be addressed with sensitivity and understanding by service providers. This chapter will include discussion on responses from the interviews with learners as well as the responses from their parents. This involved repeated reading through the data in order to become familiar with it. During the review of literature, events, ideas, feeling, and quotations from the interview were constantly sifted. These were written down in order to be able to retrieve the information easily.

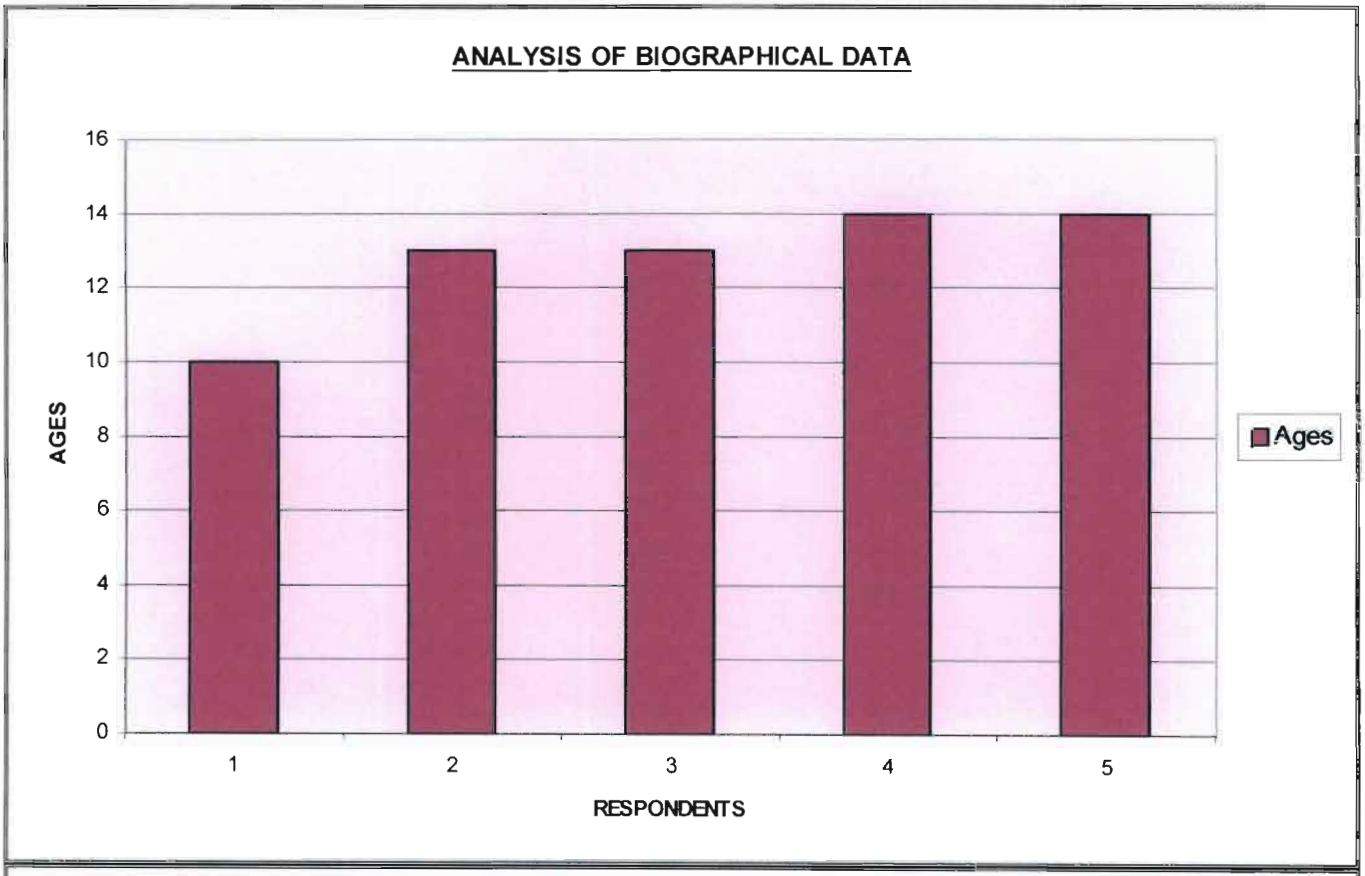
Appendix A on page 82 has the transcript of the interviews. All references made on the findings are in the appendix as it was the only data collected in this research.

5.2. ANALYSIS OF BIOGRAPHICAL DATA

All the participants are coming from an informal settlement of Amaoti. They were all boys from grade four to grade seven.

The Graph below shows exactly their biographical information:

Figure 1



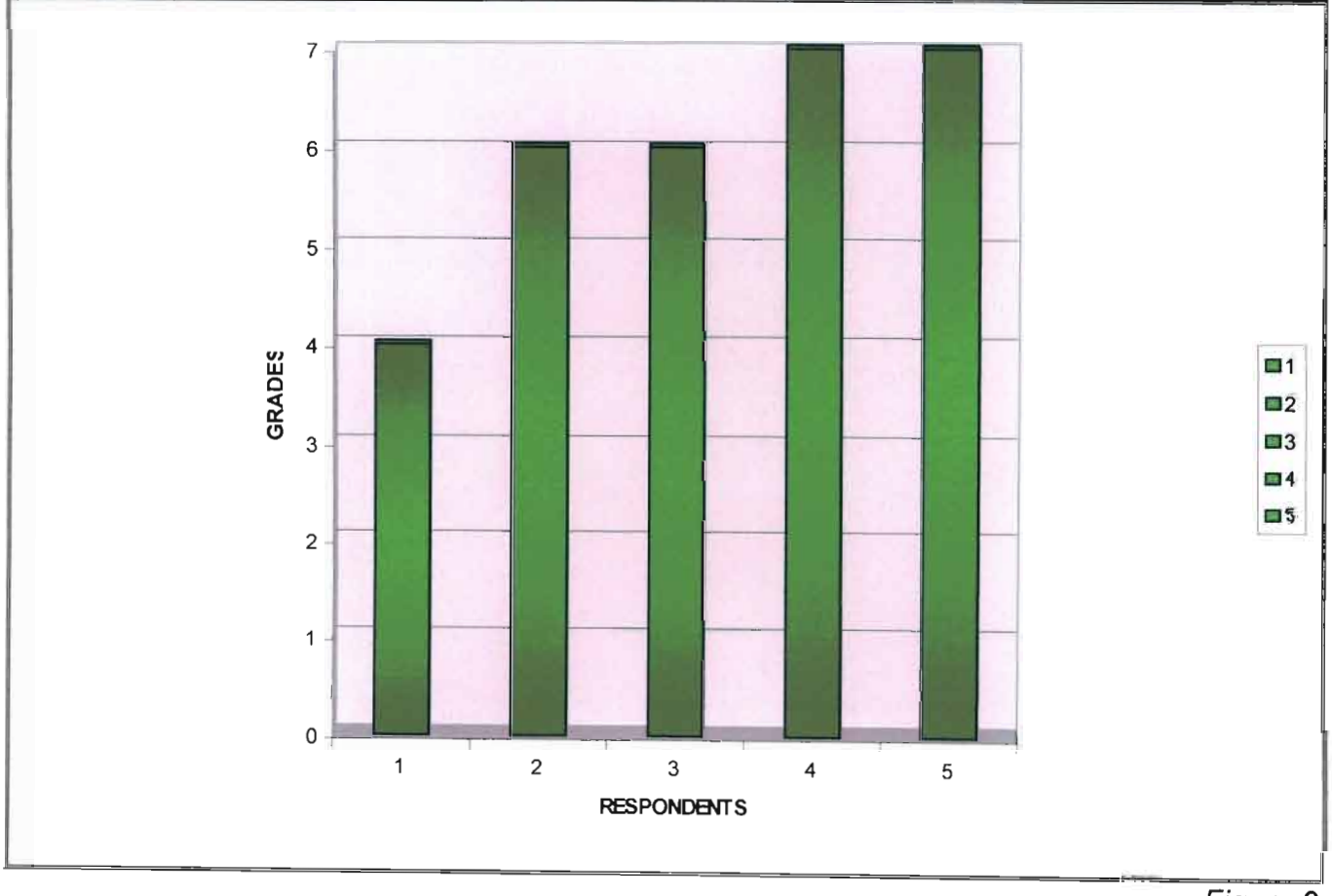


Figure 2

The above graphs show the respondents ages and their grades. The youngest respondent is ten years old and in grade four. The other respondent is twelve years and in grade seven and the last two respondents are fourteen years and in grade six.

5.3. SOCIO-ECONOMIC FACTORS

All the five learners and their guardians reside in an informal settlement. Generally residents of informal settlements are poor. As the interviews revealed, the financial status of all respondents' families portrayed a picture of being financial deprived. For instance when Thabo's mother was asked who provided support for the family, she said her husband was working but he earned very little. She also went on to say that she did not give her son spending money because she had none.

Respondent's 4's grandfather, who is responsible for the welfare of his grandson is a pensioner. Usually pensioners do not earn enough to satisfy their families needs. In 1999 Gideon had to leave school and look for odd jobs because the family could not afford school fees. Thabo's answers demonstrated the relationship between socio-economic factors and substance abuse. The researcher asked him what he does after school and over the weekend, his response was that he goes to Phoenix and beg for food and money. The money they get from the street is used to buy drugs and food. The researcher asked Gideon who his friends were and how they met.

> *"I have two friends who are nineteen years and not schooling. We met in Phoenix where were doing odd jobs, that year my grandparents didn't have money to take me back to school."*

The above response clearly shows that these children are from a poor community and that leads them to rely on friends and later do drugs with them.

5.4. PEER PRESSURE

All the respondents seem to be influenced by friends to start abusing drugs. It is common for growing children to be influenced by friends into certain types of behaviour, be it good or bad. In all the respondent's answers friends seem to play a pivotal role.

Respondent 1 (Zolisile) who is fourteen has four friends and two of them are working. Throughout the interview he keeps on referring on how his group acquire and smoke drugs. When asked if he would like to stop using drugs, he said he was willing, but his friends come to him and they go into the routine of drug abuse.

His guardian, who happens to be his sister, attributes her delinquent brother's behaviour to his friends. She also complains that her brother's friends are older than him and they carry him home when he is drunk.

Respondent 2 (Lifa) who is twelve years old has three friends ranging from fifteen to seventeen years of age. When they do drugs they are always together. When asked by the researcher why he takes drugs, he said he takes them because his friends do. His father also acknowledges the fact that he goes away with friends and comes home sleepy with red eyes and black mouth.

Respondent 3 (Thabo) who is ten years old has friends ranging from thirteen to seventeen years old. According to him, his friends fetch him from to go to Phoenix to beg. The money that they make from begging is used to buy drugs. When examining the above reasons given by the respondents in the study, it clearly shows that friends have a very bad influence on young children.

5.5. FAMILY COMPOSITION

Another theme, which stands out, clearly is the family composition of all respondents. The socio-cultural model of abnormality makes the assumption that people's behavior - both normal - and abnormal is shaped by the kind of family group, society, and culture in which they live. We all are part of a social network of family, friends, acquaintances, and even strangers, and the kinds of relationships that evolve with others may support abnormal behaviors and even cause them to occur (Lester, 1993:532)

According to the sociocultural model of abnormality, then, the kinds of stresses and conflicts people experience, but as part of their daily interactions with the environment –can promote and maintain abnormal behavior. Although people who violate social rules may be labeled by the society as showing abnormal behavior, in reality there is nothing wrong with such

individuals. Rather, there is something wrong with a society that is unwilling to tolerate deviant behaviour.

To support the position that sociocultural factors shape abnormal behavior, theorists say statistics show that certain kinds of abnormal behavior are far more prevalent among certain social classes that others, and poor economic times turned to be linked to general declines in psychological function (Pines 1982: 220).

Zolisile is living with his sister in the shacks. He left his real home long time ago because there was no one who could afford his education.
Lifa is living with his stepmother; his biological mother is living with her boyfriend in Mayville Township. That on it's own is dysfunctional. The researcher asked Gideon who does he live with. The response was

"I do not have parents, I only have grandparents."

There is a relationship between a dysfunctional family and substance abuse where the parent or guardian abuses his or her children. Respondent 3 was asked by the researcher who else in the family is taking drugs.
Children learn from their parents.

"I drink beer with my uncle, every Friday".

It is not proper to drink with a minor.

Table 2 shows the family structures (composition)

Type of family	Frequency	Percentage
Nuclear family	4	80%
Extended family	1	20%

5.6. MORAL DECAY, BRAVADO AND SOLACE

The act of an adult drinking beer with a minor is both morally and legally wrong. As one respondent said:

> *"I drink beer together with my brother-in-law especially when he is off duty as I have told you that everybody knows in the family that I take drugs"*

Lifa, the second respondent, when asked who else is there in his family, he explained that:

> *"my mother has three children including myself and my father has many other children from different women. My mother has two other children from another man".*

The third respondent, when asked who does the cooking at home, he said

> "*Mother does the cooking if she is not drunk, but if she is drunk my father cooks".*

He told the researcher that his uncle drinks alcohol on Fridays, because Fridays are his paydays. He said that

> *"I drink with my uncle"*
> *"Both my parents drink and my mother smokes cigarette, but father smokes dagga".*

The other reason he gave was:

> *"Because I am the only one who is smoking dagga, and that does not worry me that much, moreover even my brother in-law drinks and smokes nothing wrong with that".*

This respondent is doing drugs because there is a respected figure in the family who takes drugs, and he sees no problem in taking drugs.
He went as far as saying; the other reason of taking drugs is that,

> *"I want to forget the death of my mother"*

The reason given is a solace. He wants to get over or forget about what happened to him in the past two years.

Among other reasons given by the second respondent as to why he take drugs, he said.

> *"I just take them because my friends do, and you cannot be a good man without drinking at an early age. That is the boys' habit, then there is nothing wrong with that".*

There is solace and bravado are other reasons given by respondents. Most of these learners have experience with drugs. The first respondent started while he was in grade four, he is very much experienced, of two years now. The second respondent has been taking drugs for two years.

> *"I started before the death of my other brother the one who was selling drugs to the people".*

That is how he was exposed to and started drugs. The third respondent started last year with friends.

The use of drugs by these learners has affected adversely their self-esteem. When the researcher asked them how they felt after taking drugs/ alcohol, they gave the following feelings:

Respondent 1 said:

> *"I feel very hungry. We take drugs in the room so that other members of the community could not see us."*

The second respondent, said;

> *"I feel very tired, you like dead and hungry. Also when we are together we end up insulting each other, use vulgar language and end up fighting sometime"*

> *" You do not have to eat before smoking the pill because you vomit and you get punished when you vomit".*

All the above demonstrates that these learners are having a serious drug problem, both in Primary and Secondary schools.
Asked if they want to quit, 60 % were positive as opposed to 40% that said "No"

5.7. PSYCHOLOGICAL FACTORS AND SELF-ESTEEM

It seems that drug abusers tend to drift into a pattern of using drugs, only gradually becoming hooked on the behaviour as they move through a series of two basic stages that culminate in the drugs taking habits (Hirschaman 1984: 632)

- Preparation
- Initiation

Maintaining the habit: In this stage there is an interaction of both psychological and biological factors that makes drug taking a routine behaviour. The most important psychological mechanisms include the establishment of a learned habit, positive emotional reactions such as stimulation and relaxation, a decrease in negative emotional reactions such as tension and anxiety, and social factors such as peer group approval and support from other drug users (Oskamp, 1984: 533). But it is also clear that apart from the purely psychological factors, there are biological reasons for maintenance of drug taking.

All the respondents have a belief that when you are under the influence of drugs their thinking ability increases. When the researcher asked Zolisile the first respondent, how does he feel after taking drugs, the response was:

> *"Eh, yes, I just take dagga because they are cool, you think very quickly when you are with friends".*

It is the opposite of what they think because Zolisile further explained that after taking drugs they sometimes end up fighting over nothing and harass people and the next day they forget all that. They feel very hungry and they buy bread and lock themselves so that no one else sees them.
Psychologically the respondents are aware that what they are doing is absolutely wrong because they hide themselves under the roof.
Lifa was asked by the researcher that how does he feel after taking drugs, the response was:

> *"I feel very tired and hungry".*

The researcher asked Thabo why he takes drugs, and is there anyone in the family who takes drugs. The response was that

"Eh, everyone in my family takes drugs, why should I stop? My father gives my mother money to buy her liquor and he goes to his friends and comes home very late"

The above statement shows that children do learn or mimic bad behaviour from their parents. It is like Thabo learnt taking drugs from his parents and it clearly shows that he never started taking until the age of ten.

He started at an early age because his parents both take drugs. Later this will affect Thabo psychologically because his parents would end up fighting when under the influence of drugs. His self-esteem will always be negative more especially in class when the teacher comes back with the subject of drugs.

> *"They start fighting over nothing. My mother send me to buy her cigarette and liquor very late at night"*

The above quotation from the interview clearly demonstrates that Thabo is taking drugs because of the influence he is receiving from his parents.

Charity begins at home. Parents and guardians are usually the children's role a model, what the parent does the child always imitates.

Most of the respondents do not participate in sport because they avoid exposure, they do not want to be seen because of drugs. That on its own shows the sign of low self-esteem.

5.8. DATA ANALYSIS: PARENTS AND GUARDIANS

This analysis is from the data collected from the respondents' parents and guardians.

Zolisile's sister was asked whether is she aware of her brother's behaviour and is she aware that her brother is taking drugs. The response was:

> *"Zolisile is now involved in drugs, he has bad friends who are not school and are far older than him"*

The above quotation clearly shows that their parents are aware of their behaviour. She further explained that:

> *"Zolisile comes home very drunk on weekends, his friends use to bring him drunk".*

The environment they are coming from plays a very big role in their lives. They are living in slums and coming a very sick society. Zolisile's sister also went as far as there is a group of people calling themselves "*Rastafarians*". This small group of people influences young children because they are taking drugs.

Lifa's father mentioned that Lifa's mother was very permissive and Lifa did as he pleases.

> *"My boy started doing drugs at age ten, his mother was very permissive and overprotective, that is why I took my son from her".*

The above quotation demonstrates that sometimes overprotective parents spoil their children.

The researcher posed the question to Thabo's mother whether is she aware of his son's friends, the response was:

> *"I cannot know them all but what I know, they go and play in Phoenix".*

Thabo's Mother is aware that her son begs on the streets. That is moral decay and displays abnormality and negligence and lack of love.

Since Lifa started taking drugs his scholastic performance dropped. Last year he repeated grade six. His father told the researcher that:

> *"He never wrote examinations last year, he changed drastically, he never wanted to be in the limelight of other people. Since everyone in the area (Mayville) was aware that he is taking drugs, his self-esteem was very low. Then I was forced to remove him from Bonella Primary to Amaoti where he is not known".*

Drugs affect these children academically, socially and emotionally. Most of them are dropping down on their scholastic performance. Siyabonga's mother further explained that:

> *"I was once invited by his classteacher about his unsatisfactory academic progress".*

Twenty percent of the respondents' guardians have tried to help their children from taking drugs, by sitting down trying to find reasons why. The very same percentage tried by using corporal punishment. Lifa's father used sjambok to punish. But Lifa did not stop. All the parents and guardians rely on the teachers to help and curb the drug problem at school.

CHAPTER SIX

6. RECOMMENDATIONS

As a result of the findings discussed above as to how prevalent substance abuse is in Primary Schools, the researcher feels that there is a need for intervention. The following are recommended intervention strategies

6.1. Life-skills Program: There is a great need for life skills education in all schools. Schools can add a crucial component to the drug prevention efforts of parents by incorporating prevention strategies within the context of health, science, and family life curricula. Schools should also provide an organized peer-group setting in which learners can develop communication and decision-making skills.

6.2. School Drug Policy: Schools need to have a clear drug policy. Some schools require learners and parents to sign an agreement form that all drug-related offenses will be referred to the police and that learners who use drugs, including alcohol, will be required to obtain counseling or else be suspended.

6.3. Community Involvement: For schools to respond effectively and complement the activities of the family, the entire community must be involved. When community members were asked to provide input into the schools' strategy to combat drug abuse, they can make valuable contributions to the effort and, in turn, add legitimacy to the schools drug prevention program.

Students' assistance programs have proven to be quite successful in combating drug use in many schools. This program involves teams of learners, educators, administrators, parents and counsellors trained to recognize causes and symptoms of substance abuse and provide or recommend appropriate intervention. For example, educators can hone the problem-solving and decision-making skills of learners by incorporating drug prevention strategies into daily lesson plans that are geared toward the social and intellectual needs of their learners.

6.4. Peer helpers: The use of "peer leaders" has been successful both in and out of school. In middle school, for instance, peer pressure can be intense. Middle school educators may use role-playing to help small groups of learners practice ways to resist peer pressure to use

alcohol and other drugs. Peer leaders receive special training to help them develop strong communication and problem-solving skills. They may lead discussion groups to give other learners a forum to voice their questions and learners. The peer-leader strategy provides positive role models for other learners and strengthens the self-esteem of the peer leaders.

6.5. Family Involvement: To encourage parent involvement in school drug prevention programs, schools should make efforts to increase family trust. To encourage parents initiation of anti-drug interventions at home and, with other parents in the community, schools need to equip parents with information and strategies to increase the effectiveness of their efforts.

Outreach should be respectful of parents' innate abilities and ultimate responsibility for child rearing. Information can be provided directly in anti-drug forums, but experience has shown that parent participation is greater when drug prevention is included in a more comprehensive program. For example, a life skills program can also offer English language instruction, job training, help with dealing with public agencies, and other services benefiting disadvantaged families. A family wellness program can also cover developing and maintaining good family relationships and solving family problems.

6.6. Parenting skills: One key topic for parents to explore is how to develop and maintain their natural leadership in the home. This involves good communication of values and appropriate expectations, active listening to their children's concerns, and good family problem solving.

6.7. Public Education: Two major ways of preventing drug use is by educating the public about drug use and structuring the environment to eliminate factors so the availability of drug will be limited. Education in school systems and within the community is essential to prevent drug abuse from occurring. One way is to give positive alternatives to children. More emphasis is placed on extracurricular activities, volunteer services, recreational activities, and participation in cultural events. Detox and abstinence programs are still used to get the addict to stop totally or at least reduce the use of drugs

CONCLUSION

Effective school-family collaborations to prevent youth drug use require mutual respect, an accurate understanding of the nature and concerns of community members and the local problems, and an ongoing commitment of time and resources by everyone involved. It is important that the responsibilities for both decision-making and tasks be shared, and that assignments be clearly stated. Above all, families must feel confident that they can share problems with others, that confidentiality will be maintained, and that they will receive useful and sustained help and support. With effective school and community partnership, the scourge of drugs can be dealt with.

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APPENDIX A

Interview Schedules

Appendix A

Semi-structured interviews were used as a data collection tool at Amaoti Primary School situated in the heart of Inanda, city of Durban. The researcher has used five learners as participants in the study. This chapter demonstrates the field notes of data collection. The reseacher's participants were in the Intermediate and Senior phase, which is Grade Four to Seven. They were all boys. The researcher has used pseudonyms for their identity.

INTERVIEW WITH THABO

He is a shy little boy. His clothes are torn he comes very dirty to school. He is coming from a very needy family. This boy is under-nourished.

Researcher : Thabo, how are you this morning, I just want to talk to you about your background and your family composition. Just tell me more about yourself.

Thabo : I am ten years old, and I am in Std 2 I have two siblings, my sister who is sixteen years and my younger brother who is three years. I live in tin town right here at Amaoti.

Researcher : What about your parents?

Thabo : Well, they are there too, they are working in town in Dalton my mother is a domestic worker and my father is a handy man in one of the factories in Dalton.

Researcher : Who does the cooking at home?

Thabo : Mother does the cooking if she is not drunk, but if she is drunk my father cooks.

Researcher : Your parents do the cooking, what does your sister do?

Thabo : My sister does not stay with us she comes every Friday, she is schooling at Clermont and she stays with my other aunt

Researcher : I am listening Thabo continue...

Thabo : My uncle stays near by my home every Friday he sends me to buy him liquor.

Researcher : Why every Friday, Thabo?

Thabo : Fridays are his paydays.

Researcher :Who does he drink with?

Thabo : He drinks with me.

Researcher : Yes, and.....

Thabo : Both my parents drink and my mother smokes cigarette, but my father smokes dagga.

Researcher : How did you start taking these drugs and alcohol?

Thabo : I started this year together with my four friends of which three of them are not schooling.

Researcher : How old are your friends?

Thabo : They like from thirteen years to seventeen years. They use to come to my home and they take me to Phoenix to beg for money on the street.

Researcher : How do you spend your money you get from the street?

Thabo : We get something like R5 a day each of us, people give us food instead of money. The money we get put it together and buy drugs like pill ("Mercedes") – mandrax and cigarette and slope of zol.

Researcher : What other drugs do you use?

Thabo : It is glue

Researcher : How often do you go to Phoenix Plaza?

Thabo : Almost everyday after school and on weekends.

Researcher : Every weekend.

Thabo : Yes, sometimes even during the day, my friends come to my home in the morning and ask me to go with them that is why I am sometimes absent from school.

Researcher : Is there anyone in the family who is aware of that.

Thabo : My mother knows, she even asks me how much I made from the street, then she takes my money.

Researcher : Now, tell me more about things you do when you are together with friends.

Thabo : We buy food and drugs/ alcohol and hide in the forest then we start doing drugs. We only smoke glue if we are on the street. We hide in the forest because we do not want to be seen by other big boys, because they take our money.

They also have their corners where they beg for money on the street, you do not have to stand on somebody's corner otherwise you will be in trouble.

Researcher : Do you want to stop taking drugs?

Thabo : eh, everyone in my family takes drugs why should I stop? My father gives my mother money to buy her liquor and he goes to his friends and comes home very late.

Researcher : Then.....

Thabo : They start fighting over nothing. My mother sends me to buy her cigarette and liquor very late at night. When my parents fight, neighbours come and break up the fight, and then my father goes straight to bed.

Researcher : Your parents are working and you are schooling, what about your brother?

Thabo : My brother is not schooling, I take him to the neighbours every morning.

Researcher : I am listening Thabo

Thabo : If the neighbours are not there I look after him. If he is sick I take him to the clinic. Before I go to school I do the household chores I even make my mother's bed.

Researcher : Thabo, is there anything else you want to share with me?

Thabo : I think that is all I can tell you.

INTERVIEW WITH THABO'S MOTHER

This interview was between the researcher and Thabo's mother. Semi-structured interview was used. To interview took half-an hour.

Researcher : Greetings

Parent : Good-morning.

Researcher : I would like us to share information about Thabo. We shall look at his birth history, family composition and background and his scholastic performance

Parent : Eh, Thabo is my second born child. He is ten years old. We are family of five but my first-born does not stay with us due to the financial problems. She is living with her aunt at Clermont and the last one is a three-year-old boy.

Researcher : Who is providing the welfare of your family?

Parent : Well, my husband is working but he is earning nothing. I am also a casual worker where my husband works.

Researcher : Now, both of you are working, who looks after your baby?

Parent : Well, Thabo takes him every morning to the neighbours and collects him every afternoon.

Researcher : I am listening.....

Parent : The reason why Thabo takes care of my little son, is because I leave home early in the morning and I come very tired in the afternoon.

Researcher : What does Thabo do after school?

Parent: He does the household chores then I do cooking myself, if his father has not done it. Soon as he is finished he goes out and play.

Researcher : Thabo goes out and play, who does he play with?

Parent : Well, he plays with his friends

Researcher : Can you tell me about his friends.

Parent : I cannot know them all but what I know they go and play in Phoenix.

Researcher : They go and play in Phoenix, what type of games do they play?

Parent : He said to me they beg for money on the street.

Researcher : Do you give him spending money everyday.

Parent : No, I do not give him because I have nothing.

Researcher : How are his friends?

Parent : I can say they are bad because what I know about them they do drugs.

Researcher : His friends do drugs, what about Thabo?

Parent : Well, eh er... It is more likely that he is taking these drugs because his class teacher wrote me a letter reporting about his absence from school now and again and his poor scholastic performance. Well, this child every weekend he goes to the street and beg for money and I do not know what do they buy with the money they get from street.

Researcher : Have you ever asked him, why does he go to the street?

Parent : Yes, I did

Researcher : And what his response?

Parent : There was no follow up made because his father told me that my son is taking drugs.

Researcher : Oh, you are all aware that your son us taking drugs, what drugs he take?

Parent : He smokes cigarette and glue.

Researcher : He smokes.....Is there anyone in the family who smokes or ever smoked.

Parent : Eh,er, well I am a smoker and I also drink.

Researcher : Is there anything you want to share with me?

Parent : I think that is all

Researcher : Thank you very much for sharing this information with me.

APPENDIX B

Respondents and Parents Questionnaires

STUDENT QUESTIONNAIRE

DEMOGRAPHIC INFORMATION

1. (a) Age at present
   (b) Grade
   © Any repeated grades
   (d) How old when started school

2. (a) Do you have friends. if you do how many are they?
   (b) Are they schooling. if so which school ?
   © Where did you meet your friends?
   (d) How often do you meet?
   (e) Are they known to your family?
   (f) What do you do when you are together?

3. (a) Family composition
   (b) Tell me about your family
   © Who re you close with at home?
   (d) How many school going?

4. Eating and sleeping
   (a) What do you eat during the day and when ?
   (b) Do you sleep well?
   (c) Who sleep in the room with you?

5. School and academic performance

   (a) How do you feel when coming to school ?
   (b) Do you struggle to concentrate at school?
   (c) When you struggle at school. who do you go to for help?

6. Substance abuse (alcoholism)

(a) Do you consume alcohol at school?

(b) Where do you get alcohol?

(c) Is there anyone in the family who is using drug, if so who is that?

(d) Why do you take these drugs ?

(e) For how long have you been drinking?

(f) It is difficult to stop ? why ?

PARENTS OR GUARDIANS QUESTIONNAIRES

Family And Birth History

a). How was your child born? Was it a normal birth or caesarean?

b). Just tell me about your family background.

c). How does your child interact with his siblings?

d). How big is your house?

e). Whom does your child sleep with?

f). Are you married?

g). How many children do you have?

Financial Status

a). How do you earn the living?

b). Who supports the family?

Substance Abuse

a). How does your child behave at home?

b). Does he have friends?

c). Do you know his friends?

d). Are you aware that your child is taking drugs?

e). How did it come to your attentions?

f). How did you react to that?

g). Is there anyone in the family taking drugs?

h). When did you notice that your child is taking dugs?

i). Have you tried helping your child? If so, how?

APPENDIX C

Consent Letters

CONSENT FOR RESEARCH PARTICIPATION

I ----------

parent / guardian of ----------

consent to his participation in the research study examining the perceptions and experiences with drugs, conducted by Mr M.A Mhlongo of the University of Durban Westville. I understand that the child's name will not be used, that his participation involves only answering questions regarding how he feels about taking these substances, and I'm also willing to participate in this study by answering what I know about myself and my child.

Parent's name ----------

Signature ----------

Date ----------

PROVINCE OF KWAZULU-NATAL
ISIFUNDAZWE SAKWAZULU-NATAL
PROVINSIE KWAZULU-NATAL

DEPARTMENT OF EDUCATION AND CULTURE
UMNYANGO WEMFUNDO NAMASIKO
DEPARTEMENT VAN ONDERWYS EN KULTUUR

NORTH DURBAN REGION | ISIFUNDAZWE SENYAKATHO NETHEKU | NOORD DURBAN STREEK

Address: Truro House
Ikheli: 17 Victoria Embankment
Adres: Esplanade

Private Bag: Private Bag X64323
Isikhwama Sepost: Durban
Privaatsak: 4000

Telephone: (031) 360-6265
Ucingo: (Exams Help Desk)
Telefoon:
Fax: (031) 332-1126

Enquiries: Dr D W M Edley
Imibuzo: 360-6247
Navrae:

Reference: 2/12/2/3
Inkomba:
Verwysing:

Date: 15 June 2001
Usuku:
Datum:

Bheki Mnyandu
Head: Post-graduate Programme
University of Durban-Westville

Dear Bheki,

PERMISSION TO CONDUCT RESEARCH : NORTH DURBAN REGION

1. Your letter dated 21 May 2001 received in this office today, refers.

2. Your application on behalf of Andries Mhlongo for permission to conduct research has been successful. Mr Mhlongo is hereby granted permission to conduct research along the lines of the proposal outlined in your letter, subject to the following conditions:

   a. No school/person may be forced to participate in the study;
   b. Access to the schools he wishes to utilise is to be negotiated with the principals concerned by himself;
   c. The normal teaching and learning programme of the schools is not to be disrupted;
   d. The confidentiality of the participants is respected; and
   e. A copy of his research findings must be lodged with the Regional Chief Director, upon completion of his studies.
   f. Kindly note further that if Mr Mhlongo is an educator in the employ of the Department of Education and Culture, KZN, he may NOT utilize teaching time for this research.

3. This letter may be used to gain access to the schools concerned.

4. May I take this opportunity to wish Mr Mhlongo every success in his research.

Yours faithfully,

M Edley

Dr D W M Edley
Regional Co-ordinator: Research
For REGIONAL CHIEF DIRECTOR

Copy
13.11.2001

University of
Durban-Westville

PRIVATE BAG X54001 DURBAN
4000 SOUTH AFRICA
TELEGRAMS: 'UDWEST'
TELEX: 6-23228 SA
FAX: (031)204-4383
☎ (031)204-4111

21 May 2001

Attention: The Superintendent
Department of Education and Culture
Truro House
Durban
4001

Dear Sir

PERMISSION TO CONDUCT RESEARCH AT AMAOTI PRIMARY SCHOOL

I am registered as a student in the Combined Masters in Education and Training (COMET) programme at the University of Durban Westville. As part of the degree requirements, I am working on a dissertation which focuses on substance abuse among primary school learners.

I am writing to request permission to interview learners at Amaoti Primary School. The principal, Mr J. Mfeka, has provisionally agreed to my request. I shall only be in position to continue my research, however, once you have granted official permission.

The title of my dissertation is as follows: Substance abuse amongst primary school learners in Inanda: Five case studies examining learners' perceptions and experience. Should the department agree to my request, I shall seek consent from both learners and their parents to conduct interviews and research with the children over the month of June 2001. It is hoped that the kind of understandings that will emerge from my study will assist schools in both remedying the effects of substance abuse among young learners and offer a way forward for preventative programmes.

Should you need further clarification please contact either myself at 083 6679298 or my supervisor, Miss Clark, at 2044606 (o/h).

Yours faithfully

Andries Mhlongo
Masters student

Bheki Mnyandu
Head: Post-graduate programme