ADDICTION AND RECOVERY FROM WHOONGA: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS OF THE LIFEWORLD OF YOUTH FROM INK TOWNSHIPS "IN RECOVERY"

UKUBHENYWA NOKUSIMAMA EKUBHEMENI IWUNGA: KUHLUNGWA NGOKUHLOLISISA NGE-PHENOMENOLOGY EHUMUSHAYO UMHLABA WEZIMPILO ZENTSHA YASEMALOKISHINI ASE-INK "ESIMAMAYO"

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Declaration

Thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy in the School of Applied Human Sciences, Discipline of Psychology, College of Humanities, University of KwaZulu-Natal.

I, *Thabani Khumalo*, declare that:

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Abstract

In dealing with a rampant increase in addiction to whoonga or nyaope, a heroin variant drug that has taken hold amongst Black youth in South African townships, the employment of addiction treatment that includes harm reduction measures is advanced. Complementary to these approaches, this study speaks to addictions to whoonga from an ecological perspective, a macro level approach concerned with eliminating addictions by identifying their root causes. In seeking solutions and intervention from the environment that begets addictions, recovery draws empirical evidence from overcoming addiction, a science of factors prompting, sustaining, and supporting abstinence and long-term recovery. This is a person-centred approach that begins with an understanding of recovery from experiences of those "in recovery", people who are in the process of resolving their addiction issues, to advance interventions that people would identify and be familiar with.

To make sense of addiction and recovery from whoonga from the perspective of those who were involved, six young Black African males between the ages of 20 and 33, who had desisted from whoonga use for an average of 3.3 years, were recruited from the communities of Inanda, Ntuzuma, and KwaMashu (INK) townships, north-west of Durban. Participants were recruited through snowballing, and by using advertisements. Participants were interviewed in-depth, and one-on-one at their original homes, using semi-structured interviews. These interviews were guided by an interview schedule derived from literature on addiction treatment, self-change models, as well as recovery frameworks. Interviews were recorded and transcribed. Transcripts were subjected to interpretative phenomenological analysis (IPA), a qualitative methodology derived from hermeneutic phenomenology that was developed within psychology to add an idiographic component. To understand what addiction and recovery from whoonga meant for participants, four superordinate themes: becoming *iphara*, being *iphara*, curative confrontations (becoming human) and nurturing potentials (approximating citizenship), guided discussions.

Results show that addiction to whoonga transformed participants in profound and deleterious ways. Addiction was characterised by a state of being *iphara*, a term that describes the embodiment of dedicated whoonga use. While whoonga addiction was initiated in pursuit of pleasure, escaping difficult life situations, and boredom, and where the influence of friends and peers dominated, it soon became a burden that began with the body becoming the site for pain. The state of being a whoonga addict is described as a preoccupation with the drug and the now, in which there is a deficiency of care for oneself, others, and other life concerns. Largely because of crime committed in the pursuit of the next fix, whoonga addicts are marginalized and

ostracised by the community and family members. Other than isolation, to be an *iphara* is a perilous and precarious lifestyle, in which vigilante attacks from the community retaliating would put addicts' lives and the lives of those close to them in danger. Arrests presented criminal records with huge implications for future employability. Recovery from whoonga was founded on survival instincts and a sense of self-preservation when difficult conditions as an addict were presented to participants' lives. The crossroads within whoonga addiction lives jolted participants to the correct orientation to the truth, demanding reorientation to the present, that involved the evaluation of the past and concerns with the future. Although desistance can be coerced, an inner resolve to end addiction lives was deemed necessary; and such bolstered courage to attempt desistance. Desistance involved the use of Methadone: this was difficult particularly for participants who desisted from whoonga use without recourse to medication and professional help. Recovery marks a sense of growing and maturing; taking responsibility for oneself and others, which are efforts of becoming *umuntu*/human; making amends with peers, family members, and the community.

Participants in this study present evidence of overcoming whoonga addiction. They offer an opportunity for the emergence of recovery support in the creation of peer recovery-support groups. Participants would model recovery, presenting hope to those addicted and the community, that overcoming whoonga addiction is a reality. Such should alleviate stigma and create pressure on the unwilling. Peer-recovery groups provide communities of former whoonga addicts with a place to go to. Such communities are best positioned to support early recovery experiments in empathic and non-judgemental ways. To filter preventative measures, reorientation of youth to traditional African ways that support and bolster a sense of pride in who they are, is necessary. Instilling mechanisms of earning membership to the community, and guidance on navigating transition to adulthood, for example, rites of passage amongst youth, would be necessary. The message is that actions and behaviours reverberate, affecting their communities. For youth to understand the plight of own communities, teaching individual responsibility to the health and welfare of communities, is important for prevention.

Keywords: Addiction, Black African youth, recovery, recovery capital, whoonga/nyaope, *ubunsizwa*, townships, *Ubuntu*

Iqoqa

Ekuhlahleni indlela iNingizimu Afrika ezobhekana ngayo nokubhebhetheka kokusetshenziswa kwesidakamizwa esibizwa ngewunga noma i-nyaope, nokuyisidakwamizwa se-heroin exutshiwe esesithathe isizinda kwintsha eMnyama ehlala emalokishini, kuhlongozwa ukulandelwa kwezinhlelo eziphakamisa ukusetshenziswa kokulashwa kwezidakamizwa umhlabawonke nezifaka izinhlelo ezehlisa umonakalo odalwa izidakamizwa. Ekuhlangabezeni ngokulekelela lezizindlela, lolucwaningo lubheka ukubhenywa kwalesisidakamizwa ngokusibheka ngokwesimo semvelo, nokuyindlela ebanzana efaka ukuqedwa kokubhenywa kwezidakamizwa ngokuthola izimbangela eziyizinzika edala ukubhenywa kwezidakamizwa. Ukuthola izixazululo nendlela okungangenelelwa ngayo ngokwezendawo edala ukuhuqwa kwalezizidakamizwa, ukusimama ezidakamizweni kuhlongoza ukuqhakambiswa kwezindlela abantu abasimama ngayo ekubhemeni izidakamizwa, nokuyisayensi yokusimama efaka ukuthi yini eyenza abantu baqalise ukusimama, bakulondoloze futhi balekeleleke ukuthi baziyeke futhi baqhubeke bengazibhemi izidakamizwa. Lokhu kubeka phambili umuntu ombandakenyayo, okuqala ngokuthi siqondisise kahle ukuthi abantu abasimamayo, nabaziyekile izidakamizwa benzenjani, ukuze sikwazi ukuthola izisombululo ezizojwayeleka kubantu ngoba zisuselwa kulokho abakwaziyo nokwenzekayo ezimpilweni zabo.

Ukuqondisisa kahle ukubhuqabhuqwa nokusimama ekubhuqwabhuqweni ukubhema iwunga kususelwa kwizindlela abayibona ngayo labo abambandakanyekileyo, izinsizwa eziMnyama eziyisithupha ebezineminyaka esukela kwamashumi amababili kuya kumashumi amathathu nantathu, nababesebeyiyekile ukuyibhema iwunga isikhathi esingangeminyaka emithathu nezinyanga ezintathu sebebonke, batholakale kumphakathi wamalokishi aseNanda, eNtuzuma naKwaMashu, kwinyakatho ntshonalanga yeTheku. Ababambe iqhaza kulolucwaningo batholakala ngokuthi bamemane, kwasetshenziswa nezikhangiso. Kwaxoxwa nabo kabanzi kwizinkulumo ubuso nobuso besemakubo. Lezizingxoxo zazingakhululekile ngokuphelele ngoba zazilandela imibuzo eyayihleliwe. Lemibuzo ehleliwe yasuselwa kwimibhalo nezingcwaningo ezidlule kwizifundo zokulashwa kokubhuqabhuqwa izidakamizwa, ukuziguqula kwabantu ngokwabo kanye nakwizinhlaka zokusimama ezidakamizweni. Lezizingxoxo zaqoshwa zabhalwa phansi umcwaningi. Lemibhalo yabe isihunyushwa kusetshenziswa i-interpretative phenomenological analysis (IPA), nokuyindlela yokucwaninga e-qualitative, esuselwa kuhlobo lwe-phenomenology ehumushayo eyabe isifakwa ukuhluza i-idiography ngaphansi kwazo izimfundiso zoMoya. Ukuthi ingenziwa njani lendaba yewunga izosuselwa kwizinhlaka zokusimama. Ukuqondisisa ukubhenywa nokusimama ekubhemeni

iwunga, kuzosetshenziwa lezizingqikithi ezikhuluma ngo: Ukuqala ube iphara; Uma usuyiphara, Ukunqwamana nezimo ezinzima kodwa ezilulamisayo (Usuqala uba umuntu), bese kuba ukwenza izinto eziqhubekisela phambili impilo uzokwazi ukubuyela usebenze njengomuntu ojwayelekile (okungukwenza izinto ezisimamisayo neziwubuntu).

Imiphumela yalolucwaningo itshengisa ukuthi ukubhuqwabhuqwa iwunga kwabashintsha ngendlela egxilayo nenemiphumela emibi kubona siqu sabo, nokuchazwa njengokuba iphara nokungukuba isimo sobuhambuma. Nakuba ukuqala ukubhema iwunga kwakungukuhubha intokozo nokuthanda izinto, kubalekelwa izimo ezinzima emakhaya nesimo sokungenzi lutho, lapho kudlange ukushomana nokuthokozisa abangani, iwunga yabe isisuka iba umthwalo, okwaqala ngomzimba usugqamisa ukuba sezinhlungwini. Ukuba iphara kuchazwa njengokunaka iwunga kuphela nentokozo yamanje, lapho umuntu akasenandaba naye, abanye abantu kanye nokwenza ezinye izinto ezibalulekile empilweni. Ngenxa yobugebengu, ukuba iphara kusho ukunyongozwa umphakathi nemindeni, bakukhiphela ngaphandle. Ngaphandle kokunyongozeka, ukuba iphara impilo enobungozi lapho intukuthelo yomphakathi ongahlasela ubeke impilo yakho kanye neyomndeni wakho encupheni kungenzeka. Uma beboshwa babuya benamarekhodi obugebengu okwenza kubenzima ukuqasheka. Ukusimama ukubhema iwunga kutholakala lapho impilo isikubhincisela nxanye sekusele ukuzisindisa wena sekufike izimo ezinzima ezihambisana nokuphila impilo yokubhema iwunga. Lesisimo sokukhetha sihlokolozwa ukuzibuzisisa nokubheka impilo ngendlela eyiqiniso ephoqa ukuthi umuntu abuke isimo lapho ekhona, abuke emuva bese ecabanga ngekusasa. Nakuba ukushiya iwunga kungaphoqwa, uma kusuka ngaphakathi kuyaye kumthwale umuntu ukuthi amelane nezinhlungu zokuyeka. Kwasetshenziswa i-Methadone ukuyeka iwunga, kunzima kakhulu ukuyiyeka, ikakhulukazi kulabo abavele bayeka bengasebenzisanga muthi bangaya nakwabezempilo. Ukusimama kunokufana nokukhula, uyimele impilo ubenendaba nokuzinakekela unakekele nalabo abaseduze kwakho, okuyimizamo yokuba umuntu, uphinde uzwane nabantu, imindeni, abangani kanye nomphakathi

Ababambiqhaza basivezela ubufakazi bokuyekeka kwewunga. Basinika ithuba lokuqala izindlela zokulekelela labo abafuna ukuyiyeka, kanye nalabo esebeyiyekile, bengabuyeli. Bangahlahla indlela etshengisa abanye ukuthi iwunga iyayekeka. Bangahlanganyela ndawonye basize laba abasandakuyiyeka ngendlela engezobanyongoza bezozwelana nabo ngosizi abalwaziyo bonke. Ukubhenywa kwewunga emalokishini kuqeda isithunzi, lapho uma ubuntu bufundiswa kwintsha kungaveza izindlela zokuziphatha, nokubaluleke ekuqhubekezeleni umphakathi phambili. Lokhu kungasiza ukuthi balulame nokuthi bengayiqali nokuyiqala iwunga.

Amagama aqavile: Iwunga noma i-nyaope, ukubanjwa izidakamizwa, intsha eMnyama, ukusimama, interpretative phenomenological analysis, IPA, amalokishi, i-recovery capital, ubunsizwa, ubuntu.

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Abbreviations

AA – Alcoholics Anonymous

Aids – Acquired Immune Deficiency Syndrome

AOD – Alcohol and Other Drugs

ARV – Antiretroviral medication

CBD – Central Business District

CDA – Central Drug Authority

DoH – Department of Health

DoJ&CS – Department of Justice and Correctional Services

DSD – Department of Social Development

FET – Further Education and Training

HIV – Human Immunodeficiency Virus

INK – Inanda, Ntuzuma, and KwaMashu

IPA – Interpretative Phenomenological Analysis

LSD – Lysergic Acid Diethylamide

NA – Narcotics Anonymous

NAS – Neo-natal Abstinence Syndrome

NIDA – National Institute on Drug Abuse

OST – Opioid Substitution Therapy

QoL – Quality of Life

REC – Research Ethics Committee

RIT – Recovery-Informed Theories

SA − South Africa

SACENDU − South African Community Epidemiology Network on Drug Use

SAMHSA − Substance Abuse and Mental Health Services Administration

UK – United Kingdom

UNODC – United Nations Office on Drug Control

USA – United States of America

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CHAPTER ONE
INTRODUCTION

South Africa is taking a trajectory in dealing with a wave of addiction to whoonga or nyaope, a relatively new heroin variant drug vexing mainly Black African youth in South Africa. Such a pathway is an adoption of universalised approaches based largely on addiction treatment, and extending such treatments to communities (Scheibe et al., 2018; Waetjen, 2019). However, Kolker (2017) found it an ethical imperative to addiction professionals to seek alternatives to such reductionist, reactionary, mechanical, and individualised models. Despite monopoly over the drug-addiction industry, addiction treatment has been spectacularly unsuccessful in making a dent, let alone ending addictions, worldwide (Gori, 1996; Hall et al., 2015; Kolker, 2017; Levine, 2009). Devoid of a broader social framework and contextual factors that drive addiction, Orford (2008) finds "brilliant success" of single-factor models in yielding "empirically supported therapies" to have reached a dead end. In reducing addiction problems to a problem of the person who is consuming an addictive drug, the notion that addiction resides solely within the individual (Graham, 2009); medicalization, moralization, and pharmacologization of drug addiction enables disease and moral perspectives that aid the discrimination, marginalization and ostracization of people addicted to drugs (Alexander, 2014; White, 2007ab). While nurturing the development of victimism, helplessness against a drug, personal agency to get well, or to recover is excluded (Ngo, 1994); and prevention is relegated to other agencies. Even though the person is not held responsible for addiction, as with the moral model, they are, however, held responsible for change; such is a personal responsibility to get well or to find the solution (Marlatt et al., 1988; McLellan et al., 2000). Therefore, while the disease model is a guilt-assuaging metaphor (White, 2002b), recovery is expected, amounting to victim blaming (Wilbanks, 1989).

This study adopted recovery as an organising construct (White, 2005), drawing from the ecological and recovery approaches to dealing with addiction to drugs (Alexander, 2010; Weinberg, 2000; White et al., 2005). Brown and Ashford (2019) argued that recovery-informed theories (RIT) have grown to a fully developed model that can rival grand theories on addiction. This position proposes that recovery divorces itself from addiction treatment, opting to draw empirical evidence from itself (Brown & Ashford, 2019). The basis for ecological models in approaching drug addiction in this study, is linked to the dislocation theory. This theory has been positioned by itself and by its detractors in ways that are downright antithetical to addiction treatment (MacBride, 2017). The ecology of addictions finds a drug, the object of addiction, to be insufficient in explaining addictions. With regard to harm-reduction measures, both these micro

and macro theories agree, that for the welfare of persons addicted to drugs, a need to mature away from that hostility suggests finding ways to work together (Alexander, 2009; McKeganey, 2011). The use of addiction treatment under the harm-reduction banner reflects an eagerness of society for humane treatment of addicts (Anderson et al., 2014) that is important in initiating recovery. Nevertheless, the ecology of addiction problematises the medicalization of human and social problems (Alexander, 2000; Weinberg, 2000). Laudet and White (2010) present an accusation of treatment institutions in their detachment from the larger and more enduring processes of recovery. This means that such institutions are found to be disconnected from the physical and cultural contexts in which recovery either succeeds or fails (Laudet & White, 2010). The environment that propagates addictions, for White (2002), is an ecosystem that can either crush or nourish recovery experiments. Recovery frameworks are a micro-level approach in dealing with addictions that present pragmatic, resistant, and survivalist solutions applicable to a whoonga situation. However, to eliminate drug addictions, connections are important, and make a crucial link to spiritual orientation among African people, prioritised in encouraging community agency.

This chapter introducing this research report began by establishing the problem the study addresses. This included the theoretical stance. Although the approach grew out of dissatisfaction with addiction treatment, and is a position that can be adversarial, it advances a complementary role in the context of whoonga addiction. The following section will discuss the background to the problem. This will lead to the section that discusses the aims and the objectives of the study. The next section will present research questions the study addressed. This section will be followed by limitations and delimitations of the study. The last section of this chapter will present an outline of the rest of the research report, focusing on what each chapter presents and discusses. Following on from this chapter, there is a section that defines key terms. Concluding comments will follow.

1.1 Background to the Research Problem

Amongst a multitude of illicit drugs entering the South African democratic environment, whoonga or nyaope is the most enduring opioid, popular since the early 2000s amongst Black African youth in townships and informal settlements around the country (Ephraim, 2014; Montesh et al., 2015; Moodley et al., 2012). Its prevalence was reported to have peaked in Durban, spurred on by the 2010 World Cup frenzy, during which whoonga use spiked. Whoonga usage is now confirmed as nationwide, having spilled to rural areas and neighbouring countries (Dube, 2014; Kapitako, 2017; Nevhutalu, 2017). This drug is described as a whitish powder comprising cheap heroin that is mixed with an array of bulking agents, to increase the dealer's yield, since pure heroin is expensive: it is nevertheless highly addictive (Boomgaard, 2010; Ghosh, 2013; Kempen,

2019; Venter, 2014). Although heroin can be snorted, inhaled, injected, or smoked, particular to its South African variant, whoonga, is that it is sprinkled on a cannabis joint before being smoked (Kuo et al., 2020; Ross, 2013; Shembe, 2013). Anecdotal evidence shows that whoonga is now ingested through "chasing the dragon" – inhaling its fumes from heated aluminium foil. This method of ingesting heroin is the "traditional" way heroin is consumed worldwide (Strang et al., 1997). Perhaps a commentary and a warning on the increasing availability of purer heroin in South Africa (Kempen, 2019; Marks et al., 2020), there are reports that whoonga can also be injected (Mabena, 2017; Tsipe, 2017). Such information brings fears of increasing a spread of blood-borne diseases. Treating whoonga addictions and the health conditions that the drug intersects with, is aggravated by its intravenous use (Reid, 2009). Such use is linked to HIV/Aids, Hepatitis B and C (Scheibe et al., 2019), and other medical complications (Meel et al., 2014; Thomas & Velaphi, 2014), presenting a challenge that further stretches limited health and mental-health care resources (Mokwena, 2015).

While the consideration of costs would shift a focus to addiction treatment expenses (Weich, 2010), the social damage and its future ramifications are difficult to quantify. Whoonga addiction is forecasted to derail the gains of the socio-political emancipation ushered in by the transition to democracy in 1994. In turning youth that Freeman (1993) described as "the lifeblood of change" and able-bodied members of these communities into dysfunctional human beings, renders whoonga addicts as a liability, recovery from Apartheid being thwarted. In pursuit of a whoonga high, addicts drop out of school (Shembe, 2013). To feed addiction, some whoonga addicts sell scrap metal, or perform menial jobs like washing minibus taxies, now considered the whoonga economy; others steal (Chapman, 2014b; Hunter, 2018). Whoonga addiction propagates criminality, prostitution, and other social ills (eNCA & SAPA, 2014; Ghosh, 2013). Owing to crimes some people addicted to whoonga commit, their dirty and unkempt appearance, begging on streets, whoonga addicts are perceived as a social nuisance (Barclay, 2015; Motsoeneng, 2015). There is a general sense of repugnance towards them (Zibi, 2018). There are clear views that whoonga addiction destroys youth (Masombuka, 2013; van Zyl, 2015). For Naik and Serumula (2015), addiction to whoonga "sends their future up in smoke". Whoonga addiction destroys families (Mafokwane, 2017) and communities affected by whoonga addiction (Nkosi, 2017; Simelane & Nicholson, 2013). The "born frees" or the "Mandela babies", an identification of those born after Apartheid in South Africa, a second cohort behind the "struggle" generation (Mattes, 2012), are ravaged by whoonga. The previous generation nearly lost the struggle against HIV/Aids (van der Vliet, 2001). The two previous generations of the 1970s and 1980s were involved in a political struggle, sometimes at the expense of their education (Seekings, 1995, 1996). Continuing

lack of skills and unemployment render Black African youth unable to participate in a meaningful way economically, further rendering them susceptible to drug use (Dlamini, 2014; Mlatsheni & Rospabé, 2002). Compared with other race counterparts, there is no relief for the majority of South African Black youth from a situation that can be described as under siege for the past four decades, excluding the classic colonial years (Seekings, 2008; van Kessel, 2000).

What has been established is that drug use among youth leads to problems and dysfunctions (Hawkins et al., 1992). A call for what needs to be done to address whoonga addiction was made in the context of an identified need to support those wishing to cease using whoonga (Mokwena, 2016). In a study in which whoonga addicts requested their plight to be considered, participants did not want to take whoonga anymore but could not stop; pointing to excruciating and painful withdrawals; they had many failed attempts (Mokwena, 2016). As a concern with interrupting the cyclical use-relapse-reuse, there were suggestions for a need to support people addicted to whoonga, to initiate long-term recovery. Other support options were concerned with limited resources and a need to consider the context of addiction, recommending community-based approaches (Mohasoa, 2018; Mokwena, 2015; Ramson, 2017). These ideas are derived from a consideration of the enormous number of whoonga addicts given limited access to rehabilitation centres, both public and private, as well as to the non-existent after-care facilities (Mahlangu & Geyer, 2018; Mokwena, 2015; Mokwena & Huma, 2014; Mokwena & Morojele, 2014). In that space, professional intervention will be systematically availed to communities to alleviate the psychosocial anomalies that drug addiction attracts (Fernandes & Mokwena, 2016). These suggestions by researchers further find limitations in acute care: individuals return to communities, the environment that enabled addiction in the first place; hence often relapsing (Davidson et al., 2010; Mokwena, 2016). For Bain (2004, cited in Swanepoel et al., 2015) and Copeland (2014), relapse even months after abstinence began, can be triggered by this return to the old environment, the place where the drug was initially taken.

The government has availed funds for the delivery of substance-abuse treatment, increasing state-funded treatment slots, and training additional health and social workers (Myers et al., 2012, p. 667). Furthermore, while they are not limited to admissions for whoonga addiction, new public drug-rehabilitation institutions are being built (Mabuse, 2014). Unlike softer drugs that have always been available in communities, whoonga is a hard drug, and its effects are described as severe, intense, and pernicious (Kaminski, 2014; Mokwena & Huma, 2014). Given its unique and pervasive nature, whoonga is a drug that has created dedicated users in large numbers over a short time. In dealing with whoonga addiction in South Africa, the suggestions are such that it cannot be business as usual. Such views support tailor-made strategies (Khumalo, 2016), efforts

that go beyond normal substance-abuse-intervention programmes. Further calls are made for collaboratory and multi-sectoral interventions that would begin with aggressive educational campaigns nationwide (Dintwe, 2017; Khumalo, 2016; Monyakane, 2018). Such would be filtered to schools and other community levels of intervention (Khumalo, 2016). The roll-out of a drug to mitigate pain and suffering from withdrawals, and to initiate and augment recovery, is also advanced (Cole, 2016; Marks et al., 2017; Sowetan Reporter, 2015).

However, in some sections of the country having prolonged experience with drug use among youth, for example, on the Cape Flats, where the use of drugs, particularly methamphetamine, called "tik", is rampant (Watt et al., 2014 as cited in Dennis, 2018; Weybright et al., 2016), a number of rehabilitation centres exist (Ramson, 2017). Despite this, drug addictions do not diminish; and community-based approaches are further suggested (Ramson, 2017). In this context, these suggestions propose the need to address drug addiction at differing levels of ecological functioning (Ramson, 2017). This is a proposal for the consideration of social and environmental factors that drive addictions (Mokwena, 2019; Mokwena & Morojele, 2014). This view is consonant with suggestions that interventions should be multi-faceted, incorporating biopsychosocial approaches to address "individual, family, and/or community levels" of functioning (Khumalo, 2016; Griffin & Botvin, 2010, as cited in Ramson, 2017). Practically, these suggestions propose that such community-based networks, organisations and programmes are a nudge towards a holistic and a comprehensive or integrated approach that supports addiction treatment. Similar proposals are drawn from macro-level interventions that link the complexity of factors driving addiction, for example, poverty and unemployment, to the causes that determine and influence the course of whoonga addiction (Mohasoa & Mokoena, 2017; Mokwena & Morojele, 2014). This consideration of the cyclical interdependence of socio-economic factors and addiction to drugs acknowledges the role of psychological consequences of poverty and marginalization. Such factors lead to economic behaviour, which, while a means of escaping the environment and its adversity, makes it difficult to escape these conditions, perpetuating, and thus entrenching them (Haushofer & Fehr, 2014). For example, in a study in Britain, in which communities engulfed by mass drug addictions were of low socio-economic living, addiction to drugs by these communities was associated with further economic decline (Buchanan, 2006).

This study conceptualised addiction to whoonga from a recovery perspective, an ecological model that is applicable at micro-individual and local or community levels. There is a concern with how to interrupt addiction lives by supporting long-term recovery. The basis for a recovery model is a growing recognition that people do recover from drug addiction (Best & Lubman, 2012; Prince, 1994, & Waldorf, 1983, as cited in McIntosh & McKeganey, 2000). Evidence of mass

recovery was documented from studies of Vietnam-war veterans in the early 1970s in the United States of America (USA) (Robins et al., 1974). Data mined from the West found that 58% of people addicted to drugs do eventually find sustained recovery from drug addictions (Kessler, 1994, as cited in White 2004). Some 71% were generally discovered to recover from AOD over a span of their lives (White, 2012). People who initiate their own recovery using available support hardly ever consult institutions. In a South African study by Pryce (2006), six individuals who overcame addictions, did so independently. With regard to whoonga, news media have presented this evidence, and in all of these case reports, individuals were assisted by strangers, individuals who could be considered Good Samaritans (Molobi, 2018; Saving Jesus: How addict Jesus survived the nyaope epidemic, 2019); and by communities (Kuaho, 2018).

1.1.1 Recovery and subjective experiences

Driven by the medical and the moral gaze, the study of addiction within addiction treatment has excluded individuals who were being treated, marginalising them. For Reith and Dobbie (2012, p. 512), accounts of recovery pose a problem for the biomedical model. They interrupt the narrative of drug addiction as a chronic relapse disease that is difficult to surmount. As users are experts in this area, Pryce (2006) is concerned with deriving knowledge of addiction from users themselves, the breaking of this "silence". In the study of addictions, according to Alexander (2000), only experimental and medical research has been considered really valid. In finding potent medication for social problems, Bulhan (2015) finds this neglect of screaming historical, social, economic, and cultural factors driving those problems the maintenance of the status quo, and the perpetuation of metacolonialism. For Anderson et al. (2014), such is centred on racial inequality. Support of treatment ignores the socio-economic and cultural causes and effects of addiction, ignoring the history of those affected. For Brown and Ashford (2019), the systematic understanding of successful recovery phenomena begins with and is guided by the experiences of those who have successfully resolved their substance-abuse issues. In the context of heroin addiction in other countries, studies in this area have used phenomenological approaches, including interpretative phenomenological analysis (IPA), to excavate pathways to recovery; as well as their experiential and subjective nature and overlays (Bloom, 2016; Flaherty et al., 2014; Rossini, 2016; Shinebourne & Smith, 2010; Williams, 2002). This is a shift from the use of dominant methods in contemporary drug research that have remained largely quantitative (Rhodes & Moore, 2001). For Alexander (2010), this is a movement of the study of addictions from medicine to the domain of social sciences.

Qualitative research methods are considered appropriate for the study of experiences with drug addiction (Rhodes & Moore, 2001). Applied to research, phenomenology is the study of the nature and meanings of phenomena (appearances) (Finlay, 2009, as cited in Kafle, 2011). A focus on lived experiences attends to how people perceive the world they live in and what this world means to them (Langdridge, 2007, as cited in Kafle, 2011). A strong case for phenomenology in psychology, the dedicated study of human beings, is made by Molenaar (2005). In a manifesto for idiographic psychology, the focus on subjective experiences is considered the putting back of man into psychology (Molenaar, 2005). Larkin and Griffiths (2002) define subjective experiences of addiction as psychology of addiction. To understand addiction and recovery from whoonga, IPA was used. IPA's focus on ideography is a look at experiences as they are; how they are experienced by a person in a certain context, to make sense of the phenomenon (Shinebourne, 2011; Todorova, 2011). African philosophers have found hermeneutic phenomenology, the basis of IPA, despite its European source and composition, to be emancipatory. Hallen (2004) described the interpretation it espouses, a rendering that arises from the contexts of which it is a product and which it, in turn, may thereafter transform. For Smith (2018), the experience of what is happening is turned into an event by the importance the person involved, and who is potentially changed by it, places on it. As a turning point, signaling change or transition, "recovery" for each participant signified a profound, innermost, and personal experience (Kelly & Hoeppner, 2014).

1.2 Aims and Objectives of the Study

For Dreyfuss (1991, as cited in Daher et al., 2017), the quest for creating formal models and the development of decontextualised theories has not succeeded in capturing human complexity. The study of addiction and recovery from whoonga from the perspective of those who overcame whoonga addiction, is the study of addiction as a complex, meaningful, and a human phenomenon. For Williams (2002), this subsumes subjective experiences overlooked by the mechanistic/reductionist approaches concerned with the moral aspects of addiction. Reflecting on the medical gaze in addiction treatment, for Bloom (2016), what experts ponder about addiction is important, and they could even be correct. However, a proper understanding of addiction is an experiential/phenomenological understanding (Bloom, 2016). In a Taiwanese study on addiction to heroin, researchers noted physical, psychological, and economic struggles endured by dedicated drug users. Researchers associated the prevalence of negative attitudes − stigma and marginalization, with lack of empathy and misunderstanding of addicts' lived experiences (Hsieh et al., 2017). For mainstream addiction methods, this is an understanding of user experience that follows a pragmatist approach (Wright & McCarthy, 2008). According to Wright and McCarthy

(2008), experience is the basis of all action and interaction that generates frameworks for conceptualising and working with everyday experience.

The aim of the study is to give these important stakeholders, people who were involved themselves, a chance to be heard, and a voice that is often silent in dominant approaches. This voice may change the way addicts and addiction to whoonga is viewed, which has the potential to influence conditions leading to addiction and supporting those who are addicted to initiate and maintain recovery; and this includes prevention. Owing to its newness, and despite widespread use (Mokwena, 2019; Mokwena & Huma, 2014), very little is known about recovering from whoonga, let alone from an insider perspective. The objectives of this study centre on the creation of an empathic understanding of the plight of those addicted to whoonga. This helps direct necessary support that is further advanced by the identification of conditions that drive and retard addictions and recovery. Such objectives also include seeking ways for instituting preventative measures. An empathic understanding of addiction to drugs induces helping relations in which empathy, emotional authenticity, and encouragement empower people to do things for themselves that they had been unable to achieve by themselves (White, 2002b). The trail individuals took to recovery sheds light on what prompts recovery and how it can be achieved. Aggregated, these pathways inform on recovery trajectories that make recovery possible. Such pathways to recovery direct addiction professionals, teachers, and schools, policymakers, and government departments, as well as families and communities, on how to support recovery. Importantly, participants in this study present evidence that addiction to whoonga can be overcome. This would model recovery, showing to addicted individuals that it can be done, and how it can be done. This will further link to a means of support for people to initiate recovery, i.e., to support those wishing to stop. It also includes creating ways to support long-term sobriety. Drawn from people who were involved, this further yields relevant interventions that people would identify with and relate to. The study is an understanding of recovery at both macro and micro levels, and this interaction is an appreciation of a person's embeddedness within social and cultural life (Granfield & Cloud, 2001).

1.3 Research Questions

The position assumed by this study is that whoonga addiction has deleterious effects on individuals involved, as well as on their families and communities. This presents a need to curb whoonga addiction linked to the political, socio-economic and cultural recovery needs for Black African people in townships and informal settlements of South Africa. Such a position is opposed to a libertarian and/or Szaszian approach, an idea that maybe drug addictions are beneficial to individuals who take them. As a substance of abuse of their choice, perhaps such brings meaning

to them; encouraging them to stop is infringing on their liberties (Alexander, 2015b; Azibo, 2016). This involves the idea that addiction should be allowed to take its course. Although recovery can be coerced, this study does not encourage violent and often persecutory measures to end drug use; it is oppositional to the war on drugs (Friedman, 1998). The contention here is that Black African communities cannot recover from many years of racial and economic subjugation amidst addictions to whoonga by their youth, a view that whoonga addiction perpetuates the effects of Apartheid.

By adopting ecological approaches, the study finds solutions from people involved, drawing from their experiences ways of supporting them to initiate sustained sobriety. This approach is different from top-bottom approaches concerned with the treatment of addictions. The study concerns itself with finding solutions in the context of whoonga addiction by enabling and engaging communities. The broader social and cultural factors associated with addictions are taken into consideration. The focus on ending addiction is a focus on life after sobriety, rather than temporal efforts to mitigate suffering that is widely promoted in the context of whoonga addictions. Solutions are sought from communities by addressing the fundamental causes of the problem, drawing from their strengths, as opposed to a focus on pathology.

To understand what it is like to be addicted to whoonga involves experiences of addiction and accompanying feelings, thoughts, and expressions as they appear to the participant in the context of his or her life (Shinebourne & Smith, 2009). From experiences of individuals that had partially resolved addiction from whoonga, what addiction and recovery as ways of being-in-the-world means, is explored. Recovery capital, an encompassing term for internal resources and social support necessary for recovery, including elements that support and retard addiction and recovery, was investigated. This involves the identification of elements that supported addiction and those that promoted and hindered recovery. The conception is that recovery is initiated by an individual; however, individuals will require support to both initiate and to maintain sobriety. Therefore, this research study sought to address the following research questions:

1. What are meanings that recovering whoonga addicts from INK townships attribute to the experience of addiction with whoonga, and recovering from whoonga addiction?
2. What are the individual, family, and community/organisational enabling dynamics in the recovery process, from the perspective of the addicts/former addicts?
3. How do individual, familial, and community/organizational dynamics constrain the recovery process, as narrated by the recovered/recovering addicts?

1.4 Limitations and Delimitations

This study comprises views by male participants between the ages of 20-33. Even though whoonga is a male-dominated drug, there are indications that there are more women addicted to whoonga than to any other substance of abuse in South Africa (Dintwe, 2017; Reddy et al., 2011). This limits what can be concluded about women addicts. Participants are isiZulu speakers from INK townships, and an urban environment. Since whoonga addiction has spread nationwide and to rural areas, this limits conclusions that can be made with regard to other ethnic groups, and those in rural settings. Participants were at their early and stable stages of recovery, limiting insights into experiences with prolonged recovery. Even though participants reported to have been addicted to whoonga, none of them had received a formal diagnosis of their addictive behaviour. This is close to the client-centred view according to Valentine (2000, as cited in Best et al., 2015), that supports the notion that such people were in recovery because they said they were. Only one of the participants had attended an institution. By admission to such an institution, this participant would have been considered an addict, even had the institution not been a formal drug-rehabilitation institution. Participants were whoonga addicts based on their personal, family, and community evaluation, sans professional diagnosis. As an IPA project, the study hopes to limit its findings to the participants and the context of the research study. The study hopes for the transferability of findings, rather than for generalizations.

1.5 Outline of the Research Report

This chapter introduced a report of a research study on lived experiences with whoonga addiction and recovery, from Black African youths in INK townships who were addicted to whoonga and were recovering from whoonga addiction. The next chapter reviews literature on the progression of addiction theories, from the moral, medical, and the harm-reduction approaches. The chapter will further introduce the dislocation theory as the basis of ecological theories that will link its application at local levels to recovery frameworks. Chapter Three introduces an Afrocentric approach to drug addiction, as way of sense- and meaning-making, by focusing on an African experience in formulating an ecological approach to dealing with drug addictions among African communities. Chapter Four will focus on the empirical review of literature, the discussion of authoritative and pioneering studies on whoonga addiction in South Africa, shedding light on what has been done. This will position the problem the study is addressing, and by identifying a gap, show the need and the utility of this project. The fifth chapter on research methodology will outline how the study was conducted. Chapter Six on findings, will present two superordinate themes that illuminate the experiences of addiction. Chapter Seven will expand on findings, by

focusing on the experiences with recovery from whoonga by this sample, guided by the two superordinate themes. Chapter Eight discusses recovery capital, evidence of internal and external resources employed in desisting from, and subsequent recovery from whoonga addiction. Chapter Nine, on discussions, will build from findings to make sense of, and to elaborate on experiences with addiction and recovery from whoonga, focusing on what it was like for participants to be addicted to whoonga. This will further include experiences with recovery, focusing on desistance and maintaining sobriety. This chapter will make deductions from what participants saw as enablers to the addiction situation, as well as elements that support recovery. The last, tenth chapter, will give an overview of the study, discussing conclusions, and making recommendations for interventions and for future research.

1.6 Definition of Key Terms

- "In recovery" – subjective reference by those undergoing recovery (Shinebourne & Smith, 2009), referring to their new sober, productive lifestyles (White et al., 2010). *Recovered* and *recovering* are terms used to describe the process of resolving, or the status of having resolved, severe alcohol and other drug problems (AOD) (White, 2007a). Such means of ridding oneself of psychophysiological effects of drug addiction is extended to the social element of not only mending ways, including those used to acquire drugs; but also of forming relationships with peers, family, and the community (White, 2016; White & Cloud, 2008).

- Addiction – harmful involvement with drugs that produces *withdrawal symptoms or tolerance* (Alexander & Schweighofer, 1988, p. 151); the continuous use of an intoxicating substance, despite evident harmful effects it causes (Le Moal & Koob, 2007). Such addiction is compulsive, as it involves repetitive, paradoxical, and "appetitive" behaviour (Griffiths, 2015; Larkin & Griffiths, 1999, as cited in Larkin & Griffiths, 2002).

- Cannabis – class of cannabinoids. Cannabis is reported to date early in the African history, cultivated largely in the Southern subtropical areas of the sub-Saharan Africa under various names, including *insangu* for Nguni-speaking tribes. In South Africa, the drug is also known as dagga (du Toit, 1976). As the drug used by the natives, this use was associated with deviance, truancy, and their evil nature (Bourhill, 1913).

- Heroin – illicit opioid or opiate, diamorphine; in purer form this is crystalline powder ranging in colour from white to dark brown. It can be smoked in a traditional way using aluminium

foil. This way is known as “chasing the dragon”; it can either be smoked, snorted, or injected (Harper, 2000; Kempen, 2015).

- Lifeworld – linked mainly to hermeneutic phenomenology that explores the sense that participants make of their personal and social worlds (New World Encyclopedia, n.d.), while recognising the contribution of the researcher in elucidating the participants’ interpretations of their experiences (Reid et al., 2005; Wagstaff & Williams, 2014). “The world as it appears from the perspective of a given person” (Larkin, 2015, p. 8).

- Opioid – poppy or opium plant (*papaver somniferous*) extract, including morphine, codeine, heroin, etc. (Padwa & Cunningham, 2010; Swanström & Cornell, 2004; Weich, 2015). Opiate refers to the synthetic kind. The pharmacological use was once as an analgesic, but was redirected to illicit drugs, and is highly addictive (Moore, 2014). Opioids act on mu-opioid receptors in the brain; providing pain relief, euphoria, sedation, and, in increasing doses, inducing coma. Examples include heroin, morphine, opium, Methadone, and pethidine (Kempen, 2015; Moore, 2014; Padwa & Cunningham, 2010).

- Opioid Substitution Therapy (OST) – The use of substitution drugs to treat withdrawal syndrome from opioid abuse (Amato et al., 2013). This therapy works to wean an addict off drugs during the early phases of ceasing to take the drug. Methadone syrup is available in South Africa (Weich et al., 2008).

- Phenomenology – the study of lived experiences as characterised by pre-conceptual and pre-theory understanding (van Manen, 1984); or the study of essences, a philosophical position that studies consciousness, and as a research method, seeks to describe the experiences within a phenomenon (Laverty, 2003).

- Recovery – characterised by abstinence and active participation in society; “a voluntarily maintained lifestyle characterized by sobriety, personal health and citizenship” (The Betty Ford Institute Consensus Panel, 2007, p. 222). Recovery from dependent drug use is about sustained, not temporary, abstinence (McKeganey, 2011).

- Recovery capital − the sum of resources necessary to initiate and sustain recovery from substance misuse (Best & Laudet, 2010, p. 2).

- Township – Also known as "location", these are "Black" residential areas created by the apartheid enacting segregationist policies of the former South African government (Japha & Hüchzermeyer, 1995, as cited in Swartz, 2007).

- *Ubuntu* – African philosophy of becoming and being human, drawn from "*Umuntu ngumuntu ngabantu*", meant to denote that "I am human because I belong. I participate, I share" (Tutu, 1999, as cited in Swanson, 2007, p. 58).

- Whoonga/Unga – infamously known as nyaope (Swahili for white) (Kuo et al., 2020; Slater, 2010, as cited in Mabokela, 2018), or Unga (Swahili for "flour") (Eligh, 2020), is a whitish or brownish low-grade heroin that is largely smoked, although it can be injected (Mabena, 2017; Tsipe, 2017). It is a concoction of cannabis, cigarettes, and bulking agents (Kempen, 2019; Motyka & Marcinkowski, 2015). Also known as BoMkon (Venter, 2014), "Kataza" (Swahili for 'Forbid') in Gauteng, "Unga" in the Western Cape, Whoonga in Durban, and "Pinch" (Swahili for a measurement unit of heroin which is an equivalent to 1/8 gram) in Limpopo and Mpumalanga (Mabokela, 2018; Phokedi, 2018; Eligh, 2020).

1.7 Conclusion

Consistent in reports on drug addictions around the world is that they are on the increase. Mainstream approaches have not been successful in their interventions. Their monopoly has proven to thwart alternative approaches. A call for alternative paradigms is made by ecological and recovery approaches that consider a multidimensional nature of being human. This consideration of the inclusion of different levels of human functioning is an attempt to address root causes of drug addictions. To prevent drug addiction and to support long term recovery, community agency is invited. To institute support, this study takes cues from people involved. To understand their journey from inception to recovery, the study traverses both addiction and recovery from addiction. The following chapter (Two) will discuss addiction and its treatment repertoire. Taking from where addiction treatment ends, the chapter will re-introduce ecological and recovery models as a necessary and an inevitable evolutionary process in an ethical approach to drug addictions by addiction professionals.

CHAPTER TWO
ADDICTION AND RECOVERY MODELS

2.1 Introduction

The burgeoning model of recovery in approaching treatment of addiction to hard drugs signals a worldwide shift from a focus on addiction treatment and acute care, to a focus on recovery and chronic care (Laudet, 2007). For El-Guebaly (2012), Laudet (2008), and White (2008), this shift from long-standing pathology and intervention paradigms is a movement toward a solution-focused recovery paradigm (White et al., 2012, p. 1). Fundamentally, this is an evolution from the treatment of addictions, the focus on the "what" and "how" of addiction that attends the person and the drug that an individual is addicted to. In a consideration of "why" addictions occur, a focus on root causes of addiction is a concern with identifying macro-level factors that render people susceptible to drug addictions. The ecology of addiction and recovery includes the identification of strengths and appropriate support drawn from the very context that drives addictions in the first place. From the concept of "recovery capital", economic and human resources that support recovery from addiction are ideas that draw from individual efficacy, the interaction with the world, external resources, family, community, institutions and organisations, to initiate and to support recovery.

This theoretical review of literature discusses models spanning addiction to drugs and recovery from them. While it can be considered an evolutionary process as these models developed historically, such parallels are confounded by the lingering moral perspectives that overshadow a linear historical progression of these models. Recovery models predate mutual-aid recovery programmes in light of recovery networks emerging before the prohibitionist movement against AOD (White, 2004a). With regard to drug addiction, moral approaches and drug addiction stereotypy have remained. In the era of the medical model, the moral-aligned patterns championed by the war on drugs, continued to flounder into the medical model narrative (Rothschild, 2015). Ideas coupled with addictions as a disease that would be difficult to recover from, cement and enforce aphorisms like "once an addict, always an addict" (Barros, 2012; Waldorf, 1983). Therefore, a comprehensive approach that makes a cleaner break from previous models would appear antithetical; and ecological approaches as they developed might have grown from such a dissenting position. However, as Laudet (2008) asserted, recovery builds from addiction treatment. According to West (2013, as cited in Zautra, 2015), there is benefit in unifying different theories in an integrative framework that would incorporate the pertinent aspects of each individual theory, combining them into a single and robust model that can be used to improve treatment strategies.

This means that ecological theories cannot exclude neurochemical changes caused by drugs that are a reality of the physiological reaction to drugs. While the model accepts a multi-sectorial approach from this angle, such a model would be incomplete and misdirected without involving the community affected by drugs.

This chapter will begin with physical, psychological, and then social approaches that address interventions at individual and social levels of functioning. This is a presentation of the mainstream approach to drug addiction worldwide that informs the direction South Africa is taking in dealing with whoonga addiction. The chapter will delineate its basic presuppositions and the critique of these models, finding them insufficient in dealing with whoonga addiction. The consideration of social, cultural, and economic factors associated with a comprehensive model of addiction − ecological, and recovery frameworks − is introduced. The discussion of ecological models on drug addiction links their fundamentals to the dislocation theory. This section will expand on the ecology of recovery; which are models or frameworks applicable at both individual and community levels of intervention. The next section will give an overview of corresponding models that theorise on the interaction of the individual and the context of the family, and socio-cultural factors that drive and can remedy addiction to drugs, supporting recovery. A useful overview of studies on subjective experiences with addiction and recovery will follow.

2.2 Addiction Treatment

The mainstream approach to dealing with the problematic consumption of hard drugs is (largely directed by) a medical model. As a third wave in addiction treatment, it developed a concern with humane treatment of people addicted to drugs, in offering harm-reduction measures. In the evolution of narcotic addiction from the eighteenth to the early nineteenth century in the West, from whence this model was adopted, the initial conception was that addiction was “a bad habit” (Berridge, 1978). Now considered a disease, this foundation is traced to laboratory rat experiments conducted in the 1960s, particularly the “disease” model of alcohol use by Jellinek (1960, as cited in Matto & LCSW-C, 2004), and early 1970s (Alexander, 2010; Badawy et al., 1982). However, its fundamental propositions date to the temperance movement, that advocated largely moderate use of alcohol (Alexander, 2010, 2011, as cited in Alexander, 2012; Koski-Jännes, 2004; White, 2004a). Such included a variety of institutional responses and support rendered to people presenting with problematic use of alcohol and other drugs (AOD), largely by mutual-aid recovery groups (White, 2001). According to White (2001), mutual-aid recovery groups existed long before the traditional AA/NA (Alcoholic Anonymous/Narcotic Anonymous) organisations’ addiction treatment was largely associated with a global problem, including Africa.

AA/NA organisations, the Minnesota model, resumed after the end of the prohibitionist movement, the complete clampdown on the use, mainly of alcohol, in the USA (Anderson et al., 1999; White, 2004a). Today, research on laboratory animals continues to expand the understanding of the neurobiology of addiction to hard drugs (Le Moal & Koob, 2007). This neuroscience of addiction explained the physical and neurological processes of addiction, beginning from the neurochemical effects of drugs at an initial encounter; experimenting with the drug. Drugs attach themselves to pre-existing receptors. They release various neurotransmitters stimulating the pleasure centres, largely associated with dopamine, and they are highly reinforcing (Kemp, 2019). Frequent use, according to Kemp (2019), distorts the brain's ability to produce these endogenous transmitters. This sheds light on the progression of the disease, which includes the compulsion and motivation for continued ingestion of the drug, with resultant psychological effects (Gardner, 2000; Le Moal & Koob, 2007).

Drug dependence, now considered a chronic relapse disease, could have been a response to the moral outlook on drug addiction, presenting addiction as a disease for which a person needs treatment (Leshner, 1997). The calls for "evidence-based" interventions were promoted, which meant that interventions should be deduced from empirical research (Leshner, 1999). Though not overt, this meant that quantitative research studies, the signature approach to the study of addiction, were prioritised; and "alternative"; or qualitative approaches were discouraged and excluded. Interventions were largely at a physiological level, supplemented by psychological levels of intervention, i.e., behavioural therapy (such as counselling, cognitive therapy, or psychotherapy), medications, or a combination of these (Leshner, 1997, p. 1315). Acute care begins with detoxification, ridding the person of the psychophysiological effects of the drug (Courtwright, 2010). To manage withdrawal from the drug, substitute antagonist drugs would be administered (Weich et al., 2008), preferably in an institution. Institutions have professionals that guide and monitor the intake of substitute drugs, rendering psychological help and teaching life-skills (Baloyi, 2011). Institutions take individuals away from the demands of the daily grind, allowing them to focus on recovery. At the end of treatment, individuals return to their families and communities. This acute process takes place over a short time, according to Dennis and Scott (2007, as cited in Laudet & White, 2010). It includes the screening, assessment, treatment, then a discharge, where care for a person seeking help would need to be continued, albeit not professional care (Laudet & White, 2010; Leshner, 1997).

Continued professional help rendered to patients as after-care or outpatients is associated with enhanced treatment outcomes. There are various means of rendering continued support when an individual is assisted to reintegrate into the family and the original community (Jason et al.,

2007). Ideally, the means will include support rendered by professionals to outpatients; or community outreach programmes, as well as those driven by mutual-aid organisations, largely in the form of support groups (White & Godley, 2003). After-care support services offering structural and functional assistance (de Leon & Wexler, 2009, as cited in Mackintosh & Knight, 2012), assist with the re-entry into the community that would include transitional housing, and programmes that prepare individuals with difficult interpersonal relationships, boosting occupational skills, employment, and other needs to assist the reintegration back into the original community (Mohasoa, 2010; Ramlagan et al., 2010).

2.2.1 Formulating the model of addiction from rat experiments

On one hand, the idea of presenting evidence from animal models is to compare original findings of addiction treatment and the development of the dislocation theory. For Eisenstein (2014), such reveals what the subsequent emphasis on evidence-based models was about, a deliberate attempt to suppress this socio-political and economic ["proof"] explanation of the causes of drug addiction, since they were both conducted and presented around the same time. On the other hand, Eisenstein (2014) draws parallels with ways our lives are shaped under the capitalist system existence, that resemble those of cage rats, correctly dubbed "the rat race". Harping on the lack of replicability of environmental effects proposed by rat-park experiments, these rebuttals cite Petrie (1985, 1996). They find flaws in the original experiments (MacBride, 2017). The insistence on the adoption of "science based" approaches to addiction, resulted in ecological approaches being muzzled (Alexander, 2014). There is a proposal that the worldwide approach to drug addiction was driven by the political climate, particularly the punitive approach that ensued, rather than by "scientific" findings (Courtwright, 2010). Given links to the fundamentals of the temperance movement, whether it was scientific at all, is muddled. In what can be considered the winds of change, the social causes of addiction are gaining hold among addiction professionals (Gage & Sumnall, 2018; Wilson, 2018). Drug addiction treatment is the medical model that could easily be considered a National Institute of Drug Administration (NIDA) model (Courtwright, 2010; Zautra, 2015). NIDA funds propagated the medical model worldwide (Chavelier, 2019), and as Whiting (2014) confirmed, it is the model on which South Africa benchmarks.

In traditional laboratory experiments on morphine addiction, rats were exposed to a choice between drug-laced and glucose-only solutions (Badawy et al., 1982). These caged rats preferred a drug-laced solution. After some time taking the drug, rats will take it continuously, this being known as dependence. This continuous intake increased with subsequent dosages, known as

tolerance. The increase in drug intake would end with overdose, from which most rats would, over a period of time, die. In later experiments, in which addicted rats were removed from the drug after some time addicted to them, these rats would seek a drug on a cue of stimuli reminding the rat of the drug origin, or the drug-taking environment (Le Moal & Koob, 2007). A pursuit that began hedonistically stimulating pleasure centres and temporarily soothing an individual evolves into dependence on the drug and a subsequent struggle to function without a drug (Koob & Le Moal, 2001). Drug addiction unabated involves destructive behaviour, including death by overdose.

In humans, neuro-imaging techniques have shed light on the neuronal effects of drugs (Chavelier, 2019). Illicit drugs introduced to the brain mimic neurotransmitters that occur naturally. They bind with receptors of these neurons evoking or limiting their effects (Koob & Le Moal, 1997). For example, opioids are so-called, after the name of the binding receptor of such drugs in the brain, the mu-opioid receptors on which they act (American Psychological Association [APA], 2012; Bart, 2012). Prolonged exposure will cause the brain to limit the overproduction of such effects, sometimes reducing neurotransmitters at dendrites and neuronal nodes to exert control at synaptic clefts. Such feedback loops explain the intensity of the initial high and the resultant dependence that leads to tolerance of the drug. The initial high is unique, intense, and exhilarating. Addiction to a drug occurs because the individual pursues this high. Some consider the idea of chasing the dragon to stem from such an effect (Morgan et al., 2019; Strang et al., 1997). The individual will chase the initial high that decreases with subsequent dosages of the drug. Unachievable, the chasing of this high would lead to addiction; the increase of the drug to achieve the same effects, eventually leads to an inability to function without the drug. The continuous intake of the drug leads to habituation that results from the solidification of particular neural circuits and pathways. This explains difficulty in stopping as well as relapses, now that the brain is being rewired for the consumption of that substance of addiction.

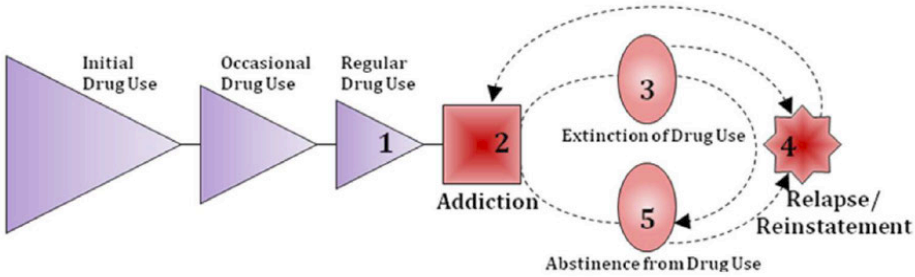
2.2.2 The progression of the addiction process

The word addiction comes from its Latin derivative “addicere” (Le Moal & Koob, 2007) or “addictus” (APA, 2012; Williams, 2002). This was a reference to a person’s enslavement by someone, for example, a debtor; or something (Weinberg, 2002), a surrender or condemnation, or sentence to a particular fate (Williams, 2002). Although the term has changed from its medieval meaning with some positive and admirable connotations of dedication to a craft (Alexander, 2014), it is now firmly attached to the illustration of the negative effects of drugs; the pull that compels an individual to take a drug continuously (Gori, 1996; Le Moal & Koob, 2007). An individual would experiment with a drug mainly in succumbing to peer influence, modelled by the family

member, out of sheer curiosity, or boredom, that among youth is complicated by identity-seeking (Smith & Seymour, 2004). For most individuals, this initial drug use leads to a continuous use that moves from occasional to regular use (Murray et al., 2012), illustrated in Figure 1 below.

Figure 1

Illustration of the addiction process from inception, and as a chronic relapse disease



Note. Illustration of the addiction process from inception, and as a chronic relapse disease. From N-Acetylcysteine as a treatment for addiction, by J.E. Murray et al., in *Addictions: From pathophysiology to treatment* (pp. 355-380), by D. Belin, 2012, InTech (https://doi.org/10.5772/50210).

Elements of drug dependence involve (a) compulsion to seek and take the drug, (b) loss of control in limiting intake, and (c) emergence of a negative emotional state (e.g., dysphoria, anxiety, irritability) when access to the drug is prevented (Koob & Le Moal, 1997, as cited in Le Moal & Koob, 2007, p. 378). Drug addiction begins with a voluntary experiment with a drug; however, for most, there would be a compulsion (Leshner, 1999), and a high motivation to take the drug (Le Moal & Koob, 2007).

Between experimenting and addiction, a gradual process of increased ingestion of the drug moves from occasional to regular use. Abstinence happens when an individual stops taking the drug. Through relapses, and a pull to use again, individuals would return to using a drug again (Tuwani, 2013). In sustaining sobriety, an individual would reach an extinction stage, in which the effects of the drug have waned (Murray et al., 2012). Even during extinction, individuals have the potential to relapse. In Murray et al. (2012), terminating drug use can result in relapses, the return to using again. In the process of trying to recover, this is usually a setback that requires starting afresh. Psychic dependence is a condition in which a drug produces a feeling of satisfaction, and a psychic drive that requires periodic or continuous administration of the drug either to produce pleasure, or to avoid discomfort (Eddy et al., 1965, as cited in Le Moal & Koob, 2007). Even after stopping, human addicts rarely extinguish the need to take the drug. In animals, short and long-

term abstinence leads to relapse when (even cues of) the drug-seeking/taking environment returns (Le Moal & Koob, 2007).

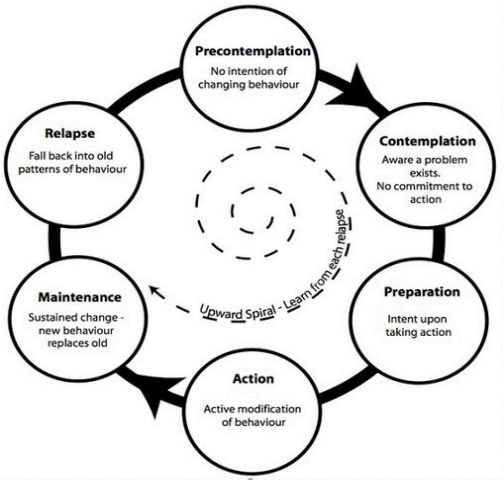
2.3 The Transtheoretical Model of Change

The integrative model presents a temporal dimension of change and construes recovery as a process. Prochaska and Di Clemente (1982) refute proposals that such is an extension of the drug-addiction model, as proposed by Bandura (2004). Bandura (2004) saw cognitive transformations in this model as embedded in health belief, preventative, and promotional models. For Reith and Dobbie (2012), the transtheoretical model of change understands addiction as a problematic behaviour that fluctuates over the span of its life course, and therefore is not static. However, it is still rooted in the bio-psychiatric explanations of individual behaviour (Reith & Dobbie, 2012, p. 512). These models acknowledge the effects of social and environmental factors in addiction (Prochaska et al., 2008); but do not consider them as interactive, dynamic, pivotal, and integral in behaviour, as the social-learning theory by Bandura (2004) proposes. Particular to addiction, Bandura (2004) found addiction an interactive relationship between the agent of change and the environment. These are levels of confidence people have in their ability to implement a course of action in their world. However, proponents of this transtheoretical model of change rebut the idea that they are a drug-recovery model, but rather, an integrative model has been used to deal with smoking (Aveyard et al., 2009). This transtheoretical model is widely used in health promotion, focusing on formalised treatment that transposes to treating addiction. The model conceptualises treatment within the framework of making change; and as such, change is seen as processes made of stages (Prochaska et al., 2008) that may be accorded time frames (Prochaska & Di Clemente, 1983).

According to this model, a process of change helps us ascertain key influences that promote change and increase recruitment, retention, and the successful cessation among substance abusers (Di Clemente et al., 2004, p. 103). This involves personal considerations, commitments, reasons, and intentions that move individuals to perform certain behaviours (pp. 103-104). The addicted person moves from being oblivious to the need to stop (pre-contemplative), in which addicted individuals have little or no current interest in considering change, to considering ceasing taking the drug (Di Clemente et al., 2004, p. 104).

Figure 2

Stages of change in which change processes are emphasised



Note. Stages of change in which change processes are emphasised. From "Transtheoretical therapy toward a more integrative model," by J. O. Prochaska and C. C. Di Clemente, 1982, *Psychotherapy Theory, Research and Practice, 19*(3), 276-288, (https://doi.org/10.1037/h0088437).

A variety of factors prompt individuals to act on the perceived need to cease taking the drug. When the damage addiction has caused and continues to cause the person, the next step, known as the contemplative stage, ensues. For persons dealing with addiction, conditions usually grow worse. This downward spiral leads to a need to consider doing something about it, and for an individual to consider seeking help (contemplative – a risk-reward analysis leading to decision-making) (Di Clemente et al., 2004, p. 104). Addicts would consider initiating change prompted mainly by bad experiences in the involvement with eliciting drugs that present a danger to the person's well-being and security.

Such experiences could include witnessing the death of a fellow addict through overdose, a personal near-death experience, or other physical and social damage addiction has caused – being arrested, acquiring an illness or condition, possibly the physical results of the addiction to a drug (Prochaska & Di Clemente, 1982). For persons dealing with addiction to a drug, a turning point is associated with "hitting rock bottom" (Larkin & Griffiths, 2002) or reaching the crossroads in their addictive behaviour. To mitigate such, the addict would consider desisting from the drug (Prochaska & Di Clemente, 1982). A preparation stage involves commitment and planning; it entails the intent to stop taking the drug. Some addicts would move to acting on their decision to stop, a stage called an action stage (taking specific steps to implement the plan) (Di Clemente et al., 2004). This resolution to stop taking the drug leads to approaching rehabilitation institutions,

where withdrawal will be managed. Maintenance is a stage in which new behaviour adopted after recovery becomes normative (Di Clemente et al., 2004).

2.4 The Relationship between the Medical and the Moral Models of Addiction

The identification of a need for the science of addiction was raised within the context of limiting pervasive moral approaches at that time (Lindesmith, 1938). The moral approach to drug addiction is located in an era in the West where untoward and destructive behaviour from consuming AOD was connected to spirits and demons (Ngo, 1994), with addiction considered a sin (Wilbanks, 1989). However, the pervasive nature of the moral outlook associated with stigma and discrimination and further perpetuated by the war on drugs, is such that it is perhaps the most dominant approach to treating people addicted to drugs (Alexander, 2012). Perhaps a frustration with why people simply cannot stop taking drugs, can be associated with anger, retaliation, and disgust with negative social effects. Stigmatization and discrimination feature profoundly in addicts' lives (Chung, 2015; Hsieh et al., 2017).

There is a phase in the history of development of a means to combat problematic drug use in which addicts would be referred to a priest. Early conceptions of drug use, drawn from problematic behaviour of persons addicted to a drug who astonishingly continued to use the drug despite the concomitant negative consequences, could be that the user was possessed, and the drug itself a demon. Intoxication of any sort is seen as sinful, hedonistic, antisocial, antireligious, and deviant (Ngo, 1994; Wales-Smith, 2015; Wilbanks, 1989). Moralists demonised the drug and the person addicted to it for making poor moral choices (Wilbanks, 1989). Damning the drug has not subsided; and can be thought to have been escalated by the persecution of addicts in the "war on drugs". For Rothschild (2015), the remnants prevail in the treatment protocol, and through stigmatization and criminalization of substance abusers. In all its permutations, the moral model is still the most prevalent strategy directed towards addicts (Alexander, 2012).

Considering a drug a demon and damning the drug addict for making poor moral choices, or lacking strong will, responses would target both the person and the drug. For example, the war on drugs has seen the militaristic pursuit to end peddling and possession of illicit drugs (Fellingham et al., 2012). Such approaches have been associated with conservative agendas. Approaches were skewed towards the persecution of particular races and classes that consume a particular drug deemed illegal (Beckett & Sasson, 2005). Such can be argued to be the case in South Africa's stance under imperial context in response to cannabis smoking (Chattopadhyaya, 2019). Such interventions have always presented detrimental effects for those classes and races, sparking notions that such approaches were a means of social control. The topic associating moral

and medical responses to addiction, proposes that even scientific approaches did not alleviate the moral gaze. They may have served as the scientific basis supporting that drugs were responsible for addiction, and the person taking them a moral culprit. In considering drug addiction as a disease caused by a drug, both the moral and the medical gaze encourages discrimination of people addicted to drugs (Ngo, 1994).

2.5 Harm-reduction Measures

Considered a "third wave", harm-reduction measures are an incremental ethical improvement from the preceding moral and medical models of addiction (Rothschild, 2015). For Anderson et al. (2014), harm-reduction measures are a society's attempt at the humane treatment of drug addicts. Measures are reported as non-judgemental, and treating the addict as a person (Marks et al., 2017). The focus is on reducing drug-related harm that addiction to drugs generates and propagates (Scheibe et al., 2017). Such measures will avail opioid substitution therapy to help people addicted to drugs manage painful withdrawal symptoms (Hunt, 2003). They will avail professional help to address social and psychological issues (Marks et al., 2020; Whiting, 2014). Measures that support reintegration into the community, as well as reskilling and life-skills training, are included. This is a concern with the welfare and humane treatment of addicted persons, and less of a concern with ending addiction lives (Needle et al., 2006), a focus on desistance. Perhaps it is important to state that models of recovery have questioned the role of harm-reduction measures in ending addiction (Alexander, 2009; McKeganey, 2011). With a particular focus on accessing and expanding drug treatment Substance Abuse and Mental Health Services Administration (SAMHSA), (2013, as cited in DiReda, 2014) found that they had minimal impact in encouraging people towards desistance, i.e., on solving the problem of encouraging drug abusers to seek treatment [abstinence]. These are concerns with people who "park" − prolonged engagement − on OST.

Abstinence-based measures of intervention for drug use, like the recovery framework frown upon the continuous use of drugs (prescribed or unprescribed) if the aim is to assist recovery (McKeganey, 2011). Recovery models welcome the use of medication and other means of initiating sobriety. White (2009) believes that addicts can do whatever it takes to stop, but that the focus should be on supporting them to remain sober. These are findings that, even if we believe that addiction to drugs is a chronic-relapse disease, we should acknowledge that people addicted to drugs are capable of stopping taking a drug. However, through relapses, people revert to drug use. People must therefore be assisted to maintain sustained sobriety, and we would therefore respond to its chronicity by availing long-term intervention or support (White et al., 2006). For

Laudet and Best (2015), the recovery models build on addiction theories. This implies the validity of the neurobiology of addiction and the need for the treatment of withdrawal symptoms using OST. In a whoonga situation in South Africa, harm-reduction measures advocate the roll-out of OST (Marks et al., 2017). Therefore, from this angle there should be a truce between the models, with the call that they should work together, particularly in the initiation of recovery (Alexander, 2009). Recovery from drug use is concerned with the prolonged intake of prescribed drugs being biased towards abstinence (McKeganey, 2011).

2.6 Ecological Approaches to Drug Addiction

The ecology of recovery assumes theoretical frameworks that consider addiction a result of an interaction between an individual and the context they inhabit. Such views are demonstrated in traditional experiments with rats. Recovery approaches present interventions that are tenable at micro level, local, and community levels. For the global approach to addiction, macro-level interventions must oppose dislocation, the results of geopolitical and economic forces that alienate individuals and drive them to find solace in drugs. Altering one's consciousness is seen as an escape from the alienating consciousness of one's socio-economic, cultural, and political existence. This section discusses the basic tenets of various ecological approaches to addiction, focusing on an individual's interaction with the social environment, and advancing social and cultural levels of intervention. The discussion will draw from the dislocation theory as a scientific overarching theoretical stance for such theories. It would not be surprising were other advocates of recovery quietly agreeing; however, they have not made such a link other than Alexander, himself the main proponent of this approach (Alexander, 2015b). Perhaps this is because the social causes of addiction have remained a controversial issue, winning Alexander an award for creating a controversy in addiction treatment (Alexander, 2012; SFU News, 2007).

2.6.1 The dislocation theory

Alexander (2014, 2015ab) considered the medical response to drug addiction modern society's futile attempt to medicalise its way out of its social, economic, and emotional problems. Leading to their dead end, for Alexander (2015b, p. 1), these theories do not take into account the broad, historical causes of a society that carries a huge burden of severe addictions. This historical outlook finds fragmentation of societies to be deeply entrenched, and to best account for the worldwide escalation of addiction. Alexander (2015b) finds it to have started back in the voyages of discovery that resulted in the displacement of local populations. The tendency to place profits over human interests that drove colonialism and its violence has continued unabated (Dimitrov,

2006), leading to further alienation and continuing addictions to medicate it. Alexander finds the ongoing increase in addictions to drugs and drug-linked behaviour as the corrosion of the human spirit (Levine, 2009). Other than debunking the myth of a demonic drug, Alexander (2015a) finds addictions to be caused by a lack of psychosocial integration. For Alexander (2008, as cited in Levine, 2009) psychosocial integration is experienced as a sense of identity. Alexander (2015a) finds stable social relationships to provide people with a set of duties and privileges that define who they are in their own minds. These factors insulate an individual against alienation, because they belong in an order and hierarchy they understand.

2.6.2 From "rat park" experiments

Alexander and his colleagues confirmed that caged rats, when exposed to both a drug-laced and a sucrose solution, will choose a drug (Alexander et al., 1981). The drug will be consumed in incremental and increased dosages. Animals left to own devices eventually die from overdose. However, ecological theories argued that the substance of abuse, the drug, was not enough to explain addictions, a thread common to all ecological models. In rat-park experiments, a rat haven was created (Alexander, 2010). These rat parks were larger cages where experimental rats had contact with other rats, making friends, breeding, and not living isolated in cages. These rats were given play toys, and sawdust on the floor to make the environment comfortable. To make this environment even more familiar, researchers went on to paint the walls with forest scenes, the natural setting for rats (Alexander, 2010). In another experiment, researchers confined rats to cages and subjected them to drugs for 57 days. These addicted rats were then moved to a rat-park setting (Alexander et al., 1981).

Results showed that rats in rat parks did not prefer drugs. Those who entered the rat park addicted took less and less of the drug, eventually weaning themselves off drugs. None of these animals died of overdose (Alexander et al., 1981). Alexander and his colleagues concluded that drug addictions were originating in the state of alienation or dislocation in cages. This state of dislocation means the absence of belonging, identity, meaning, and purpose (Alexander, 2015b). The socio-economic and cultural ecosystems or the context of addiction became the focus of intervention in alleviating dislocation (Alexander, 2015b). These conditions are considered the source of addiction and other appetitive behaviours. Altering them would be a solution to reducing and ending these behaviours. This view is congruent with the escapist theory and the adaptative views of drug addiction (Alexander, 1987, 1990). All consider the need for people to take to drugs as a way of dealing with or counteracting the void or emptiness (Alexander, 1987, 1990; Chavelier, 2019). Such is caused by alienation and lack of contact with others − the uprooting of people from

traditional settings that supported individuals caused fragmentation, alienation, and dislocation (Alexander, 2001, 2015; McKnight & Block, 2010). In what is considered the rat race, human beings are placed by the capitalist model to compete among themselves (Eisenstein, 2014; Weiss, 2015).

For Alexander (2015a, as citing Alexander, 2008/2010 & Watson, 2015), addiction can provide dislocated people with some much-needed relief and compensation for their bleak existence, when nothing else seems to be working. Unable to summon requirements for a capitalist model owing to faulty upbringing, marginalization, and lack of environmental support, despair sets in (Alexander, 2015a). Alienation is considered at the centre of what entices people, both rich and poor, to seek solace in drugs, owing to an unbearable lack of culture and identity (Alexander, 2010). In dealing with addiction worldwide, dislocation theory seeks to address structural foundations that cause alienation. At macro level, geopolitical and socio-economic factors that enforce alienation need to be eradicated – to restructure modern society. Realistically, this would require a global movement. At local levels, both individual and community levels, suggestions for minimising dislocation involves the creation of connections, reducing the need for addictive compensations. Such involves the provision of community-oriented support, acceptance, spirituality, as well as treatment to help individuals overcome addictions (Alexander, 2015a). For Weiss (2015), connections propagate caring, and caring is an antidote to drug addictions. For people who are individualised, disconnected, competitive, and uprooted from traditional connectors, clinging to drugs is a logical response when they have nothing else to keep them going (Alexander, 2015a). This means that people take to drugs to substitute this intrinsic need to connect, reminding us that we are social beings; and connecting is a human need. Communities become the locus of intervention (Aguirre-Molina & Gorman, 1996), and welcoming or therapeutic communities denote the ability of communities to be a supportive and healing medium (Best et al., 2014; Vanderplasschen et al., 2013).

2.7 Evidence Base for Recovery Models

Proponents of the dislocation theory did not use the word recovery to refer to laboratory rats moved to a rat-park environment, going on to wean themselves off drugs (Khumalo et al., 2019). Studies on Vietnam-war veterans sparked ideas about recovery, presenting evidence of addiction to hard drugs as a retractable disease when there was a large number of people who underwent instantaneous remission from drugs (Robins, 1974, 1993). Addiction to opiates had before 1973 and after the end of the Vietnam war, been thought of as an intractable problem (Waldorf, 1983). Conventional wisdom had showed that individuals seldom recovered without

institutional help (Waldorf & Biernacki, 1979). The return of the Vietnam-war veterans ended the bleak picture on addiction and brought hope by providing a social-psychological explanation of addiction (Waldorf, 1983). In this study, of the 35% of the Vietnam-war veterans who were returning, 20% were addicted to heroin when at war, but only 1% had, within 12 months after departure from Vietnam, continued to take heroin (Robins, 1974). Only 2% (8% of those addicted in Vietnam) reported, at the time of retesting, to be using narcotics; and 1% were detected to have used opiates through urine analyses (Waldorf & Biernacki, 1979).

This spontaneous remission from drug use is associated with natural recovery, in which an individual would stop taking the drug without treatment or institutional assistance (Waldorf, 1983). Subsequent research studies on natural recovery showed that individuals who successfully quit on their own, appeared to have already reduced drug use before the decision to quit (Price et al., 2001). With or without assistance, recovery involves moving away (either physically or symbolically) from the opiate scene, avoiding opiate users, and creating new interests, new social networks, and a new social identity (Molobi, 2018; Waldorf, 1983). Current studies in the USA show that about 58% of individuals do eventually recover from drug addiction (Kessler, 1994; Dawson, 1996; & Robins & Regier, 1991 as all cited in White, 2004b).

Recovery approaches may emerge from dissatisfaction with addiction treatment. Such approaches may not identify with the dislocation theory, an approach deliberately ostracised for opposing the fundamentals of the addiction treatment; threatening its monopoly. The dislocation theory was considered to have not been replicable by a subsequent study by Petrie (1985, 1996), and was thus fundamentally flawed and dangerous (MacBride, 2017). The dislocation theory was deemed “controversial”, when what should be controversial is that, despite suppression, this socio-economic and cultural or global approach to addiction is gaining a foothold around the world (Alexander, 2015a). As a macro theory, the dislocation theory is consistent with models that explain the depletion and degradation of the environment we are facing today, where addiction to power and greed are setting the human race and the environment down a destructive course (Alexander, 2015a; Dimitrov, 2006). The message in the dislocation theory could have been “lost in translation”, as Gage and Sumnall (2018) would argue: it profoundly changed the narrative of addiction. The dislocation theory is revisited in this study to explain the macrosystemic effects on drug addiction. This ecological model underscores the erosion of the human and communal spirit in the escalation of the use of drugs worldwide. It links *ubuntu* philosophy as an antidote in counteracting isolation, dislocation, and fragmentation associated with the causes of addiction (Tutu, 2010, as cited in Alexander, 2015a). As a community strength in dealing with adversity, this study draws from this philosophy that defines the way of life of African people. African

researchers and scholars have found the African philosophy of *ubuntu* a refuge, mechanically applied; or as an all-encompassing philosophy, it is a spiritual and a moral guidance that forges ways for them to deal with their problems (Mazama, 2001, 2016). As an approach to dealing with addiction to drugs, "*ubuntu*" will be presented as a way that advances an understanding of drug addiction among African people, including recovery support, but importantly, prevention.

In Africa, as in the rest of the world, recovery from drug addiction is largely associated with AA/NA and such related interventions that include step-based programmes (White, 2004a). However, historically, abstinence-based mutual-aid recovery societies predate these organisations (White & Pitts, 1998; White, 2004a). Recovery frameworks focus on long-term recovery. This is a shift in which addiction treatment moves from a strictly acute care model of intervention to a model of sustained-recovery management (O'Brien & Kleber, 2000, as cited in White 2002, 2008). AA/NA in the USA have already embraced this movement (White, 2008c). In Brown and Ashford (2019), a recovery-aligned stand is presented as having a sufficient and coherent theoretical framework to be a grand theory. This takes recovery out of "the addiction field"; a refusal to be co-opted by addiction theories. For example, El-Guebaly (2012) found it difficult to define "partial recovery" within addiction, even though such a need for categorization was important. Recovery seeks its own science, i.e., to uncover its own base of evidence focusing on recovery (Brown & Ashford, 2019). How people recover from addiction has remained mysterious. It has not been clear as to what prompts and sustains such recovery (Best & Laudet, 2010; El-Guebaly, 2012).

2.8 Recovery-focused Models of Drug Addiction

To initiate recovery takes the deployment of internal and individual resources (Best & Laudet, 2010); the technologies to govern the self (Foucault, 1988). Such views point to the importance of cognitive and emotional processes that influence the motivation to stop taking drugs. To break the cycle, the habit the drug was to the person, and to end the stop-relapse-stop cycle, addicts are assisted to maintain long-term sobriety. As indicated above, the conception is that, even were drug addiction to be considered a chronic relapse disease (White et al., 2003), this would suggest that people do stop taking drugs. Relapses mean that desistance is short-lived. Addiction viewed as a complex human problem affecting different aspects of life suggests that support in other areas of functioning is crucial. Therefore, in the employment of external resources, the focus is on social and communal factors that support both the initiation and the management of long-term recovery (Laudet, 2007). These factors, both internal and external, are christened within the recovery-aligned frameworks as the recovery capital (Best & Laudet, 2010). The focus on strengths, and the healing function, present a situation in which communities take the

responsibility to support their own health and well-being (Best et al., 2016). Therefore, communities become the locus of intervention that further counteracts discrimination and stigmatization, bolstering prevention (Alexander, 2015b; Best et al., 2016).

2.9 Conceptions of Recovery

Within the mainstream approach to drug addiction, studies have largely been on addiction as well as its treatment. Considered a new frontier, the recovery paradigm is concerned with how to interrupt addiction careers (White, 2004b). A guideline, therefore, would be to define recovery to facilitate research, policy formulation, as well as intervention. Fundamentally, there are components that can be extracted from various definitions forwarded by researchers and institutions in this field, to operationalise recovery. From the initial recovery definition by The Betty Ford Institute Consensus Panel (2007), a panel of representatives of addiction treatment, policy, and research that included those who were themselves in stable recovery, recovery is a voluntarily maintained lifestyle characterised by sobriety, personal health, and citizenship. Although it can be coerced, for example, in the case of arrests or forced treatment, recovery involves the willing and voluntary pursuit of behaviours that constitute recovery (The Betty Ford Institute Consensus Panel, 2007).

Recovery from addiction is not an event: healing and growth processes span years rather than weeks or months (El-Guebaly, 2012). For White (2007a), recovery from addiction is "the experience (a process and a sustained status) through which individuals, families, and communities impacted by AOD problems utilise internal and external resources to voluntarily resolve those problems" (p. 236). Thereby, they heal the wounds inflicted by AOD-related problems, actively managing their continued vulnerability to such problems, and developing a healthy, productive, and meaningful life (White, 2007a). Therefore, recovery involves progress toward global (physical, mental, emotional, relational, spiritual) health, improving one's quality of life (QoL), making amends and forging reintegration with peers, family, and the community. This involves sustained sobriety, a productive lifestyle, as well as participating as a full citizen (Laudet, 2007; The Betty Ford Institute Consensus Panel, 2007; White, 2004b).

Recovering from addiction involves a decision to stop taking the drug, and to maintain this decision (Bloom, 2016; Prochaska & Di Clemente, 1982, 1983). The recovery agenda emphasises abstinence and recovery; abstinence from AOD; together with both prescription and non-prescription drugs (Page et al., 2016). Drawing from Foucault, recovery is an appeal to "technologies to govern the self" (Foucault, 1988), and to unlearn the habit drug addiction was to addicts (Laudet, 2007). This involves self-governance and the realization of a bountiful "new life",

an ongoing process of growth, self-change, and of reclaiming the self (Laudet, 2007). The notion of self-identify as "in recovery" is working on oneself, self-improvement; trying to live drug-free (Laudet, 2007; Shinebourne, 2011). For addicted individuals, surviving addiction brings a new sense of self, and of purpose characterised by flourishing beyond the limits of the disability (Deegan, 1988, as cited in Best et al., 2015). Recovery is drawn from Foucault's notion of the enduring "care of the self" (Foucault, 1988). Recovery further involves leaving or avoiding the drug scene, thus exiting the drug subculture that encouraged the drug-taking behaviour (Anderson, 1995).

2.10 Initiating Recovery

Drug addiction is characterised by a compelling need to consume the drug continuously. When individuals try to desist, the resolution does not last. Victims would have bouts of relapsing in the course of their addiction careers. In breaking this cycle, the conception of recovery is an initiation of sobriety that includes its long-term management. Kolker (2017) proposed seeking alternatives to conceptions of drug addiction as a chronic-relapse disease. One should move from the same position as other ecological methods in proposing that the drug itself is not a good enough explanation for drug addiction. Individuals took to drugs to escape from emotions that their present situation evoked, being unable to deal with those emotions. Kolker (2017) proposed that the cause of drug addiction would be an individual's inability to soothe him- or herself. Kolker (2017) draws from attachment theories, suggesting that such resilience would occur if it has been modelled. The attachment theory proposes that the parent-child relationship and such early socializations can be generalised to social environments (Bowlby, 1969, 1979, as cited in Becona-Iglesias et al., 2014). Positive family bonds and attachments with initial caregivers serve as a buffer or a protective factor in drug addiction. What this would also mean is that drug addiction is a maladaptive response to the ebbs and flows of life. From this view, drug addiction does not become the problem, but a solution. The problem would be the young person's inability to regulate their emotions. Such a problem could also result from an inability to handle emotions linked to abusive and traumatic situations at a young age. The ability to regulate one's emotions means that the individual would cease looking at outside sources for soothing. What this further means is that recovery involves finding different ways to deal with these difficult emotions.

As with Bandura (1999), attachment theories propose that it is the individual's inability to deal with the world that could be a struggle. These models involve ideas around perceived self-efficacy, the confidence to manipulate the environment to be able to carry out one's intent. The individual-social dyad defines such socially oriented models that provide the social and structural

means for transforming drug-dependent lives into productive ones. These models are the interaction between the individual cognitive abilities, perceived strengths, and resources to deal with that problem, and to be able to summon resources that would yield successful results. For Bandura (1991), enabling factors equip people with skills and resilient self-belief to be able to exert control over their own functioning, and taxing environments. Summoning resources include both internal resources, the individual perceived self-efficacy, for example, in the ability to endure the undertaking, but also to summon resources in the world to do so. These people maintain abstinence despite bouts of negative affect. If people are to be spared relapses, they must learn how to avoid troublesome situations (Bandura, 199). People must develop strategies for dealing effectively with situations that tax their self-regulatory capabilities, learning how to recover from setbacks (Bandura, 1991).

2.11 Types of Recovery

Among ways people desist from addiction to drugs, are entering recovery without addiction treatment, and without any assistance (Humphreys et al., 2004, as cited in The Betty Ford Institute Consensus Panel, 2007; Sobell, et al., 2000). Some individuals would get "sick and tired" of their addiction lives. Such would include notions of "maturing out" or "growing out" of the drug (Cunningham et al., 2009; Lee & Sher, 2018; Maddux & Desmond, 1980; Searby et al., 2015). Other than growing out of the drug, this is linked to other personal reasons like spiritual transformation (Williamson & Hood, 2012); religious, or secular (Flaherty et al., 2014; Larkin & Griffiths, 2002). These ideas present recovery prompted by the change of circumstances that results in the redefinition of identity and the self. This involves seeing life anew, driven by a new resolve, and a different will (Flaherty et al., 2014). Types of recovery include the nature of the trajectory individuals in recovery take to initiate desistance and to achieve sobriety. Types of recovery include natural or unassisted or untreated recovery and assisted or treated recovery that involves medical treatment and professional interventions (Flaherty et al., 2014). Transformational recovery includes changes associated with mutual-aid organisations and step-by-step processes. It can further involve spiritual or religious transformations. To further categorise recovery, the length of time individuals had been sober is included. For El-Guebaly (2012, p. 1), these various forms of recovery include "natural," "transformational," or "medication-assisted," to further describe a choice of pathways individuals take to recover.

2.11.1 Natural recovery

Recovery from addictive drugs or behaviour can be owing to a variety of reasons. Some individuals will terminate their addiction without benefit of treatment or self-help-group assistance (Cloud & Granfield, 1994). Natural recovery is a term used to describe those who have initiated and sustained recovery from a behavioural health disorder without professional assistance or involvement in a formal mutual-aid group (White, 2004). There are a variety of terms researchers ascribe to this phenomenon. White (2004) lists these references and researchers who used them, among others, as "autoremission" (Vaillant, 1983; Klingeman, 1992), and "self-initiated change" (Biernacki, 1986). For White (2004), this type of resolution of AOD problems has been christened "maturing out" from the work of Winick (1962, 1964), proposing that there comes a time that individuals reach an age, usually after mid-thirties, when they cease taking a drug (Waldorf & Biernacki, 1979). Natural recovery is often the product of a sudden event that is unplanned, positive, and permanent (White, 2004; Miller & C'de Baca, 2001; as cited in White, 2007). For Ngo (1994), this is a choice made by an addict informed by a realization that addiction is not coherent with the addict's personality, identity, or composure.

For White (2004a), such involves an experience that radically defines a personal identity including interpersonal relationships and prior patterns of substance abuse. For White (2004a), this solo (natural) recovery involves the use of one's own intrapersonal and interpersonal resources (family, kinship, and social networks) to resolve AOD problems, without benefit of professional treatment or involvement in a recovery mutual-aid community. This often involves profound religious, spiritual, or secular experiences that radically redefine a personal identity, interpersonal relationships, and a prior pattern of substance use (White, 2004a). There is an acknowledgement of epidemiological study findings in which 58% of people with lifetime substance dependence eventually achieve sustained recovery (Kessler, 1994, as cited in White 2004a). Evidence for recovery from substance use disorders (SUD) without institutional help or participation in self-help groups began with studies in the 1970s of Vietnam-war veterans, discussed above.

2.11.2 Transformational recovery

Transformational recovery refers to sudden, unplanned, positive, and permanent change (White, 2004b). Because of the focus on change, such recovery is associated with mutual-aid organisations, where change follows a process. In the first idea, perhaps the change of the addict's circumstances is less a natural form of recovery than it is transformational. This is particularly because transformational recovery is the goal of most institutions, and the most prevalent way of treating addiction (El-Guebaly, 2012). For example, spiritual awakening is, in many ways, an

institutional assistance, such as the church − even though an addict may not go to church or have their addiction relief induced by the church/religion/religiosity. However, for traditional organisations like AA/NA, and other rehabilitation institutions, transformational recovery includes the use of "recovery oriented stages of care" (El-Guebaly, 2012). These stages of care start with pre-treatment support services that strengthen the engagement and motivation process, removing environmental obstacles to recovery (El-Guebaly, 2012).

2.11.3 Assisted recovery

In the course of a transition to recovery, it is difficult to imagine change without any form of assistance or support. Nevertheless, it involves all the strategies employed to manage withdrawal so that addicts can cease taking the drug. While assisted recovery usually means the use of institutions and medication to initiate recovery, both treated and untreated recovery would require assistance (White, 2002b). Therefore, assisted recovery refers to the use of professionally-directed treatment services or participation in mutual-aid groups to initiate or sustain recovery from addiction (White, 2002a).

2.11.3.1 Medically assisted recovery

Medically assisted recovery involves the administration of opioid substitution therapy and other antagonist drugs (Weich et al., 2008). These drugs include early detoxification. Such drugs are tapered, monitored by professionals, preferably in an institution, to further provide psychosocial intervention and skills (Department of Health, n.d.). In a whoonga situation, medication-assisted recovery refers to the administration of Methadone (Cole, 2016) and other substitute drugs, particularly Naloxone that had been introduced in package of community trials in Tshwane (Scheibe et al., 2020). Such would involve professionals who consult addicts and prescribe these drugs (Myers & Sorsdahl, 2014; Scheibe et al., 2020). Drug addictions require high-end and specialised professional expertise, and in light of competing health and mental-health-care demands, innovative ways were suggested in other countries. The possibility of availing prescribing professionals has been discussed. The use of clinical associates in South Africa (Scheibe et al., 2020) seems to avoid the situation for amending legislation to allow medium-level professionals to prescribe these drugs.

2.11.4 Stages of recovery

At this stage, The Betty Ford Institute Consensus Panel (2007) has given guidelines to categorising the level of sobriety, based on the time since desistance. These periods are longer,

because they espouse long-term recovery. This panel suggested that early sobriety involves sobriety lasting for at least 1 month, but less than 1 year. Sustained sobriety referred to sobriety lasting for at least 1 year but less than 5 years. Stable sobriety referred to lasting for at least 5 years (The Betty Ford Institute Consensus Panel, 2007).

2.12 Managing Relapses

The biggest struggle in desisting comes with maintaining the decision to stop taking the drug, in that it could lead to relapses, reverting to drug use (Moos & Moos, 2006; Tims & Leukefeld, 1986). Relapse means that the addict will have to start at the beginning again. The common conception is that being drug-free and in long-term recovery means avoiding relapse (Prochaska & Di Clemente, 1982; Prochaska et al., 1992). Life after desistance from a drug involves the management of the pull to use again. Negative emotional states (e.g., stress, depression, anxiety) and continued involvement in criminal activities are risk factors related to relapse (Hser, 2007). Protective factors include elements that bolster self-efficacy and supportive social networks (Hser, 2007). These coping strategies are required in achieving long-term sobriety. Drug addiction is associated with painful emotional states, largely in childhood or in a difficult upbringing in which a drug serves as a tool to numb the pain (self-medication). Emotional scars remain, and their experience could coarsen without the drug. Dealing with stigma could contribute to emotional stress that could induce relapses. Individuals with personal and social resources and support, and those who believe in their ability to master a situation (self-efficacy) and develop coping skills (other than resorting to drug use for dealing with life stress) are likely to achieve and maintain stable recovery (Hser, 2007). At individual level, the creation of therapeutic communities and peer-support-groupings models recovery to peers hooked on drugs. The message that such a drug can be overcome is made visible, modelling recovery. In a study by DiReda (2014), many participants reported that, prior to their involvement with recovering, they had not been exposed to positive role models. In guiding recovery, how such recovery was achieved helps inform on recovery, propagating ways of going about such, indicating to an addict that it can be done. This facilitates the same kinds of salutary behaviour changes noted by Humphreys and Moos (2001, as cited in Kelly & White, 2012, among others) to approximate those of trained professionals.

At community level, people in recovery, who have gone through the struggle of recovering, celebrate recovery together, supporting one another to remain sober (Best & Colman, 2018). Such people can model recovery, showing that it is possible; and in this way they encourage people to overcome their addiction (McKeganey, 2014). The community also assures them support empathically and in non-judgemental ways, in peer-support groups (White, 2008a), evoking

similar ideas of recovering helpers (Rácz et al., 2015). However, the general community, the subset of the population of which the addicts are members, have a responsibility. In a whoonga situation, convergences with harm-reduction measures, despite different aims, are a recommendation for community-based support. For example, in initiating recovery, substitute antagonists can assist individuals to manage withdrawals. The availing of such drugs should therefore be supported. However, unlike harm reduction, that tolerates those who "park" on antagonists, the aims of recovery revolve around resolving the use of illicit or non-prescription and prescription drugs (McKeganey, 2014).

2.13 Community Recovery Capital

The aims of RIT involve the creation of a world in which recovery can flourish (White et al., 2012). Best et al. (2015) argue that recovery is socially constructed and socially negotiated. For Best and Laudet (2010), recovery capital is idiosyncratic and personal, however, its manifestation is inherently social- and community-based. For these researchers, recovery is located in the culture and the values of particular communities. Recovery is contextually shaped, suggesting the social embeddedness of recovery (Cloud & Granfield, 2001). For Moos (1994), personal resources may assist individuals to overcome life crises that include the destructive use of drugs, and individuals may be jolted to change. However, in the continuing context of economic, interpersonal and health difficulties, they will find it difficult to sustain recovery (Moos, 1994). Lack of support is associated with poor recovery outcomes. A need for general support and support for people in recovery is deemed important. Among emerging elements and representative activities in recovery models in the USA, White et al. (2012) noted the role of media communications of recovery lifestyle magazines. Added to these were efforts on conventional radio that endorse the presence of recovery, recovery advocacy, as well as efforts by community leaders, among others (White et al., 2012).

2.13.1 Welcoming communities − more than treatment

Recovery support refers to coordinated recovery support services, using a chronic-care model of sustained recovery management (Laudet & White, 2010). For Laudet and White (2010) "recovery," the ultimate goal of services, requires more than abstinence. This is largely because negative emotional states (e.g., stress, depression, anxiety) and continued involvement in criminal activities present risk factors that relate to relapse. Welcoming communities refer to supportive social networks. Where self-efficacy is identified as having networks, the suggestion is that

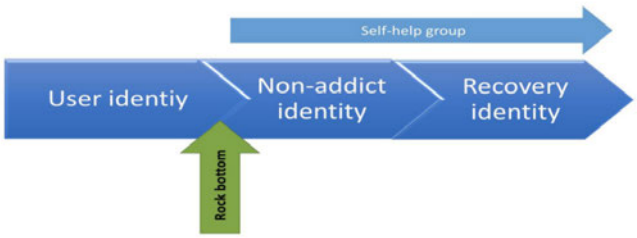
recovery requires strong engagement in recovery groups. The lack of support is correlated negatively with recovery (Laudet & White, 2010).

2.14 Recovery as Transformation or Identity Change and Redefining the "Self"

There seems to be a general consensus that addiction to drugs is so profound an experience that it alters the person's demeanour, behaviour, and outlook on life, changing the core of the person. Kemp (2019) finds the universal impact of drugs to attack the very foundation of what it means to be an individual. Recovery involves the construction of a self-identity, for Hughes (2007, as cited in Mackintosh & Knight, 2012), this identity does not incorporate the characteristics of a "substance abuser." Change brought about by recovery, for Waldorf and Biernacki (1981, as cited in Reith & Dobbie, 2012), involves identity reverting. There is the re-establishment of an old identity that was held in abeyance through years of drug use. There is a sense that an old identity, who the person was before drug use, would, as a result of drug use, be irretrievable. Studies on lived-experience of recovery perceive recovery to involve the development of a new "self" (Kemp, 2019). Who one is and how one fits into the world becomes important, which for McIntosh and McKeganey (2001) is realised through reflection from the input by others. Turning points in the addiction process involve transitions from a non-user to an addict. For McIntosh and McKeganey (2001), recovery involves the transition from an addict identity to a non-addict identity. In a study focusing on people who underwent changes after recovery, in Rácz et al. (2015), former drug addicts assist those in recovery that would, through recovery, become healer/recovering helpers.

Figure 3

Process of identity change during addiction and recovery



Note. Process of identity change during addiction and recovery. From *Using Interpretative Phenomenological Analysis (IPA) to Assess Recovery Processes - Qualitative Analysis of Experience and Identity* (p. 15), by S. Kassai, 2019, (Unpublished doctoral thesis). Eötvös Loránd University, Budapest (https://doi.org/10.15476/ELTE.2019.028).

In mapping the process of identity change from addiction to recovery, I am going to use the visualization presented by Kassai (2019) to demonstrate the change of identity, beginning with a user identity from available literature on the subject. Koski-Jännes (2002, as cited in Kassai, 2019) finds the experience of the "rock bottom" to facilitate the recognition that addicts have not cared for themselves before. According to Kassai (2019), this new identity develops as a result of reinterpreted "user self" and reconstructed self-image. Kassai (2019) acknowledges that this development is not linear; it involves the movement from the non-addict identity to a recovery identity. Assistance may resume after a choice to abandon the user identity. These stages coincide with some aspect of cognitive processes postulated by the metatheoretical model of change discussed above.

Literature on recovery seems to point out that, at the core of recovering from addictive behaviour, is the element of the change of identity that further involves the redefinition of the self. The initiation for recovery is associated with reports by addicts wishing to opt for a new life, increase well-being, working on oneself, self-improvement, as well as learning to live drug free (Shinebourne & Smith, 2009). A construction of a new identity, i.e., a non-addict identity, further involves self-respect and confidence (McIntosh & McKeganey, 2000). Recovery means to unlearn the habit drug addiction was to addicts. From this perspective, recovering from addiction as from an illness and a habit includes reconstituting selfhood, which is described as the management of the "burden" of the past, finding new ways of being in the world, where life is not about the drug anymore (Shinebourne & Smith, 2009). The transformative nature of recovery affects addicts' own bodies and souls, and thoughts, conduct, and way of being (Shinebourne & Smith, 2009). Recovering addicts would not see themselves as victims; they may mourn the loss of identity. This is what they would consider to be who they were before the drug; and an inability to express true self, and who they are at heart (Copoeru, 2014; McIntosh & McKeganey, 2000).

2.15 Experiences with Recovery

Although there are limited studies worldwide on experiential or idiographic experiences with addiction, this view is nevertheless considered an appropriate way of understanding addiction, given the idiosyncratic nature of the experience of addiction. El-Guebaly (2012) acknowledges that, at the core of treating drug addiction, is "reclaiming one's self", which, for McIntosh and McKeganey (2000) is the management of the "spoiled self." This involves the person they were before the drugs, the person they have become, and the person they aspire to be. The junkie lifestyle has prevented them from becoming the person they could have been. Recovering from addiction means the search to be whole, which for Vandermause (2011) involves

caring for and being with others. This is where a recovering addict faces loss and suffering, and the refusal to use again. There is a need for establishing connectedness to the family and social life while grappling the pull to use the drug again. For Watson and Parke (2009), profound tragedy has occurred in some addicts' lives. Their study focused on women addicts going through an institutional recovery process. Victims had endured childhood trauma and abandonment, sometimes having to take more responsibility as children. These were significant features in the addicts' early life or childhood that were associated with addiction.

2.15.1 The role of individual agency in recovery

Recovery from addiction is initiated by an individual. This includes the idea of self-changers, a conception that links to the natural recovery from addiction, individuals who recover without seeking professional help. Motivational processes established involve both avoidance-oriented and approach-oriented goals (Granfield & Cloud, 2001; Laudet et al., 2006, citing Walters, 2000). For Laudet et al. (2009) these are negative consequences of drug use (past consequences and fear of future consequences) and "wanting a better life" (Laudet et al., 2002, as cited in Laudet et al., 2006). For Laudet et al. (2006) the multiple negative consequences of substance use may include poor physical and mental health, financial difficulties, homelessness, criminal justice involvement, and estrangement from family and friends. Laudet et al. (2006) found that stress levels are very high among active users. Recovery would become a means of relieving stress; and recovery is driven by a wish to return to "live a normal life" (Laudet et al., 2006).

2.16 Addiction and Recovery from Drug Addiction

Studies focusing on addiction and recovery from drugs from the perspective of people in recovery, span experiences before addiction and after desistance, the resumption of recovery. Kemp (2019) tabulated patterns in these experiences by reviewing studies focusing on these phenomena. Kemp (2019) found meta-themes that emerged to confirm existing understandings of addiction and recovery from drugs. For addiction, these include the issue of loss of control, the devastating effects of drugs on the body, and over-involvement with finding and consuming drugs (Kemp, 2019). In relating to others, Kemp (2019) found that lying and untruth feature, and where addiction itself is characterised as an untruthful life (Kemp, 2009).

2.16.1 Meta-themes on addiction narratives

In a meta-analysis of studies on addiction and recovery using qualitative methods, experiences with both addiction and recovery yielded meta-themes. According to Kemp (2019), these are common experiences in the narration of experiences with addiction.

1. Negative childhood experiences: events associated with unhappy childhoods, physical, and sexual abuse, form precedents linked to addiction. These individuals would present with a confused sense of self, lack of life meaning, or poor relationships.
2. Addiction becomes a solution to life problems that begins with a pursuit of pleasure. It turns destructive, and continuous use yields minimal pleasure/effect from drugs.
3. Destruction caused by addiction extends to the destruction of addicts' sense of self, in which acts of transgression form part of the addictive identity. Addicted persons are torn between saving themselves, and the continued need for the consumption of the drug. These people think of themselves in ways such as self-loathing, inauthentic, or having bad faith.
4. Addiction is associated with negative emotional states, − shame, guilt, anxiety, and depression − which contradicts the initial use associated with a means of regulating emotions.
5. People describe themselves as having limited self-control or having lost such, in describing behaviour as lacking in will, or as a constant battling. The desire for control is not limited to addiction: it pervades other aspects of life.
6. Relationships are usually compromised. They fail or end prior to addiction. Individuals are characteristically dishonest and manipulative in achieving addictive ends.
7. The revolting body becomes the site of pain, when initially it was a site of pleasure.
8. Life becomes chaotic and focused narrowly on enclosed, inactive living, where aspects of usual living are avoided or neglected.
9. Life is dominated by cravings and compulsions; there are feelings of being trapped, where the meaning of life narrows to eventually exclude everything bar the drug.

Life revolves around the now: the future is closed, even to imagination, and the past is also neglected, and tends to ossify, leaving the addicts feeling that they have lost time.

2.16.2 Meta-themes on recovery narratives

This study further discovered the following meta-themes that are common among studies on narratives of recovery.

1. When recovery starts, it can be dramatic; however, it eases to a gradual process where initial work is on gaining and maintaining abstinence.

2. Recovery is defined by nurturing the self, where a new identity would be created.
3. Underlying emotions would be addressed largely by re-evaluating the past that created them.
4. Recovery involves a reorientation to the present, where a future is considered, and people are not driven by impulsive and short-term orientation to the now.
5. Recovery involves repairing and healing existing relationships with others in balanced and complementary ways.
6. Recovery involves honest, authentic, and truthful relationships with self, and others.
7. People in recovery mention gaining capacities and limits of self-control or will power. Such is achieved through the knowledge of their limitations; responsibility for personal actions ensue.
8. Individuals who were alienated find a place in the community.
9. Recovery involves changes that lead to the re-establishment of a meaningful life.

In creating a narration for experiences with addiction, Kemp (2019) found that both addiction and recovery follow common patterns. These patterns coincide with mainstream addiction treatment as well as ecological and recovery approaches, including self and revolving identity.

2.17 Conclusion

This chapter presented moral, medical, and ecological approaches to drug addiction. Medical and moral approaches were argued to be insufficient in dealing with whoonga addiction in South Africa. While harm-reduction measures are welcomed in the initiation of recovery, their aims are within the addiction treatment paradigm, a concern with an access to OST, and complementary professional help. Within addiction treatment, very little attention is paid to long-term recovery as well as prevention. The dislocation theory was presented as a sound theoretical basis of ecological models, a range of theories that consider an individual-context interaction. Such further finds the context of addiction the cause that is also a solution to addiction problems. For practical interventions in a whoonga situation, recovery approaches presented what can be done to support recovery at both individual and community levels. The chapter ended with a metatheoretical analysis of subjective experiences with addiction and recovery studies.

CHAPTER THREE
DRUG ADDICTION AMONG AFRICAN COMMUNITIES

3.1 Introduction

The global approach to addictions or the dislocation theory is presented in this study as a macro theory, inspiring ecological approaches to addiction. This chapter develops an ecological model of drug addiction suitable for African communities, particularly those in urban settings, including townships, that is informed by an Afrocentric orientation. In linking our zeitgeist of the new economy to the causes of addiction, dislocation theory identifies the "root causes" of addiction (Alexander, 2001). The dislocation theory found addiction as a way of being-in-the-world, a coping mechanism that allows people to deal with an overwhelming sense of alienation (Alexander, 2000, 2015). In seeking treatment, McKnight (1995) evoked a diagnosis made by Robert Mendelson of similar causes of modern social ills as weak communities, characterised by a "lack of community". Treatment yields a cure to individual-oriented culture, characterised by consumerism. For Mendelson and Zemelka (1979), such involves the replenishment of traditional ecology, the ecosystems, and an environment in which human nature was caring. Treatment means to support and to build communities. McKnight (1995) presents this as the quest for "a regenerative code". Alexander (2010) demonstrated that addictions are driven by the worldwide sense of dislocation or fragmentation characterised by a void, that in the context of globalisation is so pervasive, it links to the poverty of the human spirit.

We need to understand addiction and recovery from a drug by African subjects from communitarian or collectivist backgrounds, where, according to Uwah (2012, as cited in Wissing et al., 2014), social harmony is valued above individual preferences. This ecological approach to drug addiction includes an African experience. The Afrocentric approach to drug addiction draws from *ubuntu,* a worldview that defines an orientation and a screen through which African people make sense of their world. This study further evoked elements in African culture, traditions and history that provide strength or are assets that can be amenable to the rejuvenation of transitioning from youth to adulthood. Such elements are framed to propose a refuge, a moral guide and spiritual orientation that can be employed to deal with social problems that relate to the sense of alienation among African people in the continent and the diaspora (Jayawardene, 2013), including addiction to drugs (Welsing, 1991).

This chapter will begin by linking the fundamental aspects of the dislocation theory to the macro theory of addiction driven by *ubuntu* philosophy. The dislocation theory can also be linked with other, traditional ways that can be employed to deal with alienation, particularly among youth.

The next section will delineate ways in which colonialism links to the alienation of African people, by drawing from effects of land and material dispossession, the role of colonial and Apartheid education including religion. This further links to the effects of resultant poverty driven by inequality; in which unemployment and idleness render South African youth in townships susceptible to boredom and drug use (Mpanza, 2015). The next section will introduce *ubuntu* philosophy and African orientation, homing-in on aspects that are particular to dealing with drug addiction, a spiritual guide at macro level, and the binding elements at a micro level. In forging an ideal approach to reorienting and insulating Black African youth against drug abuse, the suggestion advances the restoration of a sense of *ubunsizwa*, drawing from elements of traditional wisdom. These are ways by which to enhance group cohesion in hierarchical ways, guiding the stage of transitioning to adulthood from the most vulnerable and ambiguous stage in the development of youth (Gavazzi et al., 1992; Mazrui, 1975). This is where youth as peers, serve as "brother" (or "sister") keepers; who, through the guidance of the community and elders, assist one another to navigate a tumultuous stage of adolescence characterised by experimenting (including drugs) and identity seeking (joining like-minded groups).

3.2 Linkages to Macro- and Micro-theorizing about Drug Addiction

As an ecological theory of understanding addiction, the focus is on the interaction of an individual with their community. According to Copoeru (2014), this is an understanding based on inter-relatedness (of persons) and interconnectedness (with the world). This attests to being situated, where an identity connects the micro order (the location of the self) to the macro background (the web of social) (Anderson, 1995). A focus on the conditions peculiar to the context of the phenomenon studied, for Anderson (1995), meant that macro theories are "social appraisal sources" and a "social climate conducive to the drug used". As a macro theory of drug addiction, the ecological approach to drug addiction addresses the macro level: social, cultural, and spiritual dimensions of existence. The macro level argues that, to counteract dehumanization, inferiorization and racial subjugation that colonial forces, including Apartheid and slavery brought to African people, the resurrection of *ubuntu* and the African sense of who African people are, among decolonising projects, is a form of resistance that encourages participation and social action. At the micro level, this encourages binding elements, a source for orienting recovery support by promoting community agency. To counteract alienation that causes and continues to exacerbate addiction, Alexander (2001) found an appropriate assistance for drug addicts in the provision of a sense of community, belonging, usefulness, and positive group identities. In a way that enhances recovery and a healing platform, Alexander (2015) found the semblance of this sense

of community in recovery approaches that create belonging in peer and general communities as interventions that are suitable at local (individual and community) levels. Underlying this theory is a focus on ending alienation and thus addiction, through connections and relationships (Alexander, 2015b). Alexander (2015b) found an antidote in psychosocial integration, an Eriksonian concept that explains a sense of belonging. This is a state in which people flourish simultaneously as individuals and as members of their culture (Erikson, 1968, as cited in Alexander, 2000).

Psychosocial integration refers to the individual's experience of engagement with a group, and to the group's understanding and acceptance of the individual (Tutu, 2010, as cited in Alexander, 2015a). In finding this sense of belonging as engendered in the philosophy of *ubuntu*, this approach is a therapeutic measure and a healing medium, providing moral and spiritual guidance that is important for prevention of drug use. Although *ubuntu*, as a philosophy, is useful in many contexts, carved in this study as an ecological approach in dealing with drug addictions, it cannot be reduced to a mechanical tool. In a similar way, in considering its application in politics, Gade (2012) noted that it could not be confined to the political or any compartmentalized arena. This becomes important in what is considered the "bastardization" of Black African culture in the colonial era (Biko, 1978); and particularly during the transition to democracy after 1993. Swanson (2007) agrees with Mdluli (1987) that this cooption was misappropriation of *ubuntu* for ideological purposes to achieve political ends. Mboti (2015) found this to have been hegemonic. Nevertheless, it still remains among some cultural traits that Biko (1978) finds that African people can boast of. This is a reference to a sense of resilience that allowed African people to withstand the process of deculturation and dehumanization. Although it is applied in recovery, *ubuntu* is presented as a macro theory with both micro and macro explanations and interventions (Alexander, 2001). Importantly, however, it includes a spiritual orientation drawing from African ways that would be employed to promote prevention of drug use.

In presenting this traditional approach to drug addiction, an understanding of addiction from this view would be ecological. It refutes notions that the drug, an object of addiction, is an adequate explanation for addiction. From this view, this is a resistance from the medicalised understanding of well-being (McKnight, 1995). Fundamental to this understanding is that drug addictions are not a personal issue, a position according to Kemp (2019), that upsets notions that addictions are a physically orientated explanation dominated by the pleasurable effects of the substances. From this view, the drug-taking behaviour is seen as the manifestation of choices the environment presents to an individual. This sense of being in a township is an existence identified as a struggle, where "care" (actualising and being with others) seemed difficult (Olivier, 2015).

This does not mean that care does not exist. On the contrary, as Biko (1978), and Mampane (2014) as well as Mampane and Bouwer (2011), among other researchers, demonstrated in studies on resilience among such communities, care exists in such communities. Maximising human potential, however, becomes stringent in the life characterised by a "struggle". For Olivier (2015), lack of resources, poverty, unemployment, over-crowdedness, boredom, poor education, and violence, are environmental factors that do not support adequate functioning. Support, therefore, should focus on instilling and bolstering protective factors that insulate individuals and produce some form of resilience (Moore et al., 2003). At the same time, it should support an environment of recovery that *ubuntu* inculcates, a sense of community and belonging, but importantly, building communities.

African people acknowledge that disturbances have physical, social, and psychological causes and effects. For Nwoye (2015), this further includes the spiritual dimension. In describing alienation, Azibo (2014, 2015a, 2015c, as cited in Azibo, 2016) and Azibo et al. (2013, as cited in Azibo, 2016) define the sense of being lost to mean standing alone in this world without spiritual guidance. This is life devoid of a sense of belonging and culture that Alexander (2000) considered to be unbearable. For Mazama (2001), this discomfort would be unbearable because, in essence, life and to be a human being, is spiritual. In dealing with anomalies affecting African people, Mazama (2016) finds that it would become difficult to orient lives of African subjects in a positive and constructive manner without an African spiritual alignment.

The resurrection of *ubuntu* as a philosophy among African people emanates from a compelling need for African people to reorientate themselves in dealing with social problems they are facing, including addictions. Such a need has been identified by African scholars and researchers as guidance, directing moral, ethical, considerate and humane behaviour in a wide range of fields and applications (Asante, 2002; Masango, 2006; Msila, 2008; Mugumbate & Nyanguru, 2013), for example, social work, education, management, politics, justice, inter alia (Letseka, 2014; Mugumbate & Nyanguru, 2013; Ross, 2010). In the context of dislocation, for Mazama (2002), what may appear as "social problems" could, upon closer inspection, be cultural problems. For African people, this worldview provides ways of dealing with social anomalies linked to the alienation African people face everywhere. It is a focus on a strength rather than a focus on pathology, that delves into spiritual alignment. For Bulhan (2015), as part of the decolonising project, such an orientation plays a role of empowerment where there is a movement from the treatment of passive victims to the creation of self-determining actors.

3.3 Alienation among Black Communities

From a remark Aimé Césaire made in 1955, Ganaie (2017) agrees that colonialism is the "great historical tragedy" that happened in Africa. Together with Apartheid, colonialism is now considered to have been a gross human-rights violation (Mthembu, 2017). To describe colonialism, Ndlovu-Gatsheni (2015), also finds a voice in Aimé Césaire, who described it as a system that was disruptive, "decivilizing", dehumanizing, exploitative, racist, violent, brutal, covetous, and "thingifying". This encounter of an African with European colonialism began with a violent dispossession of the land (Bulhan, 2015). Dispossession included the loss of sovereignty and title to land for the conquered (Ramose, 2001, as cited in Delport & Lephakga, 2016). Werner (1993) finds this loss of ancestral land by indigenous communities to have dislocated people permanently. This initial dislocation was largely physical, where accompanying frontier wars were violent and brutal (Legassick, 1972). Dislocation uprooted people from their traditional settings, the kinship and bonds that had been established by communities, and cemented their sense of neighbourliness since time immemorial (Kretzman & McKnight, 1993). Secondary uprooting in communities in urban areas during forced removals from the 1960s was also recorded in resettlements, enforcing racial segregation during the creation of Black-only townships and the enactment of segregationist policies (Manson, 1981). The economic basis of slavery, for Legassick (1972) was the need for production on tracts of fertile land available at little cost in a situation where free labour was dear.

Even when cattle were taken, Werner (1993) finds that their ownership was also discouraged as it was a threat to the labour market. However, while the forced removal from land and the allocation to reserves limited the grazing land, most commentators agree that it was the indigenous people's sense of wealth that was removed; the colonial project involved impoverishment. For Legassick (1972), not only are African people landless; lack of ability to support themselves rendered them dependent. Walter Rogers (1955, as cited in Klein, 1974) argued that a large-scale underdevelopment of the people and Africa as a continent had lasting effects on the material standing of the Africans and their dignity. This becomes salient in the current capitalist world where material possessions and wealth are important. In disrupting communities, such further thwarted internal processes governing innovation among the exploited, and those that involved moving up the ladder and general progress (Klein, 1974). Slavery removed the able-bodied and human capital that would have contributed to the development of the continent, taking away functional manpower and depopulating the continent (Klein, 1974). Dislocation was not only physical, but it was also deeply entrenched, all-encompassing, thorough, scraping non-Europeans of dignity in brutal and dehumanising ways.

3.3.1 Colonialism as total dominance

For Bulhan (2015) colonialism was an encounter marked by the domination of one race of people over another, that included the domination of the world of things, the mind and the spirit. It began with a pursuit of commercial interests, in which the domination of non-Europeans began with a violent dispossession of the land (Bulhan, 2015). Such began during the voyages of discovery, when the European world or the North conquered the South. Legassick (1972) confirms economic interest that, for Bulhan (2015), propelled colonialism; where the culture of consumerism required the continued conversion of raw materials to finished products. To maintain these conditions, the complete subjugation of the body, the mind, and the spirit of Africans and other non-Europeans was necessary. However, Quijano (2000, as cited in Bulhan, 2015) finds greed to be supported by elements of self-aggrandizement that accompanied ideas of the supremacy of Whiteness over Blackness. The history of slavery, though it involved the total domination of the other, was never along race lines (Diop, 1987). There is evidence of White slaves in Egypt, and Mansa Munsu collected about 12000 slaves in his pilgrimage to Kemet (Cain, 2018). African people today still grapple with the pervasive nature of these conditions described by Bulhan (2015) as metacolonialism that continues to affect their material standing, further discouraging a means to survive this onslaught.

As a resistance, current ideas of decoloniality and metacolonialism, for me, are extensions of the decolonising project that highlights the pervasive nature of colonialism; opposing intellectual subjugation and material disadvantage. In modern times, decoloniality and metacolonialism both describe the enduring effects of colonialism that are lingering today in different guises. For Magubane (1979), the economic, political, and ideological motives that have structured capitalist relations of production in the modern world cannot be separated. While Bulhan (2015) conceived this within the framework of metacolonialism as a euphemism for globalisation, Ndlovu-Gatsheni (2015) saw globalisation today to be still driven by coloniality on a world scale. From frontier wars, to the massive recruitment of labour for building major cities that described the history of dispossession, conceptions of decoloniality and metacolonialism transmit the enduring and pervasive nature of colonial instruments at play in the modern era. From transatlantic slave trade, classic colonialism in Africa, neo-colonialism in ex-colonies to modern globalisation, these are stages in colonialism serving initial interests of the West and European centres of Europeans' power and local allies they select (Bulhan, 2015). From this perspective, Apartheid can be conceived as the manifestation of a global design in a local history, with its violence and crudeness close to attitudes within the American South during the first half of the twentieth century (Van den Berge, 1965, as cited in Giliomee, 2009).

3.3.2 Apartheid and the domination of the world of things

Apartheid was an institutional event located in a particular area in Africa, however, it encapsulated similar Jim Crow applications of White supremacist ideals in the American South (Beutel & Anderson, 2007). The system was instituted in 1948 in South Africa, legislating the ongoing colonial ideals and the racial supremacy of the White race. According to Delport and Lephakga (2016), Apartheid was not an exceptional moment in South African history, but rather, a different form of the same strategy of colonialism. Boggs (2003) believes that this legislation of colonialism signified by Apartheid was a uniform reaction by colonial settlers that ensued from the instability of the White man's world in colonies. In South Africa, the threat and the reality of violence meted out to natives was a worrying possibility that mirrored the violence unleashed in frontier wars, reflecting possibilities of "coming home to roost" (Malan, 2000). The Second World War saw Black African soldiers fight side by side with White compatriots, and this made it clear that White people were also human. In similar conditions as in the American South, such an institution of laws, the settler coloniser, insulated the world of Whiteness (Boggs, 2003).

Under the draping of separate development, Apartheid, as an ideology of Baaskaap (dominance), involved both the reproduction of labour and the maintenance of race and class relations in a theory by Christie and Collins (1982). The man considered the architect of Apartheid was Dr H. F. Verwoerd, the minister of education, and later the prime minister of the country. The crafting of social and economic conditions placed Black Africans at the bottom in the development of races as a political strategy, dubbed "separate development" (Giliomee, 2009; Shepherd, 1955). In promulgating his plan as a minister of education under the Apartheid government, Dr Verwoerd declared that there was no need to educate Africans beyond the level of semi-skilled labourer (Christie & Collins, 1982). He advised against teaching mathematics, something he thought Africans were not likely to use (Sifunda, 2015). It was considered merciful to Africans to limit their education. Verwoerd believed that Black Africans should not be exposed to greener pastures that they could not graze in (Giliomee, 2009; Shepherd, 1955). Bantu Education was therefore adequate for Black African people, a kind of education that was intended to be inferior for an inferior race (Shepherd, 1955). Bantu education was meant to keep Black Africans semi-skilled (Christie & Collins, 1982). This deliberate under-skilling continued the history of lack of skills and the resulting effect of current unemployment rate among Black Africans. In opting to revolt against this education, Black African youth became militaristic within the political involvement, determined to bring political change within this country (van Kessel, 2000). This further increased their lack of skills.

3.3.2.1 Poverty, inequality, and unemployment

Wilkinson and Pickett (2009, as cited in Pare & Felson, 2014) linked economic inequality to social evils that include drug addiction. For Percival and Homer-Dixon (1998), poverty and inequality in South Africa are aligned with conditions of unequal social distribution of a resource that concentrates such in the hands of relatively few people, while the remaining population suffers from serious shortages. For Swartz (2009, as cited in Olivier, 2015), poverty and inequality form aspects of imperialism and colonialism: the economic, political, and cultural domination of the African people by the White settlers. May and Govender (1998) attributed the continuing production and reproduction of poverty and inequality in South Africa to underlying distortions in economic markets and social institutions introduced by Apartheid. In a context in which there are adequate resources but distributed in ways that are skewed according to race, the contrast and the gap between races makes inequality starkly visible. For Magubane (1979), the pyramid of wealth and social power exists as a fact of daily experience for African people. The life of African people, for Swartz (2009, as cited in Olivier, 2015) is littered with symbols of the past economic and social exclusion and inequality of the former Apartheid regime. The enforcement of this inequality, for Seekings (2007, 2011), was demonstrated by a project intended to uplift the indigent White. Job reservations ensured that poverty was synonymous with non-Europeans. While for May and Govender (1998) it is not confined to one group, it is heavily concentrated in Black Africans.

For Dlamini (2019), poverty is a representation/signifier of Black lives and Blackness in South Africa, particularly in townships. Slow economic growth had not alleviated high levels of unemployment. Such subsequently increased soon after 1994, and accounts for the high levels of xenophobia (May & Govender, 1998). From a global view, Percival and Homer-Dixon (1998) link a state of violence to environmental scarcity. Even in post-Apartheid South Africa, Black Africans have enduring levels of unemployment and poverty (Mattes, 2012). Stead (1996) found slow economic growth characterising this era to have made employment prospects for adolescents look bleak. The slow growth of the formal sector averaged 5% in 1992 (as opposed to over 90% in the 1960s), with an unemployment rate of at least 52% among young people between the ages of 16 and 30 (Chisholm, 1993; South African Institute of Race Relations, 1994).

3.3.2.2 Boredom and idleness

In townships, boredom was found to play a key role; and was a substantial contributor to high-risk behaviour, including addiction to drugs. In a UNODC report (2003, as cited in Bruce, 2009) of youth reporting as “frequently bored”, half of them were more likely to drink and use illegal drugs. In a study by Dube (2007), boredom was reported to be one of the social factors

behind taking drugs. For Wegner et al. (2006), boredom is influenced by adolescents being engaged in leisure activities, saying that they "want to", "have to" do, or that they "have nothing else to do". The level of boredom among school learners suggested for Wegner et al. (2006) that children are either tired of the activities available to them, or they do not have access to a sufficient range of activities. In a study in Kokstad, Ettang (2017) further found that boredom was associated with lack of activity amongst students, particularly during school holidays. In a study carried out both in the rural areas, Chatikobo (2016) and in the townships by Mpanza (2015), both researchers found that boredom was associated with the lack of recreational facilities. Wegner et al. (2006) exposed that, owing to the political climate, leisure service-providers in South Africa did not focus their efforts on Black and Coloured adolescents living in impoverished and under-resourced areas. Caldwell and Darling (1999, as cited in Wegner et al., 2006) associated boredom in townships with leisure activities, in which positive use of leisure time was also lacking.

Viewed as a subjective experience, boredom requires the utilization of internal resources to deal with it (Sharp et al., 2011). From Roger's (1995, as cited in Wegner et al., 2006) theory of diffusion, how individuals deal with boredom includes the processes by which innovation is communicated through certain channels over time among members of a social system. Framed within the traditional way of life, measures that would present a model of purposeful life would assist (Wegner et al., 2006). Described by Mthembu (2017) as idleness, or by Mokwena and Morojele (2014) as "unstructured lifestyles", these concepts explain a situation characterised as "loitering". Idling was the word applied to young people not involved in education, not employed, not in training, and/or not looking for work (Ardington et al., 2016, as cited in Mthembu, 2017). For Mthembu (2017), street idling by Black African township youth during working hours suggested that they remain marginalised in the post-Apartheid era.

3.3.3 Spiritual domination

In a colonial project, Azibo (2016) finds de-Africanization, with its ramifications of permanent cancelling out of African personality, to qualify as a crime against humanity. Education in Africa was initially administered by missionaries. Glaser (2019) noted that while they were different in the way they treated their students, they were, nevertheless, anchored on White supremacist ideals. For example, while the German missionaries were "lenient", allowing their students to speaking their native languages, the British did not allow for such (Glaser, 2019). For Glaser (2019), there was no questioning of White superiority and racial segregation. Christian missions carried the arrogance of a religion that strives to civilise other nations, where according to Diop (1987), African traditions were "mocked out of existence". In some way, as Cogdell and

Wilson (1980, as cited in Oliver, 1989) noted, "to embrace a White God is to reject the Black self" (p. 19). Even though evidence is such that Jesus could not have been White, nevertheless, salvation for Black Africans was, for Mazama (2016), through, "our blond-haired, blue-eyed alleged saviour" (p. 228). Alkebulan (2016) proposed that for African persons to achieve total liberation, a religious system based on history should be included. Alkebulan (2016) further draws from this position by Massey (1883; 1881), to conclude that neither Islam, Christianity, Judaism, Hinduism, nor any other non-African religion, will suffice.

The disconnection of African people from their African roots, now considered to be at the core of their greatest problems, has been propagated as part of the colonial agenda. Whitewashing, in which movies "wash away Egypt's Black and African roots", is the christening of an ongoing phenomenon that began with the denial of such a link. Now, the obliteration of African people's participation and contribution in advancing the world (Abad-Santos, 2014), is not limited to movies. The denial of the historical heritage associated with Black African people as innovators is pervasive in nature. It litters early television, art, history, and some "scientific findings" (McGee, 1905; Rooney & Wolff, 1968). Therefore, when a pro-African magazine dominant at the height of Apartheid, placed advertisements for skin-lighteners, for Rauwerda (2007), thus reflecting pro-White Apartheid attitudes, this study presents empirical evidence of the manifestation of "double consciousness". The depth of the capture of the minds of the Blacks (Williams, 1974) is reflected in this phenomenon, that manifested itself at its crudest, as "self-hatred". African scholars attribute this description of lack of awareness of Black African people's true identity that manifests as double consciousness to du Bois (1903, as cited in Ali, 2016; Mazama, 2016). For Mazama (2001), dislocation occurs when one lives on borrowed cultural terms and apprehends reality through another group's centre. For the maintenance of own race, Dolamo (2013) finds the presentation of the contribution of African people to the history of mankind imperative.

3.4 *Ubuntu*, an Afrocentric Approach to Drug Addiction

The resurrection of *ubuntu*, for Molefe (2014), is an attempt to rediscover African cultural values eroded by both colonialism and Apartheid. *Ubuntu*/*Botho* (African humanity/humanness) is derived from the dictum, *umuntu ngumuntu ngabantu* (I am a person because of other people) (Dolamo, 2013). Considered a portmanteau or a basket term (Mboti, 2015), what seems clear, is that scholars and researchers would present the meaning of this dictum in the way in which they translated it. For Dolamo (2013), *ubuntu* is a concept that defines the core of human existence and the basis of human relationship and ethical behaviour. For Roederer and Moellendorf (2004, as cited in Gade 2012), the Nguni word *ubuntu* represents notions of universal human

interdependence, solidarity, and communalism which can be traced to communities in pre-colonial Africa, and which underlie virtually every indigenous African culture. In an African village, for Mbiti (1970), one is not allowed to live life alone, as on an island. For Nwoye (2017), no one can make it in the dance of life by living in isolation from the community. This defines "the priority of the Other" and the community of which the person is a part (Nwoye, 2017). It is a worldview in which people are interconnected (Gade, 2012), a notion underlying propositions that African people are communitarian. For Mbiti (1970, as cited in Molefe, 2014), this is encapsulated in a translation that "I am because we are".

From translating this aphorism to mean that one becomes a person through other people, Nwoye (2017) posits that mature human beings are not born, but made. From an understanding that humans are made persons by other persons (Mkhize, 2004, as cited in Nwoye, 2017), an idea that *ubuntu* is socially realised and transmitted. The failure to show solidarity, for Metz (2011) describes a failure to be a person, where one is indifferent, disinterested or antagonistic towards other community members, or the community as a whole. For Pearce (1990, as cited in Metz, 2011), individuals who exhibit discordant or indifferent behaviour with regard to others, are often labelled "animals". For Metz (2011), one can be more or less of a person, self, or human being. While the more human one is, the better, the ultimate goal in life should be to become a (complete) person, a (true) self or a (genuine) human being. For Metz (2011), actions such as deception fail to honour communal relationships. Metz (2011) finds the claim that one can obtain *ubuntu* "through other persons" explicitly to mean by way of communal relationships with others. Nwoye (2017) describes a person who is "mature", "well-cultured" as the extent to which the person is able to balance successfully this complex equation of being both communal and individual in his or her orientation to the world. For Metz (2011) such pertains to this maxim, "One becomes a moral person insofar as one honours communal relationships" (p. 540).

3.4.1 Spiritual formation

Mazama (2016) finds the inclusion of spirituality as part of the Afrocentric energy of cosmic origin that permeates and lives within all that is − human beings, animals, plants, minerals, and objects, as well as events. In the idea of life force as "spirit", God is the very source (Mkhize, 2003). For Mkhize (2003), spirituality extends to *izinyanya*, the living-dead or ancestors. *Izinyanya* ascend from people who lived well, meaning that both are earned (Mkhize, 2003). While for Nwoye, the idea would be that heaven is here, through certain rituals the living conduct for the dead, this would be an ascension closer to God. People who lived exemplary lives become good ancestors. This is a spiritual community of deceased family members who lived according to high

moral standards (Mkhize, 2003). African people believe in the invisible, spiritual world, which is the abode of the spirits, including the divinities and ancestral spirits (Mbiti, 1969, as cited in Nwoye, 2017; Mkhize, 2004; Nwoye, 2004). In the African worldview, humans are not separate from but are part of, nature (Molefe, 2014). The connectedness of the African people further links to the past, the present, and the future, and for Nwoye (2017), it is aligned with behaviour that is in accordance with the mores of the family or the community, to avoid infuriating the ancestors.

3.4.2 Parenting and child-rearing among African communities

Elders have a role as guides; and for Mageza (1975), elders are bound by their higher moral imperative to be accountable to the community and their eternal predecessors. Nwoye (2017) postulates that psychological maturity of the individual in the African context concerns each child's relationship to his or her people's indigenous social systems and values, philosophies, and worldview. In raising or socialising children, the African culture of *ubuntu* espouses the belief that it takes the whole village to raise a child (Chamberlain, 1996, as cited in Dunkley, 2013; Beguile, 2007, as cited in Kekana, 2015; Mbiti, 1977, as cited in Masango, 2006). These are multiple agents of promotion of human personhood in which supervision of children's social conduct is a decentralised process, and a community affair (Nwoye, 2017). For Mkhize (1999, as cited in Mkhize, 2003), through a practice of collective rearing of children, parental responsibilities may be assumed by anyone. In Nwoye (2017), virtues embraced by a well-bred African child include patience, perseverance, due discretion, ability to live for others, or the spirit of *Ubuntu*, obedience to parents, and respect for elders, together with modesty and industriousness. In raising children this way, McKnight and Block (2010) found this at the forefront of the creation of abundant communities. Children growing in the village are shaped as respectful people; and the concept of *ubuntu* becomes part of their lives (Nwoye, 2017). In a South African context, particularly in view of the recent political history with the "struggle" cohort, Stead (1996) reminds us of consumer and school boycotts, and Mdluli (1987) of party politics that heightened the level of conflict between parents and children.

3.4.3 The resurrection of ubunsizwa

The idea of the resurrection of *insizwa* (Dokes & Vilakazi, 1958) develops from a consideration of virtues necessary to bring a guiding framework for Black African youth. It draws from what McKnight (1995) refers to as traditional wisdom, and particularly what Mazrui (1975) described as hard virtues of the warrior tradition. Within this understanding, rites of passage include initiation rituals. Such rituals encourage age-appropriate behaviour as well as activities

that mark the transition from adolescent to adulthood. In an African culture of age-grouping and the initiation ceremonies, each age set announces its visibility and recognition within society (Nwoye, 2017). In this setting, peer modelling would allow the African individuals to draw guidance for their lives and social conduct from the behaviours of peers that are exemplary (Nwoye, 2017). Such virtues align with the aims of the National Youth agency that assert their efforts in redressing the wrongs of the past, and addressing the specific challenges and immediate needs of the country's youth (National Youth Development Agency, 2015).

3.4.4 A model of drug addiction

In the African traditional view of communalism African communities are known for, Straker (1994, as cited in Bojuwoye & Moletsane-Kekae, 2018) asserts that the conception of health is linked to relationships with others. Harmonious relationships with the universe, the local ecology, that includes plants and animals, including interpersonal relationships with other humans, defines "good" health or "ideal" human functioning. For Metz (2011), such denotes solidarity or mutual aid, to act in ways that are reasonably expected to benefit one another. This means the creation of balance, connectedness, and wholeness, both within the individual and the environment (Shutte, 1993, as cited in Bojuwoye & Moletsane-Kekae, 2018). According to Vontress (1996, as cited in Bojuwoye & Moletsane-Kekae, 2018), the spirit or life-energy essence needed for healing is not self-generated, but comes through a community with other people. From this view, group healing facilitates mutual emotional support and enhances self-esteem, leading to people feeling empowered or being in control of themselves and functioning more effectively.

Ubuntu is an African psychological theory of human personhood that is a frame of reference, or the worldview of the Africans (Nwoye, 2017). As an ecological theory in dealing with addiction to whoonga, *ubuntu* philosophy presents communities as a source and a medium of healing, a view that communities are uniquely positioned to counteract dislocation and to foster a sense of belonging. As a binding source, *ubuntu* draws from traditional ways that promote authentic neighbourliness and community support. Such virtues were eroded by the uprooting of people from traditional settings that promoted the community of first responders and subsequent support, when neighbours encountered problems (McKnight & Block, 2010). White (2002) finds indigenous healing institutions to provide relationships that are culturally grounded, enduring, and often reciprocal and non-commercialised. In regaining the dignity of the oppressed, Asante (2002) and Mazama (2016) saw the African way of life as a refuge in the resurrection of ideas of who they are. Such are means of counteracting the loss of dignity, dehumanization, and the alienation of Black Africans, that was integral in the colonial project.

3.5 Conclusion

Despite centuries of racial subjugation linked to the destruction of the African people's human spirit, conditions so alienating they open the door for drug-taking, African people continue to find traditional ways useful in making sense of this world. This chapter explored the *ubuntu* philosophy as a guide to the healing platform and function in dealing with drug addiction at micro and macro levels. At the micro level, *ubuntu* informs recovery approaches, institutions that inform support for recovery. As a metatheory, the model grounds African people through a spiritual orientation that counteracts the fragmentation and disconnections. This chapter argued that, for African people, the sense of who they are is defined by the good relationships among themselves as people, including respect for the environment. Behaviour consonant with this model suggests adherence to such norms as a concern with the welfare of others, self-improvement, tying this to citizenship. One becomes a person only when one behaves in a moral and just way towards others. To be *umuntu* means to be in harmony with other beings. It makes sense that, in an era of globalisation, characterised by dislocation on a large scale, there is an overwhelming need for such a binding agent. While the East finds spirituality located within the self, the West and the Europeans may find it in order, and in dominating the world − the outside. For Africans, however, it is the harmony they have with their environment, including other people, that is a priority.

CHAPTER FOUR
EMPIRICAL REVIEW OF LITERATURE ON WHOONGA ADDICTION

4.1 Introduction

Addiction to a hard drug that creates dedicated users, particularly the most prevalent and enduring opioid, whoonga, is a relatively new phenomenon in South Africa (Mokwena, 2015). The uniqueness of whoonga as a drug is a reference to the target population it affects the most, the Black youth in townships and informal settlements around the country (Ghosh, 2013); including, perhaps, the alarming speed at which it grew (Mdluli et al., 2010; Wessels, 2015). However, smoking heroin is a growing phenomenon in Africa (Morgan et al., 2019); around the world, heroin is rarely smoked as a joint. This has contributed to directing research towards ascertaining what whoonga is. With clear evidence that it is a hard drug, enduring signs and subjective symptoms forming part of the withdrawal syndrome were profiled, together with visual characteristics of addicts that identify users (Dintwe, 2017; Grelotti et al., 2014). Initial beliefs were that whoonga was concocted from common household ingredients. The concern was whether whoonga was a drug (MyNews24, 2014). Such was settled in identifying these characteristics, withdrawal symptoms, as well as conditions under which whoonga addiction thrives, in three different provinces (Mokwena & Huma, 2014; Mokwena & Morojele, 2014). Amidst allegations that it was an ARV-based entity, enquiries in this area were concerns with identifying and classifying the drug: ascertaining the exact contents became important (Mokwena & Huma, 2014). This further fuelled studies establishing the composition of the drug (Khine et al., 2015).

This chapter discusses research studies on whoonga addiction in South Africa to give the context of whoonga addiction, elaborating on the background to this study, showing what has been done. This will shed light on the priorities in understanding whoonga addiction; and will identify the gap, locating the need for this study and showing its originality and importance. In reviewing empirical literature on whoonga addiction in South Africa, early studies discussed first reflect an era in which ARVs were considered the main and most active ingredients in the whoonga concoction (Knox, 2012). The main concern for these studies was the redirection of ARV medication for recreational use (Grelotti et al., 2014; Kuo et al., 2020). Evidence of neurological proximity to other hard drugs (noticeably LSD (Lysergic Acid Diethylamide) and “club drugs”) and resulting psychoactive effects were inferred in what was considered theoretical neuropsychiatric attributes of ARVs in whoonga (Ackerman, 2013; Gatch et al., 2013; LSD-like psychoactivity with antiretroviral, 2013; Steadman, 2013). The depletion of ARVs could be accorded a concern (Larkan et al., 2010). There is also an indication that whoonga, as a substance

of addiction, interacts with other conditions that are a public concern, including HIV/Aids; therefore this should be a health concern. The worry is that not enough attention is given to whoonga addiction as an issue, and this position is shared by some media reports and literature on media reports on the subject (Mabokela, 2018).

Other than a health concern, whoonga addiction is a legal issue. While decriminalization or legalization has not been instituted, advocates of harm-reduction measures have been vying for humane treatment of addicts (Pilane, 2017). Instead of arresting whoonga addicts, a suggestion has been to redirect them to rehabilitation, calling for a collaboration between the Department of Health (DoH) and the Department of Justice and Correctional Services (DoJ&CS) (Monyakane, 2018). Recommendations for collaboration among different agencies, including the government and civil societies, communities, police, and social services propose that, in dealing with whoonga, a multi-sectoral approach is needed (Khumalo, 2016). Interventions will start with aggressive education (Keane, 2011) and awareness campaigns (Khumalo, 2016; Simelane & Nicholson, 2013), followed by the roll-out of OST (Cole, 2016; Gumede, 2018; Marks et al., 2017; Thathiah, 2014). If this sounds familiar, it seems to be echoing debates South Africa has had, and the trajectory the country has taken in responding to HIV/Aids (Marks et al., 2017). Parallels are drawn by experts on substance abuse, who caution against delays in rolling out OSTs. Experts emphasise that such could be too late, in similar ways to delays with the roll-out of ARVs, with disastrous consequences (Gedye, 2016; Mbulayi & Makuyana, 2017; Scheibe et al., 2017).

4.2 Whoonga Drug is an Opioid or an Opioid-based Entity

From a study of whoonga samples sourced around the country, the composition of the drug has now been identified (Khine et al., 2015). The two-pronged intersection with the preceding scourge, HIV/Aids, has received the most attention; either as exacerbating its spread as a health concern among youth addicted to whoonga, or as depleting medication rolled out to treat it (Daily Mail Reporter, 2010; Davis & Steslow, 2014; Kuo et al., 2020; Tsuyuki et al., 2015). There are psychiatric effects attributed to smoking these medications, largely formulated from a conception that ARVs were an (active) ingredient in whoonga (LSD-like psychoactivity with antiretroviral, 2013). Cautions on smoking ARVs were cited, presenting a possible danger of pre-treatment exposure that could cause resistance upon the initiation of antiretroviral therapy (Grelotti et al., 2013; Kuo et al., 2020; Kurtz et al., 2014). Despite such reports, a case is made that whoonga is an opioid or an opioid-based entity that includes largely heroin and morphine (Khine et al., 2015). With no proven effects that these “other” substances in whoonga are enhancing the potency of whoonga as adulterants, manufacturers could be bulking the mix, increasing the dealers’ yield

(Chinuoya et al., 2014; Cullinan, 2011; Rukikaire, 2011). Pure heroin is expensive. Profiteering is the motivation for bulking it.

In the choice of bulking agents, either as a distraction or a repackaging, the underworld diversifies heroin, mixing it with a variety of substances (Kempen, 2019; Moore, 2014). In a range of emerging heroin-variant drugs, whoonga is similar to *krokodil* (desomorphine) (Bayever, 2016), so named for the flesh-destroying skin condition it causes (Cole, 2014; Conway-Smith, 2013; United States Department of Justice, 2019). This mixture of morphine (codeine) and gasoline (and other inhalants) is reported to have recently spread from eastern Europe into the USA (Cole, 2014; Conway-Smith, 2013; United States Department of Justice, 2019). These heroin variant drugs are reported to be pharmacologically similar to other opioids with typical subjective effects characterised by acute abstinence syndrome (Khine & Mokwena, 2016; Nuckols, n.d.). Both whoonga and *krokodil* are highly addictive, they have salient withdrawals and signs particular to each drug, namely, stomach cramps and skin conditions, not attributable to heroin use.

4.2.1 Whoonga as a designer drug

In the initial stages, whoonga was thought to comprise household ingredients easily available, some "nasty" (Mokwena, 2015; Shembe, 2013), some outright toxic and dangerous (Cullinan, 2011), rendering a conception that whoonga is a "designer", "internet" (Liechti, 2015; Mokwena, 2015), or "new-generation" drug (Dintwe, 2017). The mystery of the drug was that since it could be concocted using common ingredients in novel ways, it was therefore easily available, fuelling the wave of addictions. In testing whoonga samples around the country, the enduring drug content in whoonga was found to be opioids, mainly morphine and heroin (Khine et al., 2015); also referred to as opiates to particularise the synthetic kind (Khine et al., 2019; Moore, 2014). Tests were conducted that isolated ingredients of whoonga drug samples (Khine & Mokwena, 2016; Mthembi et al., 2018). A subsequent study gave guidance on handling whoonga samples from when they are acquired by the police prior to testing (Mthembi et al., 2019). Such developments have yielded efforts to develop hand-held devices for the-spot urinalysis (Khine et al., 2019). These tests will be useful for criminal and forensic purposes, assisting drug enforcement and prosecuting agencies. However, before these tests, there was an intimation that whoonga was heroin (Smillie, 2013). The smoking of heroin as a drug-ingesting method seems to be peculiar to an African setting (Morgan et al., 2019). Nevertheless, the pattern of whoonga addiction, viz., progression in the administration method, intensity of withdrawal symptoms, consumption patterns, and the general progression of addiction, are hallmarks of heroin addiction (Mabena, 2017; Strang et al., 1992; Tsipe, 2017).

4.3 Availability of Heroin and Whoonga

Drugs are presenting another frontier that promotes conditions of continued underdevelopment in Africa. The availability of whoonga in South Africa was largely linked to the eastern route, largely associated with Tanzania, and trickling inland via Mozambique (Hanlon, 2018, as cited in Dunlop, 2018). Porous borders, expansive South African shores, including remote unguarded airstrips, are associated with an increase in this trade (Boomgaard, 2010; Shaw, 2001; UNODC, 2018). Unlike the western route, trading mainly cocaine from the Americas, this eastern trade route, also known as the "smack" route, ferries opium from the Middle East (Bruwer, 2016; Kempen, 2018; Swanström & Cornell, 2004; The Business Insider UK, 2015). The lifting of the embargo against South Africa at the end of Apartheid ended the country's pariah status. The end of border wars in which African people were fighting (proxy) ideological wars of the Europeans, called the cold war, military, and guerrilla warfare in the Southern African region, had ceased (Laniel, 2001). Porous borders are further linked to the end of Apartheid, and the liberal atmosphere characterising the new government in South Africa (Nel, 2004; United Nations Office for Drug Control Crime Prevention, 2002). The new democratic South Africa saw an influx of a variety of illicit drugs, with most of those in the SADC region destined for the country (Lehloenya, 2016; Peltzer et al., 2010). Some cited the involvement of senior politicians with the underworld and drug trade, a sign of moral decay at the top (Vahed, 2015).

Whoonga took hold among impoverished communities, particularly among Black African communities around the country, including rural areas. Compared with cannabis, and other "softer" drugs available in these communities, whoonga is pernicious, severe, and intense, making it a hard drug (Kaminski, 2014; Mokwena & Huma, 2014). The availability of heroin as a drug, and an object of addiction began the spread of whoonga, alleged to have moved from a White male race to largely Black African youth (Pauw, 2015). It grew to a wave now considered by some researchers an epidemic (Dintwe, 2017; Grelotti, n.d.). The availability of the drug accounts for the wave of addictions to whoonga (Kempen, 2019). There is evidence that whoonga was "marketed" aggressively to township youth in several ways (Mqadi, 2016). However, it can be argued that whoonga became an enduring drug among drugs that flooded South Africa because it landed in conditions amenable to its use. In paving the way forward, Africa, and South Africa in particular, being new to dealing with drugs that create dedicated users, should learn from other similar communities dealing with drug addictions around the world, deducing relevant solutions.

4.4 Cannabis Use

The versatility of heroin ingestion, as a drug, is that it can be ingested in diverse ways, including snorting, injecting, and chasing the dragon; also in that it can be smoked (Moore, 2014; Morgan et al., 2019; Ross, 2013). Unlike other heroin-variant drugs mixed with softer drugs, whoonga is a concoction of heroin mixed with cannabis. This is unlike *krokodil*, which is heroin mixed with inhalants. Although there are other methods, this heroin variant is ingested; particular to whoonga is that it is sprinkled and rolled with cannabis mixed with a cigarette, to make what is known as a "joint" (Marks et al., 2017; Mbanjwa, 2011; Ross, 2013). A joint is about the size of a cigarette (Hall & Solowij, 1998). Perhaps the smokability of heroin, a rare phenomenon around the heroin-smoking world, is facilitated by sprinkling it on a cannabis joint.

There are some indications that would propose that, since cannabis is a drug in its own right, belonging to another class of drugs, cannabinoids, which are hallucinogens, whoonga should therefore be identified as a polydrug. This mixture of cannabinoids and opioids would indicate that whoonga addiction could also be addiction to multiple drugs, meaning that it should therefore be considered polyaddiction. However, multiple addiction suggests (although is not limited to) discrete addictions to more than one drug. Addiction is presented in ways that suggest that the person ingests two different drugs of different classes, and at various times (Keen, 2013; South African Community Epidemiology Network on Drug Use [SACENDU], 2016). It is not clear how this would have any effects pharmacologically, nevertheless, everything considered, whoonga addiction presents with effects and withdrawal symptoms that are like effects of heroin (Statistics South Africa, 2009). In similar ways as *krokodil,* heroin-variant drugs are like other opioids, however, they produce salient symptoms particular to that concocted drug (Nuckols, n.d.). *Krokodil* produces skin problems, and whoonga produces stomach cramps (Bayever, 2016).

While there are inferences that cannabis migrated from India (*cannabis Indica*) to Africa (Chattopadhyaya, 2019), there is evidence that it has been used among traditional communities (Bourhill, 1913). The climatic conditions under which it thrives are similar on both continents (du Toit, 1976). The other species of this plant could have originated in Africa (Ren et al., 2019). While the concern with cannabis use in South Africa is its use by youth in urban settings, Peltzer and Ramlagan (2007) found the original use of cannabis among African communities to have been limited to use and control by elders. As a drug of abuse around the country, there are some arguments worldwide that cannabis leads to the use of other drugs.

4.4.1 Cannabis use: the gateway or stepping-up theory

Around the world, there is a raging argument on whether cannabis and other softer drugs lead to addiction to harder drugs. Earlier studies on the gateway or the stepping-up theory of addiction to hard drugs, ideas that cannabis leads to addiction to other drugs, present two main positions. One is that most people who are addicted to hard drugs began by smoking cannabis. The other position is that, not every person who has smoked cannabis ventures on to hard drugs (Hall & Lynskey, 2005; Melberg et al., 2010; Ontario Agency for Health Protection and Promotion (Public Health Ontario), 2019). These positions further support the decriminalization of the drug; and controlled use of the drug, including for its medical use. Generally, cannabis is considered a safer drug. A number of people who smoke cannabis are non-problematic users. Such arguments are waged by individuals, arguably of the middle-class, who support the recreational use of cannabis. Such is seen in the case for South Africa, allowing its cultivation and responsible use by adults within their own private space (Hall & Lynskey, 2005; Shukla, 2013). However, for addiction professionals, a concern would be effects of such modelling to the young and the malleable. A similar argument can be waged for smoking cigarettes as a gateway to smoking cannabis, in that this becomes a gateway to hard drugs (West & Hardy, 2013). In the context of problematic drug use as in whoonga addiction, such considerations will need to be made in light of cannabis use by youth.

4.5 The Focus on ARV Medication in Whoonga

The association of ARV medication with whoonga can be accredited with bringing whoonga addiction to the attention of the public (Scheibe et al., 2017), assisted by organisations such as Treatment Action Campaign (Daily Mail Reporter, 2010; Knox, 2012; Neuroskeptic, 2011; Rukikaire, 2011). The misdirection of lifesaving ARV medication for “recreational use”, targeted Sustiva or Efavirenz, and Stocrin, with similar reports in the USA showing the abuse of Retonovir (Chinuoya et al., 2014; Daily Mail Reporter, 2010; Davis & Steslow, 2014; Grelotti et al., 2014; Rough et al., 2014). The impression was that these ARVs were an active drug in whoonga, and media reports confirmed that HIV patients had been mugged for their medication (Lekgetho, 2019; Naidoo, 2010). Trucks transporting medication were hijacked, and some health officials prosecuted for selling ARV medication (Cullinan, 2011; Makana, 2017; Naidoo, 2010), some confessing that their intention was to concoct whoonga (Mthembi et al., 2019; Nkalanga, 2017).

Notable though, is that, in a study conducted in makeshift night-clubs in KwaZulu-Natal (Grelotti et al., 2014), and aligning with other studies associating whoonga with ARV medication (Rough et al., 2014), researchers mention heroin and/or methamphetamine as ingredients in

whoonga; however, they still stressed that the observed effects of whoonga addiction are caused by ARVs. For example, it is reported in this study that "… (whoonga) is suspected to contain illicit substances (marijuana, methamphetamine, and/or heroin), household products like …" (Rough et al., 2014, p. 1378). Researchers concluded that "participants reported that antiretrovirals were being crushed, mixed with illicit drugs, and smoked for *their* psychoactive effects" (Rough et al., 2014, p. 1379, my emphasis). Corroborating studies reported on the use of protease inhibitors, a reference to Ritonavir, which was one of these medications. Inhibitors such as these were associated with enhancing and prolonging the effects of these drugs, making references to ecstasy and methamphetamine (Inciardi et al., 2007), not heroin. Both ecstasy and methamphetamine are uppers or stimulants, which means that their effects evoke activity and excitement (Cruickshank & Dyer, 2009; Kempen, 2015). On the other hand, whoonga is reported to reduce heart and lung function (Cronje, 2015; Strydom, 2011), and is clearly not a stimulant, like "tik", a crystal methamphetamine, for example. From its effects, whoonga is described as a euphoric depressant: its high makes one feel heavy and sleepy (VICE, 2014).

The government refuted that ARVs are the main ingredients in whoonga; and assertions that the active chemical ingredients in whoonga are ARV medication were reported to be unproven (Cullinan, 2011; Rukikaire, 2011). Some dismissed such a finding as a myth based on distortion by the media and the incorrect data supplied by users who don't know any better (Kaminski, 2014). A media house commissioned a single laboratory test on six samples of whoonga powder sourced from Durban and surrounding areas including townships, finding no ARVs contained (Rukikaire, 2011). Dr Thavendran Govender, the Durban-based chemist who also tested whoonga samples for an international documentary, attested from personal experience that there would not be enough ARV medication to meet the whoonga demand (VICE, 2014).

In discussing the relationship between ARV medication and whoonga, there is no reason to believe that ARV medication has psychiatric-psychoactive effects, despite the insistence on such a relationship (DeAtley et al., 2020; Mthembi et al., 2019). Clearly, there is nothing to indicate such effects of these medications when smoked (Bristol-Myers Squibb Company, 2012). What can be salvaged is that any effect observed in a high from ARVs could be a placebo effect (Neuroskeptic, 2011). Nevertheless, there is evidence that ARVs are used in whoonga (Khine et al., 2015; Larkan et al., 2010). Albeit not the active or the main ingredient in whoonga (Grelotti et al., 2013), this has massive effects on availing ARV medication to those who need it (Larkan et al., 2010).

4.6 Whoonga, a Concoction of "Other" Substances

At the backdrop to worldwide heroin diversification (UNODC, 2018), and the rise of heroin cases reported in rehabilitation centres in South Africa, there is a view that whoonga may not be a new drug (Peltzer et al., 2010). From reports divulged by rehabilitation centres around the country, heroin, as a drug, has been consumed at less than 2% amongst prevalent drugs. The drug seemed originally to be used largely by the White male population (Statistics South Africa, 2009). In what is considered the repackaging for a new market a drug that has always been available (Rukikaire, 2011), there has been a rise of youth reporting for heroin treatment and rehabilitation. Some 65% of these addicts are Black, in what is considered the changing face of heroin use (Parry et al., 2005; Pauw, 2015; Statistics South Africa, 2009). In purer form, this whitish powder is expensive, giving the notion that the smokable brownish variant is low- or B-grade (Coppen, 2014a; Harper, 2000) because cheaper (Ghosh, 2013; Wessels, 2015; Zimpaper Digital, 2014). The reference to whoonga as "sugars" is an unfortunate and misleading misalignment of it with "*tik*" a crystal methamphetamine, and another problematic drug. As mentioned above, *tik* is a different cluster of stimulant drugs (Cruickshank & Dyer, 2009). *Tik* was witnessed mainly among Coloured and Indian communities in Durban and on the Cape Flats (Boomgaard, 2010; Farber, 2015; Masombuka, 2013). Perhaps the confusion emanated from the emergence of whoonga soon after this "epidemic" of "sugars" around Durban, and particularly in Chatsworth (Ephraim, 2014). In this form, sugars (white and brown) refer to a polydrug like whoonga (Khine & Mokwena, 2016) that includes mainly cocaine, but also crystal methamphetamine (Chapman, 2014ab; Coppen, 2014a). The presentation of sugars coincides with the forms of purer heroin, white: the injectable type, and brown: the smokable type (Harper, 2000).

The colour variants of whoonga can further assist to explain the choice of bulking agents used. Such agents are usually white, like bicarbonate of soda, powdered soap detergent, Vim (a branded household cleaning powder), ammonia, baking soda, milk powder, headache tablets, TV flat-screen powder, etc. (Daily Mail Reporter, 2010). Some whoonga powder is off-white (Khine et al., 2019), or brownish (Boomgaard, 2010). The conception is that these variants mimic the original colour of purer heroin. While colour alone cannot explain the choice of all substrates used, it is proposed that the combustibility and the smokability of that substrate, as its properties, seem a plausible explanation (Phokedi, 2018). One can imagine why a white maize meal, a commonly available substrate and as Africa's stable food, can never do as an adulterant, particularly if one has tried to burn it. Nevertheless, the variety of substances used differs from one area to another (Khine & Mokwena, 2016); and seems governed by the availability of suitable material to bulk and increase the dealer's yield and profit (Daily Mail Reporter, 2010; Rukikaire, 2011). To those

who have been close enough to the drug, a "good" whoonga mix emits a vinegary smell (Daily Mail Reporter, 2010; Kotzin, 2013).

4.7 Psychoactive Effects of Whoonga: Insights into the Whoonga High

Whatever the ingredients, the general consensus on whoonga is that it is highly addictive and compulsive in nature, were whoonga addiction to be judged by the lengths to which a person addicted to it would go to acquire the next fix (Mabuse, 2014; Wales-Smith, 2015). In a research study investigating lack of compliance with taking ARV medication by patients, unprompted responses discussed the abuse of antiretroviral medication, and from the participants' observations, whoonga addicts appeared "paranoid and high" (Rough et al., 2014). In presenting possible sources of the word *"iphara*", a common reference to a whoonga addict in Durban, Hunter (2018) presents "paranoid" as one.

In drawing similarities with the Miami study (Inciardi et al., 2007) as evidence of the recreational use of antiretroviral medication (Ackerman, 2013); Rough et al. (2014) further linked neurological and psychiatric side effects by showing similarities of LSD-like effects (Gatch et al., 2013; LSD-like psychoactivity with antiretroviral, 2013). Efavirenz is known to cause hallucinations. A study reporting on manic syndromes associated with Efavirenz was cited (Larkan et al., 2010) as well as a study linking the activity at 5-HT2A receptors of the brain when both inhaling ARVs and taking LSD, a hallucinogen, in rats (Steadman, 2013). Psychiatric effects this research study inadvertently added as effects of whoonga include paranoia, psychosis, and delusional hallucinations. Such are all reported to be similar side effects to LSD, together with visual hallucinations, impaired motor ability, manic episodes, and "feeling high" (Ackerman, 2013; Steadman, 2013). This is derived from a case report on an intentional Efavirenz and Lamivudine overdose that was linked to these effects (Boscacci et al, 2006, as cited in Rough et al., 2014). Efforts to avert such an abuse pharmacologically, initiated a study on mice. In this study mice exhibited a "twitching behaviour" when they were subjected to drugs mixed with ARVs (Ackerman, 2013).

Efavirenz taken orally is associated with uncomfortable nightmarish dreams, but whether this medical counter-indication translates to "LSD-like" or psychoactive effects, or whether it enhances heroin effects when smoked, is not clear. Studies linked smoked antiretroviral medication to LSD-like effects in that these substances had similar binding agents in brain neurochemistry (Ackerman, 2013; Gatch et al., 2013; Steadman, 2013). From these studies describing the effects of drugs by highlighting the binding agents and neurotransmitters, psychoactive effects of smoking ARVs were inferred. Experts do not think that these effects are

likely to be transferable to whoonga, or that such effects are transferable to smoked ARVs (Christian Addiction Support, 2016; Daily Mail Reporter, 2010; Rukikaire, 2011; Schetz et al., 2013). In a documentary by VICE (2014), the presenter takes the drug, and does not appear to "see wild things" but rather reports feeling euphoric and lethargic, feeling tired, quietened, and wishing to sleep. Such effects are confirmed in other reports by whoonga addicts (Dube, 2014; Manyane, 2018). The researcher had slurred speech, felt sleepy, and looked tired, reporting to feel content, evidence of a euphoric depressant. VICE (2014) corroborates this by presenting one of the participants the presenter interviewed who described a whoonga high as feelings of heaviness. This interviewee appears too sophisticated to have had experience with whoonga, a drug largely considered as a "slum" drug (Strydom, 2011); and the responding audience of this documentary were equally amazed that she pronounced whoonga as not "psychedelic" (VICE, 2014). The presupposition is that anyone who can know and pronounce the word would know about the classifications of drugs. A case that whoonga is not limited to lower-class communities was made. Such an assertion is fostered by reports of middle-class youth addicted to whoonga (McLoughlin, 2013), including a son of a politician (Chapman, 2014b; Coppen, 2014b).

4.8 The Withdrawal Syndrome, Stomach Cramps and Strychnine

In contending suggestions of the source of the word "whoonga/wunga" (Eligh, 2020), there is an inference from a subjective description of the feeling, *"wukeka*" (Mbanjwa, 2014). This is a reference to feeling cut in the stomach by barbed wire, as a metaphor for a conspicuous symptom of withdrawing from whoonga: stomach cramps (Mbanjwa, 2014). There is an association of stomach cramps resulting from withdrawal from whoonga (Ephraim, 2014) with strychnine; with ample suggestions that this withdrawal symptom could be related to another bulking agent, rat poison (Baloyi, 2011; Reddy et al., 2011). The metabolism of strychnine, the active ingredient in rat poison, presented as responsible for causing stomach cramps, has not been proven (Coppen, 2014a; Cullinan, 2011; Mungai, 2015). Strychnine in minute quantities has a history of being used as a drug or mixed with hard drugs, but its main use is that of a rodenticide, and has been used to kill stray dogs (Inglis-Arkell, 2013; Periodic Videos, 2015). Strychnine uniquely acts to block both sodium (Na+) and chlorine (Cl-), mineral elements (salt) crucial in regulating muscles and which, when its actions are interfered with, result in muscle spasms. In high doses, strychnine can cause muscles to stop working and death by asphyxiation when lungs collapse, and the heart muscles cease (Periodic Videos, 2015). While whoonga addicts would die of overdose (Zwane, 2015, Chambers, 2018), this could propose that they would die in larger numbers because of adulterants.

4.9 A Need to Raise Whoonga to a Status of a National Agenda

Despite considerations that whoonga addiction is a crisis and a national concern (Boomgaard, 2010; Conway-Smith, 2013), there is little evidence that it receives such attention it is thought to deserve. There is a concession that the damage to youth, families and the community whoonga addiction causes warrants that it be prioritised (Simelane & Nicholson, 2013). A view that whoonga addiction interacts with other national health concerns, particularly its intravenous use, complicating other conditions like HIV/Aids and their treatment, possibly increasing transmission of Hepatitis B, and C, and other blood-borne diseases, supports the need to prioritise the drug as the conditions it intersects with (Akindipe et al., 2014; Parry & Pithey, 2006; Brittany, 2015a; Sowetan Reporter, 2015). Rare conditions are noticed in adult males who injected whoonga (Meel et al., 2014): these conditions are escalating (Meel & Essop, 2018). Whoonga addiction affects children born of mothers who smoked whoonga (Thomas & Velaphi, 2014). Whoonga addictions are complicating the treatment of HIV/Aids; participants in these studies linking these rare medical conditions to injecting whoonga were all HIV-positive (Meel et al., 2014; Thomas & Velaphi, 2014).

4.10 Whoonga Addiction as a Health Concern

In studies, both conducted in Gauteng's Chris Hani Baragwanath Hospital − that admits patients referred from surrounding lower-level hospitals and clinics − long-term physical effects attributed to whoonga addiction and intravenous use of whoonga were explored. The first study was prompted by the observation of low birth-weight in neonates born to mothers who were addicted to whoonga (Thomas & Velaphi, 2014). These mothers were HIV-positive, and never attended pre-natal clinics. Both children were observed to be symmetrically growth restricted; weighing at birth 2,2 kg and 1.3 kg; and they also presented with varying medical complications that were attended to. Both children were observed to be jittery, with excessive sucking movements; and both children were diagnosed with neonatal abstinence syndrome (NAS) (Aveyard et al., 2009). Only one child needed pharmacological intervention; the other was given Methadone, but was weaned off it 9 days after birth (Thomas & Velaphi, 2014). The other baby did not receive treatment, although her mother was HIV-positive; this mother was also reported to have "refused" to stop taking whoonga when pregnant (Thomas & Velaphi, 2014). The mother was treated with Clonazepam and Methadone to ward off withdrawal symptoms after giving birth. This study presented evidence of effects similar to foetal-alcohol syndrome, in which alcohol, and whoonga in this case, consumed by the mother, affected the child.

This *in-utero* exposure to the drug can lead to the diagnosis of the NAS that requires medically-assisted treatment for the baby for withdrawal symptoms (Thomas & Velaphi, 2014). In the second study, three individuals, all HIV-positive and all administrating whoonga intravenously were presenting with right-sided infective endocarditis (RSIE), a condition that is rare in Africa, in both pre- and post-HIV eras. From this study, the relationship between whoonga and RSIE predicts that whoonga addiction will present as burdensome to the medical health-care system. This study is the official report confirming direct medical effects of the progression of whoonga use to injecting it, known as "bluetoothing" (Tsipe, 2017), which is an intravenous administration of the drug (Meel et al., 2014).

4.11 The Role of the Media

Given the devastating effects of whoonga addiction, the conception is that the media has a responsibility to inform the nation, and being ethical to their craft, would probe issues of national concern such as whoonga addiction (Mabokela, 2018). The general reporting on whoonga ranges from portrayals of whoonga addicts' existence as pariahs, to mainstream functioning, offering many reasons to be afraid of addicts, largely because they commit crime, endangering personal and property safety (Motsoeneng, 2015). Coppen (2014ab), a drama lecturer and director, reported on whoonga, prompted by a suggestion by his students that it was one of the topmost social concerns for them. Coppen went on to conduct some research on whoonga (the resulting play was recently seen in Durban theatres) (Gedye, 2016). The portrayal of whoonga addicts was described as gruesome (Chapman, 2014b; Charles, 2014), in dramatized tones (Chapman, 2013a), and not empathic to the plight of addicts as human beings, among his concerns (Coppen, 2014a). In describing their appearance, their tattered nature evokes zombie-like, other-worldly, demonic apparitions, and shock at what they are capable of doing in terms of the gruesome nature of crimes they engage in, commit, or suffer themselves as victims of retaliation.

Parallels with such observations are findings of a study of two local newspapers that cater for the communities affected by whoonga addiction in South Africa, i.e., the Sowetan, and the Daily Sun. Both newspapers were found to have reported ethically. However, a concern raised was on the presentation of a dead whoonga addict's picture on the front page of one of the issues of these newspapers (Mabokela, 2018). Portrayals of whoonga addicts came across as sensationalised. The concern was that there was no in-depth reporting intended to have these communities interrogate the issue (Mabokela, 2018). Sensationalised reports appeal to the readership, but they do not assist in averting the stigma − they could be thought to promote a

moralistic view that drives the ostracization of and repugnance towards whoonga addicts (Chapman, 2013a, 2013b, 2014a, 2014b).

For Hunter (2018), while it is true that whoonga addicts are opportunistic criminals, it should be accepted that there is a whoonga economy. Whoonga addicts hustle (*phanta*), selling scrap metal, washing cars and minibus taxies, assisting with parking, and carrying groceries for supermarket patrons, and other such menial jobs for the next fix. For Hunter (2018), the government should acknowledge this "whoonga economy". Hunter (2018) scorns the convenience of portraying whoonga addicts as urban criminals. Such serves, from his view, politicians, who can consider addiction a city crime issue. This, for Hunter (2018), partly explains the prolonged silence around the way forward in dealing with whoonga addiction. As it stands, there is no official strategy for curbing whoonga addiction (Mokwena, 2015). To enforce commitment from the politicians, there is a suggestion that they should be held responsible by the communities who are constituencies that elect them (Simelane & Nicholson, 2013).

4.12 Intervention: Is the Drug the Way to Go?

In approaching treatment, there is a suggestion that, with the pernicious nature of the drug and the resultant wave of addictions, in dealing with whoonga addictions, it cannot be business as usual. What this implies is that the limitations of the Central Drug Authority (CDA) as a coordinating body, in which collaborations should be and are still being suggested, is highlighted. The overriding suggestion is that interventions should be particularised or tailor-made strategies geared towards fighting whoonga as a national scourge (Department of Community Safety, 2014). Strategies should filter uniqueness of the drug whose interventions should be prioritised beyond available and ongoing substance-abuse programmes (Khumalo, 2016; Mokwena, 2015). Police and the justice system have indicated need for support, stating that they cannot do this alone (Dintwe, 2017). Intervention will begin with education and awareness campaigns (Khine et al., 2015; Khumalo, 2016). Programmes are recommended to restructure the lives of youths, creating chances of employment, thus reducing poverty (Department of Community Safety, 2014; Mokwena & Morojele, 2014). Harm-reduction programmes address the effects of whoonga addiction for communities, helped by professionals (Khumalo, 2016); but the main direction is the availing of OST (Marks et al., 2017).

As discussed below, whoonga addiction presents as a chronic relapse disease (Mokwena & Huma, 2014; Tuwani, 2013). From this perspective, a disease model is advocated, particularly its extension to the communities. Myers et al. (2012, as cited in Myers & Sorsdahl, 2014) propose availing of treatment as part of primary health care to improve access and to ensure that other

services are also availed to cover the full continuum of health care addicts would need. To increase access to treatment in other countries, a legislation gave nursing practitioners and physician assistants a waiver to prescribe buprenorphine (Andrilla et al., 2019).

In light of difficulties to access limited public health facilities (Mokwena, 2015) and given that private rehabilitation centres would, on average, be unaffordable for these communities (ADASA, 2012), the suggestion is that there will be the availing of OST, particularly Methadone syrup to the communities. This version of medication is available in South Africa (Weich, 2015). Coupled with concerns of humane treatment of drug addicts, decriminalization is appealing to avert arrests that result in all sorts of maltreatment of addicts; and to avail the substitute drug to a patient to manage withdrawal (Marks, 2017; Marks et al., 2017). The position with legalization of whoonga further proposes that such would take the drug currency away from the underworld; and if possible, its sales could be taxed (Britton, 2015a, 2015b), directing funds to relevant health concerns (ADASA, 2012). There is a suggestion that the drug itself, whoonga, and not its substitute antagonist Methadone, can be availed and would be administered and tapered by professionals to minimise withdrawal (Britton, 2015b). The drug could be cleaner, avoiding possible deaths by adulterants (ADASA, 2012).

4.13 Whoonga Addiction as a Progressive Relapse Condition

From inception of the drug-taking behaviour, experimenting with whoonga, the progression of whoonga addiction is presented as a chronic relapse disease (Motsoeneng, 2015; Nkosi, 2016). In a study of experiences of whoonga addicts in three different provinces, participants reported that whoonga has a calming effect, and that the initial high was intense (Mokwena & Huma, 2014). In taking the drug in subsequent larger doses to acquire the same initial high that can progressively become reduced, addicts would need to take the drug to assemble normal functioning, displaying tolerance to the drug. Despite negative outcomes of the use of whoonga, addicts feel compelled to take the drug. They feel helpless to stop; they regret taking the drug in the first place, and wish they could stop, but cannot (Mokwena & Huma, 2014). Those who have tried to stop, soon take the drug again to ward off withdrawal syndromes, largely stomach cramps, generalised pain and diarrhoea that can last some days (Mdluli, 2015; Mokwena & Huma, 2014). Deaths, including drug overdose, result from whoonga addiction (Gedye, 2016; Zwane, 2015; Chambers, 2018).

4.14 The Profile of Persons Addicted to Whoonga

In line with a need for the criminal justice to redirect whoonga addicts to rehabilitation (Monyakane, 2018), there is a need to identify whoonga addicts. In so doing, Dintwe (2017), was quick to assert that the intention was not to "profile" whoonga addicts for easy identification and arrests, rather, to assist them. This does not mean that whoonga addicts are not a low-hanging fruit to boost arrest statistics by the police (Marks, 2017). While whoonga addiction largely affects Black youth in townships and squatter settlements, with increasing evidence in some rural areas, addiction is not limited to this group, along race or class lines (Coppen, 2014b; Mthembi et al., 2019). Nevertheless, Black youths are most affected. Youths afflicted by whoonga appear undernourished, filthy, and their skin remarkable darker (Grelotti et al., 2014). The individual is described as having poor hygiene, red eyes, and appearing half-dazed, with slow movements and speech (Mokwena & Huma, 2014). In describing the third possible source of the word *phara*, the word could be short for "paramedic", given the speed at which whoonga addicts "hustle", which is swift (Hunter, 2018). Although the majority of whoonga addicts hustle, addicts are usually associated with crime, and there is a sense of repugnance to whoonga addicts. In addiction literature, this is a feeling of not wanting to be around the person addicted to a drug (Griffiths, 2015). Whoonga addicts are generally ostracised by the community (Grelotti et al., 2014). Maybe the most fitting source of the word *phara* is "pariah"; an outcast.

4.15 Effects on Families and the Communities

In individual-based approaches, the focus of treatment is the addict, and this is true around the world (McCann & Lubman, 2018). In a study that focused on how the family coped, particularly mothers whose children were addicted to whoonga, mothers were distressed by the theft and destructive acts, indicating a high level of stress that affected other areas of functioning (Groenewald & Bhana, 2015). Adolescents' substance abuse produced several stressful life events, such as adolescent misconduct, family conflict, and financial burdens that provoked feelings of hopelessness, guilt, self-blame, worry, shame, anger, and signs of depression (Groenewald & Bhana, 2015). Findings in this study corroborated that, when parents do try to deal with the problem, they can often feel unsupported (Choate, 2011; Mathibela & Skhosana, 2019). There are indications that parents may not know that their child is taking drugs. In discovering their children's addiction, some disowned their child, or felt ashamed to be associated with their child's whoonga addiction (Groenewald & Bhana, 2015). In recommending family-based approaches, Carney et al. (2020) suggest supplying required tools to parents and caregivers to respond effectively to their child's substance use.

Orford and colleagues' typology of coping "positions" (Orford et al., 1998b, as cited in Hawkins et al., 1992) classify ways relatives respond to the stresses arising from the drug problem within the family. When parents discover addiction, there are three ways of dealing with it: "engaged", "tolerant", or "withdrawn" (Orford et al., 1998b, as cited in Hawkins et al., 1992). At one end, parents and caregivers who are engaged put up a fight and involve themselves in their children's addiction lives. Others would be tolerant, perhaps allowing the addiction to take its course. Those who withdraw usually distance themselves from their children. The extent to which parents can be stretched by their child's addiction to drugs was publicised as in the extreme case of Pakkies, who strangled her own son (Prince, 2014). Anguish, pain, isolation, among others, are a range of emotions that parents deal with from first discovering, to accepting that their child is addicted to a drug (Mabusela, 1996). In a study of parents' experiences with children addicted to drugs, and who were admitted to a rehabilitation centre in South Africa (Mabusela, 1996), parents' emotional struggle begins when they discover that their child is on drugs. The struggle continues as they seek help, as well as after patients' discharge from institutions. In the first stage, these parents are shocked, frightened, and angry, exhibiting self-protecting mechanisms to deal with this, ranging from denial, to intellectualising about the situation, to dealing with anger (Mabusela, 1996). These studies confirm an emotional struggle that comes with parenting whoonga addicts, and a need for support is recommended (Masombuka, 2013; Mathibela, 2017; Mathibela & Skhosana, 2019). Added to this, children who are addicted to whoonga present a financial burden to parents who need to support them and furthermore, pay rehabilitation fees (Groenewald & Bhana, 2015; Mabusela, 1996).

4.16 How to Intervene: The Multi-sectorial Level but Precise Intervention

Officially, provincial level committees and task forces were set up to collect information on the nature of the drug, advising officials accordingly. What that means is that there has not been an official view promulgated that goes beyond the prescripts of the National Drug Master Plan (Central Drug Authority [CDA], 2013). This five-year plan sets forth a broad strategy for integrating the efforts of various government departments on substance abuse. In whoonga addiction, resources are insufficient, misdirected, and fragmented (Dintwe, 2017). Government and civil societies are unable to prevent and reduce drug-related problems, substance abuse, and illicit trafficking in South Africa (Nel, 2004); and they are considered ineffective and insufficient. The consensus among researchers in paving the way forward is that there should be multi-sectorial but coordinated efforts particular to whoonga addiction. Research studies on whoonga addiction acknowledge that addiction to whoonga will require a comprehensive, multi-faceted, precise, or

tailor-made intervention at both local and national levels (Khumalo, 2016; Mokwena, 2015). These will begin with aggressive educational and awareness campaigns. There is a need to avail OST in communities (Marks et al., 2017), and a number of high-end expert professionals must be made available. Addiction medication, including Methadone, is prescribed by doctors and psychiatrists (Calsyn, 1997).

4.16.1 Multi-sectorial collaboration

In a study in which parents had reported their child to the police for stealing their property, hoping that their offending child would receive some form of rehabilitation and be "weaned" off whoonga, the researcher cautions that mental health problems can ensue from dry detoxification: ridding the body of the drug without appropriate health care (Monyakane, 2018). The suggestion is that persons addicted to whoonga should be diverted to drug rehabilitation, pointing towards a close collaboration between government departments, i.e., Justice and Constitutional Development and Health (Monyakane, 2018). In a community-based project in Pretoria, harm-reduction approaches further found a need for inter-sectorial cooperation envisioned within a multi-disciplinary framework that would include meeting with the SAPS, local municipal authorities, the district hospital, and human-rights lawyers to address safety, security, and well-being (Scheibe et al., 2020).

4.17 Addressing the Context of Whoonga Addiction

There is evidence of drug use in communities at low socio-economic levels, such as Eldorado, Chatsworth, and the Cape Flats in South Africa (Prinsloo & Evans, 2015). When a similar trend was observed in Scotland, a proposal that such a relationship should be filtered into drug-dependence policy was made (Shaw et al., 2007). Several studies have indicated that addiction is prevalent in communities marked by poverty, (youth) unemployment, and lack of skills; youth are often left with nothing recreational or exciting to do (Daily Mail Reporter, 2010; Hendricks, 2015). In that space, peers could also be enablers in the addiction process, making it difficult to stop and to recover (Hendricks, 2015). For Whitesell et al. (2013), deviant peer relationships are among factors that led to drug use among adolescents.

In a study that examined predictors of illegal drug use by South African adolescents, Brook et al (2006) found a greater discrimination and more violence directed towards them than those with lower levels of drug use. In this study, a high level of drug use among adolescents was associated with truancy and emotional distress, unconventionality (e.g., tolerance of deviance), and greater intrapersonal distress (e.g., depressive mood) (Brook et al., 2006). Even though studies

on perceived inequality and those that relate poverty to addiction provide mixed findings, the unemployment rate among youths (15-35 years) has been considered contributing to the escalation of drug use. In South Africa, with a high unemployment rate among Black African youth, a study focusing on the interest variable for unemployment, used as a proxy for poverty, 84% of the participating whoonga addicts were unemployed, including two who were still at school (Mokwena & Morojele, 2014). From this study, addicts found it difficult to gain employment; conditions in their families and communities were adverse, and further education was difficult. Not only was it difficult to access rehabilitation centres, given long waiting lists, 75% of whoonga addicts had not been to a rehabilitation centre because available rehabilitation centres are expensive. Researchers find socio-economic conditions of communities from which whoonga addicts hail playing a role in causing and perpetuating whoonga addiction. Whoonga addiction makes it difficult for addicts to find employment, worsening conditions of poverty (Mokwena & Morojele, 2014). Community development and uplifting programmes were recommended to be instituted with the participation of the community, which would then affect other aspects of the individuals' lives. "Unstructured lifestyle" coupled with easy access to a drug and the influence of peers contribute as conditions favourable to whoonga use (Mokwena & Morojele, 2014).

4.18 Experiments on Recovery from Whoonga

Stories of recovering from whoonga addiction are rare, but they exist. Molobi (2018) and Saving Jesus: How addict Jesus survived the nyaope epidemic (2019) presented stories of Xolani Luvuno (34) and Jesus (age unknown), who had both desisted from whoonga use, assisted by support from Good Samaritans. Xolani is an amputee athlete who was also a whoonga addict. A newspaper ran a report on Xolani soon after he had successfully completed the Comrades Marathon. He was a whoonga addict who begged on Pretoria's streets, when a stranger offered him a job (Molobi, 2018). The runner is an inspiration not only to the able-bodied for completing the 87 km ultra-marathon, but also to fellow whoonga addicts, that whoonga addiction can be overcome. Although the good Samaritan, Hein Venter, refused to take credit for Xolani's recovery and subsequent flourishing, Xolani has all the praise for him for giving him a chance in life, by offering him a job and a place to live. To ward off possible relapse, Xolani joined a running team, inspired by seeing another famous amputee athlete training. This helps keep him busy and not return to whoonga and alcohol. Xolani mentioned that he had to turn away from the drug scene − that included changing friends and lifestyle. He attributes his recovery to employment, good support at work, and that Hein had always been there for him. His message to others was that "nothing is impossible", and he was pushing himself to compete in other national events, feeling

reborn, and ready to take on challenges, making up for the lost time (Molobi, 2018). In local documentaries, particularly Saving Jesus: How addict Jesus survived the nyaope epidemic (2019) and "Overcoming Nyaope addiction", the reporter and a priest took youth addicted to whoonga to a formal and a makeshift rehabilitation centre (Wales-Smith, 2015). In other communities, youth addicted to whoonga was provided enrolment to a rehabilitation institution through a community effort to pay for the fees (Kuaho, 2018). There is evidence of recovery experiments that flourish, and perhaps they are aplenty.

4.19 Conclusion

Literature on whoonga addiction has developed swiftly in the direction of addiction treatment. In its infancy, the main focus has been on classifying the drug, emanating from the obfuscations around the exact contents of the drug, given the multitude of its bulking ingredients. Such should allow us to discern exactly what we are dealing with. Interventions are treatments, benchmarking from a mainstream approach in developed economies. These are treatments whose success is contingent on support from communities afflicted by whoonga. They are concerns motivated by meagre health and mental health care resources, in which communities are an end post and less of a platform for healing. Communities are placed in a position where they support mainstream health care at the end of acute care. Drawing from recovery approaches, communities were presented as a healing medium that wards off alienation or dislocation theorised in this study to be the cause of addictions. In tackling the results and not the cause, these approaches are bandaging an infested wound. Proper treatment should bolster communities, to use its strengths to fight whoonga addiction. The South African community is popular around the world for defeating Apartheid, and that is a resource. Owing to the newness of both whoonga as a unique South African phenomenon, and of recovery frameworks around the world, very little is known about recovery from whoonga. This study of whoonga addiction from a recovery perspective is a focus on what makes recovery possible. From people who have resolved their whoonga addiction, what prompts this is derived from what it meant to them to initiate drug use, to be an addict, as well as overcoming this human problem. The study provides an empathic understanding of addiction to whoonga, while forging ways of assisting people to recover, that revolve around the initiation and the maintenance of long-term sobriety and to encourage citizenship.

CHAPTER FIVE
RESEARCH METHODOLOGY

5.1 Introduction

This chapter describes how this study was conducted. To understand experiences of addiction and recovery from addiction to whoonga; the first section will give an overview of Interpretive Phenomenological Analysis (IPA), a qualitative approach adopted in this study. After identifying this qualitative approach, a discussion of the research paradigm ensues, followed by comparisons with other qualitative research methods. This will indicate the suitability of the use of IPA in this research study. This is followed by a discussion of the theoretical and philosophical underpinnings. The next section will discuss the population from which the sample was drawn. This subsection will describe the sample, introducing each participant. The next section will describe how the research instrument, the interview schedule, was constructed. This will further discuss how the interview schedule guided semi-structured interviews. Transcriptions give rise to text that is an object of analysis; this section will discuss my experiences of making transcriptions. This will be followed by a step-by-step description of the procedures followed during data analysis, drawing from IPA. The section on data analysis will further discuss the process of hermeneutic circling, an understanding and the application of bracketing that informs the use of reflexivity. The researcher also describes how these processes informed interpretations, writing, and rewriting. The chapter will end with ethical considerations obligated by the research ethics committee (REC), first those that concerned individual participants, followed by those that included gatekeepers. Further, the various steps that were taken to ensure the quality of this IPA research study as well as trustworthiness are reflected on.

5.2 Research Approach and Paradigm

Central to IPA is understanding and interpretation, double hermeneutics (Larkin et al, 2006). This includes an understanding of experience on its own terms (Davidsen, 2013). But, in making sense of the phenomenon, the researcher tries to make sense of the participants making sense of their lifeworld. This assumes a humanist research paradigm. On one hand, this is a position that, only those with experience can communicate it to the external world (Todres & Holloway, 2004). For Roberts (2013), meaning is an understanding of experience from those who have experienced it (Larkin et al., 2006). On the other hand, in seeking to understand addiction and recovery from whoonga addiction, the research addresses the plight of addicts, seeking support for long term recovery from whoonga addiction. In getting to walk in participants' shoes, one gets

to understand how their lifeworld is like, and an empathic response is garnered to support care. The study addresses the plight of whoonga addicts (Mokwena, 2016).

As Alase (2017) noted, IPA aims to investigate critically and to interpret the impact of the phenomenon on the "lived experiences" of participants. An ensuing explicit and interpretative narration draws from critical theory paradigm (Guba, 1990). For Leornado and Potter (2010), this is a balance IPA makes between the hermeneutics of empathy, which opens up in front, and the hermeneutics of suspicion, the look behind the dialogue. Though this is an experientially informed lens, it also gives a voice (Larkin et al., 2006). This is explanatory in nature to reveal what is hidden (Willig, 2013 as cited in Goodall, 2014). This means drawing theoretical knowledge from the outside to reveal a phenomenon (Kovács, 2017). For Davidsen (2013), not only does it draw from theories from without but from outside the person. Interpretation further draws from interaction and the context (Davidsen, 2013). For Smith (1987), the researcher draws from historical basis of dominant ideologies and how they shape the lives of study participants (Lopez & Willis, 2004). This allows us to see reality in a new way, beneath the surface and embedded power issues (Lopez & Willis, 2004). For Thompson (1990), this is how ideology shapes and organises the environmental conditions that shape their lives and well-being (Lopez & Willis, 2004). For Thompson (1990), the researcher specifically teases out how dominant belief systems serves to mask, gloss over, or ignore, or trivialise the realities of participants. From this view, IPA is emancipatory, it allows us to see reality anew (Lopez & Willis, 2004).

The study of recovery from addiction to whoonga signals the movement towards understanding addiction to drugs as a human problem. This shift supports a movement to qualitative methods, a concern with how people make sense of these experiences within their environment, to understand addiction to this new drug. A qualitative approach is useful to understanding the meanings that participants accord to their experiences with addiction and recovery from whoonga addiction. Recovery, which is the science of overcoming addiction, draws from qualitative methods, particularly phenomenology, to understand subjective meanings participants ascribe to this transition from addiction (Ashford et al., 2019; Brown & Ashford, 2019; Brown et al., 2011). Schmidt (1981, as cited in Krefting, 1991) described qualitative research as the study of the empirical world from the viewpoint of the person under study. Rhodes and Moore (2001) found qualitative methods to be ideally suited to describing the lived experience of drug use from participants' perspectives. In making sense of participants' worlds, for Schnell et al. (2013, as cited in Wissing et al., 2014), meanings refer to the perceptions or experiences of coherence, direction, significance and belonging in life. As a qualitative study, the concern is with human experiences deduced from meanings people bring to those experiences (Guba & Lincoln,

1994). In opting for the science of recovery, such an approach to addiction is person-centred, though problematising dominant drug addiction approaches, it expands from them. Such ideas resonate with proposals of patient-centred care, approaching patients as equals, and asking for advice on how to prioritise and design services (Kolind & Hesse, 2017).

Among qualitative research methods, phenomenology, and particularly hermeneutic phenomenology that includes IPA, falls within an interpretive paradigm. As a worldview, for Guba and Lincoln (1989, as cited in Kivunja & Kuyini, 2017), the interpretivist paradigm focuses on understanding the subjective world of human experience. Interpretivists consider reality to be constructed (Guba & Lincoln, 1994) intrasubjectively, and intersubjectively, through the meanings and understandings drawn from our social world (Angen, 2000). The idea is that reality is grounded in a pre-reflective encounter with other persons (Messas et al., 2018). Constructivism-interpretivism adheres to a relativist position that assumes multiple, apprehensible, and equally valid realities (Schwand, 1994, as cited in Ponterotto, 2005). This means that first, everyone (researcher and the researched/co-researcher) interprets the world, that being a designate of being human (Dasein) (Heidegger, 2014). This is a position that, although knowledge is processed through own thinking and cognitive processes, it is further constructed through an interaction with others (Kivunja & Kuyini, 2017). Therefore, such constructed knowledge is social, largely a result of personal experiences of the real life within the natural settings investigated (Punch, 2005, as cited in Kivunja & Kuyini, 2017).

In using IPA as a qualitative methodology, phenomena investigated are realised as understood by the actors/participants (Guba & Lincoln, 1989, as cited in Kivunja & Kuyini, 2017). However, these phenomena are constructed and understood in the contexts that prompted and produced them as intentional acts (Ashford et al., 2019). This means that, in making sense of participants' worlds, the use of qualitative studies to understand drug addiction is an understanding of the interrelationships one has with other people and the social environment. Co-opting symbolic interactionism, this is an approach with emphasis on the significance of social processes, social interactions, and socially derived emotions of desistance (Best et al., 2017). Analysis is informed by the process of continuous revision and enrichment of understanding of the experience or form of action under study (Lincoln, 1995). Therefore, the meanings that an individual may ascribe to an event are of central concern. Access to such meanings, however, can only be obtained through an interpretative process (Biggerstaff, 2012).

5.3 Theoretical Foundations of the Method

The emergence of IPA can be dated to a paper that Smith (1996) published in the mid-1990s (Smith, 2011a). The distinctness of IPA as a research methodology within a qualitative framework arises from the various elements it comprises, which are phenomenology, hermeneutics, and ideography (Pietkiewicz & Smith, 2014; Smith & Osborn, 2009). Berglund (2007) finds roots in the common use of the word phenomenology for the distinction made by Immanuel Kant between "that which shows itself" (phenomenon) and "the thing in itself" (noumenon). IPA claims to be phenomenology because it studies phenomena from the perspective of subjects. IPA's concerns hinge on how things appear to participants, and how participants make sense of their personal experiences (Giorgi & Giorgi, 2003, as cited in Smith, 2004). Compared to other qualitative research methods, IPA as a research methodology was developed after discourse analysis had already been established to include the idiographic component that Smith (2011a) thought was lacking. Smith (2011a) wanted to include this component within Psychology, refusing to borrow from somewhere else. In using life stories, IPA is like most narrative approaches; both having the phenomenological and the interpretative (hermeneutic) component (Biggerstaff, 2012). Without the focus on subjective experiences and the particular, an idiographic component, there is no IPA (Smith, 2011b). Unlike grounded theory, IPA does not hope to develop theories. Thematic and content analyses are too limited for the in-depth focus that IPA aims for (Biggerstaff, 2012). IPA seeks to understand the participants' lived experiences from their innermost reflections (Alase, 2017).

5.3.1 Hermeneutic phenomenology

In qualitative research, hermeneutics stresses the way people construct meanings. For Daher et al. (2017), this is in order to understand their world, others, and themselves, based on their already lived, past experiences. IPA draws from hermeneutic phenomenology, a strand of phenomenology espoused by Martin Heidegger (1889-1976), and elaborated on by Hans Georg Gadamer (1900-2002), his student. Heidegger, a student of the founding father of phenomenology, Edmund Husserl (1859-1938), differed from his teacher on epoche or bracketing (Finlay, 2009; Osborne, 1990). To start with, phenomenology is described as the study of consciousness, or, according to Larkin (2015), capturing the strict Husserlian sense driving transcendental phenomenology, the "aboutness" of the consciousness. In opting for the study of the consciousness, Husserl was dissatisfied with the trajectory that psychological research was taking (Brooks, 2015). Husserl believed that the existing methods were inappropriate for the examination of human experience (Brooks, 2015). In denouncing positivist approaches that had dominated the

field since the 1930s, this approach to the study of consciousness began by confronting the Cartesian dualism postulated in Rene Descartes' *"cogito ergo sum"* in the book, *Meditations* (Luft, 2004). This presupposition of a mind-body duality is the foundation of modern science, clearly parodied in his response book, *Cartesian Meditations* (Luft, 2004).

In problematising the mind/body dualism, Husserl found fault with the object (the external viewed world)/subject (the viewer) dichotomy. Husserl presents consciousness as directional, "I am aware that my thought is pointing towards 'some object' " (Eagleton, 2011, p. 48). To describe this, Husserl introduced "intentionality" or "directedness-at-object" as a central concept in phenomenology to denote this constant interpretation of the world; expanding on the work of his teacher, Brentano (Larkin, 2015; Larkin et al., 2006). "Consciousness is consciousness *of* something" (Larkin, 2015, p. 7, original emphasis), which means that it is always directed at something. The object of intentionality may be an object, events, and ideas or concepts (Finlay, 2009). For example, recovering from whoonga addiction.

As an anti-positivist stance, phenomenology finds access to meaning to lie not in measures and numbers but in our capacity to understand and find meaning in other people's stories and experiences (von Eckartsberg, 1986, as cited in Berglund, 2007). For Berglund (2007), the search for "the things themselves" is the search for their presentation as meaningful to individuals in everyday experiences. In acknowledging the inability to divorce oneself from the world, Heidegger is seen as being "phenomenological". Heidegger finds meanings to already exist (been given) in being-in-the-world, we have always already lived-in-the-world as humans. For Dreyfuss (1984, as cited in Berglund, 2007), the world has already always had meaning for us. In proposing "descriptions" devoid of the natural attitude about phenomena, Husserl is seen as being "Cartesian" or "positivistic" (Laverty, 2003). In a descriptive or transcendental phenomenology, Husserl sought transcendental knowledge, where to reach essences of the consciousness means to find a method that suspends conditional features of consciousness (Berglund, 2007). To guide discussions, Table 5.1 below present differences between Edmund Husserl and Martin Heidegger.

Table 5.1

Summary of differences between Husserlian and Heideggerian phenomenology

	Edmund Husserl	Martin Heidegger
Metaphysical focus	Epistemological	Ontological
Description of the individual	Person living in the world of objects	Person exists by being in and of the world
Knowledge	Ahistorical	Historical
Enabling the social	Essences are shared	Culture, practices, and history are shared
Method of gaining knowledge	Bracketing affords access to true knowledge	Cultural interpretation grounds any knowing

Note. Differences between Husserlian and Heideggerian phenomenology. From Researching entrepreneurship as lived experience (p. 80), by H. Berglund, 2007, in *Handbook of qualitative research methods in entrepreneurship* (pp. 75-93), by H. Neergaard & J. P. Ulhøi (Eds.), Edward Elgar Publishing.

At least Husserl, a mathematician, still has a world to view separate from the viewer; a world that can be bracketed (Giorgi, 2007; Laverty, 2003). Husserl (1982, as cited in Berglund, 2007) found phenomenologists to be genuine positivists if "positivism" equated its absolutely unprejudiced grounding of all sciences on the "positive"; phenomenology found its knowledge from the originaliter (*in* person, the source of direct experience). For Fleming et al. (2003), Heidegger believed that Husserl's preconceived idea of science led to him missing the original subject matter being investigated. Hence, Heidegger proposes that the lived experience was, in essence, an interpretative process because "dasein" (being human) designates the business of interpreting (Shinebourne, 2011; Tufford & Newman, 2010). Therefore, bracketing preconceptions was not possible (Cohen & Ormond, 1994, as cited in Tufford & Newman, 2010; LeVasseur, 2003, as cited in Tufford & Newman, 2010), even if it is desirable (Larkin et al., 2006). In describing our very nature as dasein, translated to mean "there being" or "being there", Heidegger describes to be "there" as "always somewhere, always located and always amidst and involved with some kind of meaningful context" (Larkin et al., 2006, p. 106). Heidegger's idea that abstracting oneself from the world was impossible and that individuals' realities are invariably influenced by the world in which they live, is captured in concepts he introduced, such as *being-*

in-the-world as well as *lifeworld*, respectively (Lopez & Willis, 2004). This means that persons are inextricably involved in the world, and in relationships with others (Larkin & Thompson, 2012). It must be added that, for Merleau-Ponty, Heidegger's French contemporary, human beings are as persons, embodied (Larkin & Thompson, 2012). For Varela et al., (1991, as cited in Zautra, 2015), experiences of addiction depend upon having a body with distinct sensory stimulatory and motor action. Such depends on an individual's active bodily engagement with the environment, again embedded in the encompassing biological, psychological, and cultural context.

In this study, the concept of bracketing takes in everyday ideas of how one filters what one ultimately considers truth. According to Larkin et al., (2011), the misrepresentation of phenomenological reduction, in which the researcher's preconceptions are suspended (Fleming et al., 2003), is found when it is presented as a form of "closure" or "objectification". What this means is that such a framing usually means that subjectivity is "laundered" out (Larkin et al., 2011). In qualitative psychology, bracketing is found consonant with the tradition which questions the status of "facts" as objective constants in the social sciences (Larkin et al., 2011). These authors find bracketing more about open-mindedness than it is about doubt. The same authors refer to Finlay (2002), who sees bracketing as a means of exposing and engaging with one's presuppositions (Larkin et al., 2011). IPA is guided by double hermeneutics (Peat, et al., 2019). The process is reflective, interrogating what is presented. The researcher seeks to make sense of the participants making sense of their worlds (Finlay, 2002; Peat et al., 2019; Smith & Osborn, 2007). The concept of reflexivity means "being aware" and bringing to light how the researcher influences the research process (Peat et al., 2019). For Finlay (2009), researchers' subjectivity should, therefore, be placed in the foreground so as to begin the process of separating out what belongs to the researcher rather than the researched.

For hermeneutic phenomenology, the interpretation of the narratives provided by participants in relation to various contexts is foundational (Lopez & Willis, 2004). Experiences are seen to be shaped and organised by historical, social, and political forces (Smith 1987, cited in Lopez & Willis, 2004) from which the persons-in-context cannot abstract themselves (Larkin et al., 2006). In phenomenology, the lifeworld is described as the world lived by a person; this is the world each of us live by, the original, obvious, and unquestioned foundation of everyday acting and thinking (Messas et al., 2018); therefore a successful analysis is grounded in the context (Larkin, 2015). From this angle, for Larkin and Thompson (2012, original emphases), phenomenological enquiry is a *situated* enterprise because of the emphasis on the *worldly* and *embodied* nature of our existence. This focus on "situatedness" is proving the most distinguishing feature of IPA. For Gadamer (1990, cited in Fleming et al., 2003), the notion of historical

awareness is emphasised and valued as a positive condition for knowledge and understanding. Going forward, IPA will move more towards the context of experience rather than the diversity of its strands in future expansion and application as a methodology (Todorova, 2011).

For Finlay (2009), the general consensus among phenomenological researchers is a central concern to return to embodied, experiential meanings. In this study, an empathic strand of phenomenology (Willis, 2004), IPA, was used (Smith et al., 1999). The researcher interpreted the meanings that participants attributed to such an important transition in people's lives, focusing on the particular, the ideographic component, trying to make sense of both the physical and the emotional effects of addiction and recovery from whoonga. This brand of hermeneutic phenomenology is considered "new" phenomenology, considering its focus on the idiographic; and an empathic understanding that eidetic structures of experiences of "classical" phenomenology do not have the same focus (Willis, 2004). Fundamental to IPA is an aim to provide an in-depth and nuanced analysis of participants' accounts of their lived experience, to capture personal lived experience on its own terms, as opposed to those prescribed by existing scientific or personal presumptions (Finlay, 2009). This is considered a "return to things" themselves.

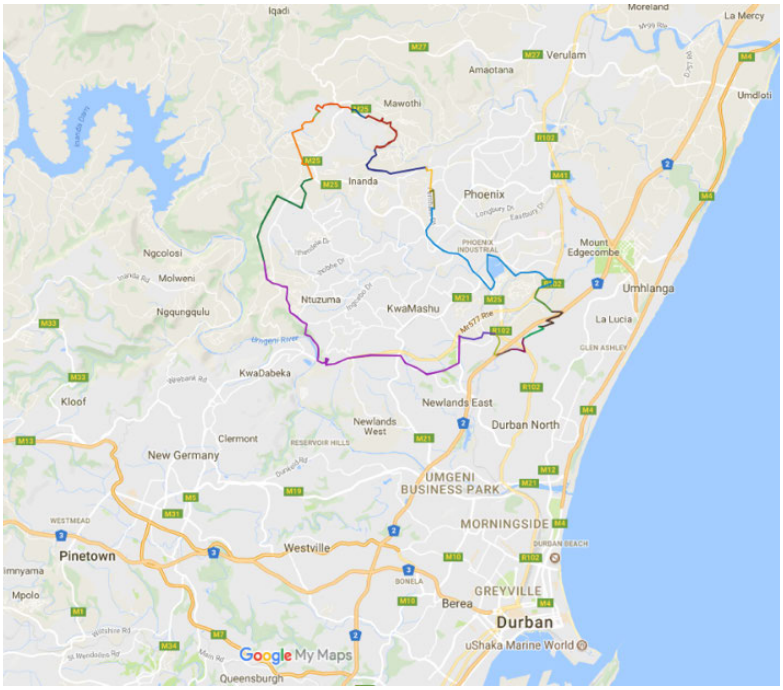
5.4 Study Population

In this section, the researcher describes Inanda, Ntuzuma and KwaMashu (INK) townships, the setting from which the sample was drawn. Townships are largely "Black" residential areas created by the segregationist policies of the former South African government (Japha & Hüchzermeyer, 1995, as cited in Swartz, 2007). Townships are settlements created in peri-urban areas for migrant workers (Manson, 1981). They are found on the outskirts of virtually every town (Olivier, 2015). They are also known as "locations", where *elokshini* in isiZulu derives. The Afrikaans word for location, *lokasie* was shortened to *ikasi*, in a language associated with the urban Black, usually known as *Tsotsitaal* (Bembe & Beukes, 2007; Hurst, 2009). INK townships span some 20 to 25 km to the north-west of the city centre of Durban (Department of Provincial and Local Government, n.d.). They cover a land area of 66.10 km^2, with a population that was estimated to be 459,656 individuals in 2011. The average density in 2011 was some 7.5 individuals per km^2 (Frith, 2011). To estimate population growth from available data, Ntuzuma township showed 114,231 individuals in 2001 and 125,394 individuals in the 2011 census (Department of Provincial and Local Government, n.d.). Since it covers an area of 17.82 km^2, its density moved from 6.4 persons/km^2 to 7.0 persons/km^2. Ntuzuma is the smallest township, developed for the middle-class Black African families, in the historical establishment and development of these townships; it is also the youngest (1970s) (Department of Provincial and Local Government, n.d.).

Although these townships developed differently and at different times, they largely served as dormitories for an expanding labour need by the growing city of Durban and surrounding municipalities (South African Cities Network, n.d.). For "working class" people living here, they spent most of their time in the working-life cycle: in the mornings they go to their respective workplaces and return in the evenings to sleep for the night (Mngadi, 2013; Mthembu, 2017). The map in Figure 4 below shows the location of these townships in relation to the Durban city centre and other adjacent townships.

Figure 4

Geographical map of Inanda, Ntuzuma, and KwaMashu (INK) townships in relation to the Durban CBD



Note. Geographical map of Inanda, Ntuzuma, and KwaMashu (INK) townships. From Google Maps (http://www.treasury.gov.za/divisions/bo/ndp/TTRI/TTRI%20Oct%202007/Day%201%20-%2029%20Oct%202007/1a%20Keynote%20Address%20Li%20Pernegger%20Paper.pdf).

The adjacent area of Inanda township (26,811 km^2) does not cover the rest of Inanda. It was clustered by eThekwini Municipality as part of INK. It is about 5 km^2 larger than KwaMashu. Inanda is an anglicised version of "Nanda", meaning to "spread widely", the name being limited (for colonial administrative reasons) to the mission station (Mngadi, 2013; Raper et al., 1989). Inanda is associated with Mahatma Gandhi, cane farming, and also the clashes in the late 1940s and mid-1980s within these communities. These are the historical, racially and politically

motivated or land-ownership driven squabbles, described as caused by the "buffer" or the "middle man" status of the Indian community in an Apartheid concentric architecture (Desai, 2014; Gwala, 1985; Manson, 1981). The emergence of Phoenix, which at one point was amalgamated with the other townships to form "PINK", complements these tensions (Department of Provincial and Local Government, n.d.). Other than divisive politics, Inanda is famous for Mafukuzela Dube, …who opened a number of schools, including a newspaper, Ilanga. Inanda is famous for the Ekuphakameni, the spiritual home of the AmaNazaretha religion, as well as for the Gandhi settlements (Frith, 2011).

The third letter of the acronym INK stands for KwaMashu, a location that was founded in 1958 and completed in 1969 (Raper et al., 1989; South African Cities Network, n.d.). It developed at the same time as Umlazi, to the south of Durban, and was named after Sir Marshall Campbell (1844-1917) (Raper et al., 1989). The name is an adulteration. It is translated to mean "the Place of Marshall", who was a former member of the legislative assembly of Natal (Raper et al., 1989). KwaMashu was built to accommodate forced removals, mainly from Cato Manor (*eMkhumbane*) (Department of Provincial and Local Government, n.d.; Manson, 1981; Mthembu, 2017).

While the dominant language spoken by 85% of the people in these townships is isiZulu, there are a number of people who speak isiXhosa, and quite a few isiNdebele and Tsonga speakers (Frith, 2011). Unlike provinces in the Highveld and the inner country where Afrikaans was spoken widely, English featured in coastal provinces that were under the British colonial rule. Called Natalia by the Portuguese, and Natal by the British when they took over, the province was amalgamated with KwaZulu, a former homeland, becoming KwaZulu-Natal. As a township, the language largely spoken by Black youth includes various versions of *Tsotsitaal* linking to an identity of an urban Black (Brookes, 2014; Hurst, 2009). The use of slang in townships has a role of secrecy (Partridge, 1935, as cited in Bembe & Beukes, 2007). Ntshangase (1993, as cited in Bembe & Beukes, 2007) described this lingo as a type of a basilect, a language used through another language, drawing mainly from Afrikaans. *Tsotsitaal* includes all the South African languages. *Tsotsi* language originated during the formation of gangs in the 1960s. While Bembe and Beukes (2007) find both *isicamtho* and *tsotsitaal* to emanate from a criminal subculture, *isicamtho* further involves wit, the aesthetic use of the culture. As a form of resistance, according to van Onselen (1977), gangs were formed in defiance of the indictment to coerced labour, largely in Johannesburg mines. For Glaser (2007), gangs were a powerful alternative to schooling, and they attracted unemployed and non-school-going male adolescents.

It was, however, a criminal element that preyed on both the White masters and township people to make a living (van Onselen, 1977). In later years the development of *tsotsis*, from

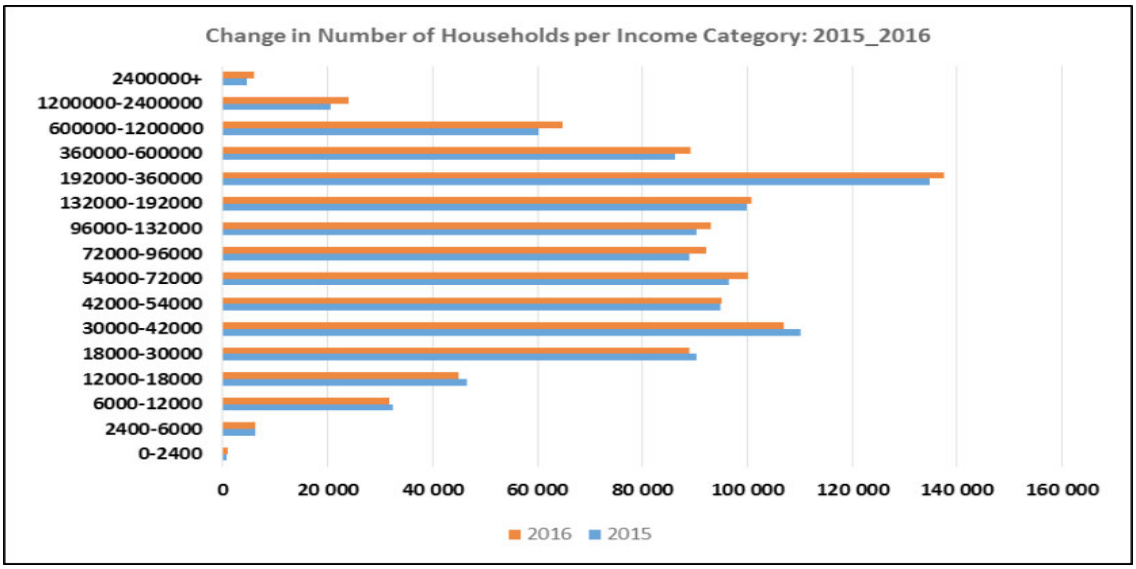
"saucy" − denoting being "smart" and "clever", with terms like *okleva*/"clevers", *olova* (loafer) or *oguluva* (groovy) denoting the refusal of the indictment to Apartheid-created norms − implied a sense of being streetwise by not participating (Hurst, 2009; van Onselen, 1977). In not participating in the political culture that ensued, particularly after 1976, the criminals landed descriptions of *com-tsotsi*, an idea that reprimanded criminality within a politicised youth structure (Hurst, 2009). This subculture included a description of a township Black youth who was neither going to school nor employed, and of a delinquent predisposition. To some extent, *uskhotheni*, the latter version, enjoyed the original meaning, but it added derogatory connotations.

The INK population is described as young, with over 65% below 29 years of age. Some 57% of the households have an average of three to seven family members; the family is male-headed (Department of Provincial and Local Government, n.d.). Until 2002, some sections did not have running or piped water and electricity (Cullinan, 2002). Some 26% did not have electricity, 30% were without piped water, and 2% were without waste-removal services (Department of Provincial and Local Government, n.d.).

Unemployment and poverty are rife. About 40% of the population is reported to be unemployed; and a third, economically inactive. This estimation is above the national level. In the first quarter of 2019, the national unemployment in South Africa was at 29% (Statistics South Africa, 2019). Some 56% of those unemployed are youths (Statistics South Africa, 2019). Education levels show about 34% who have never attended school and about 64% who have only attended preschool and school. Only about 22% have a Grade 12 level education. There is a low university exemption pass rate (Department of Provincial and Local Government, n.d.). Only 4% have tertiary education, and this includes mainly teachers, nurses, and government workers. The percentage of people living below the breadline had been reduced by 1.1% between 2010 and 2014. To understand socio-economic attributes of this population, below is the figure of the number of households per income category in INK townships.

Figure 5.2

Number of households per income category in INK townships



Note. Number of households per income category in INK townships. Sourced from Global Insight by eThekwini Municipality (2017). Integrated Development Plan: 5 Year Plan: 2017/18 to 2021/22. (p. 73). http://www.durban.gov.za/City_Government/City_Vision/IDP/Documents/Draft%202017%202018%20IDP.pdf

However, eThekwini has the highest number of indigents compared with the other four major cities in the country. Of eThekwini's approximately 742,372 people living below the poverty line in 2015, 98, 7% are African, while 0, 53% are Asian, 0, 75% are Coloured and 0.01% White. This means that 25.2% of the African, 6.1% of the Coloured, 0, 7% of the Asian and 0.04% of the White population are living below the breadline (Department of Provincial and Local Government, n.d.).

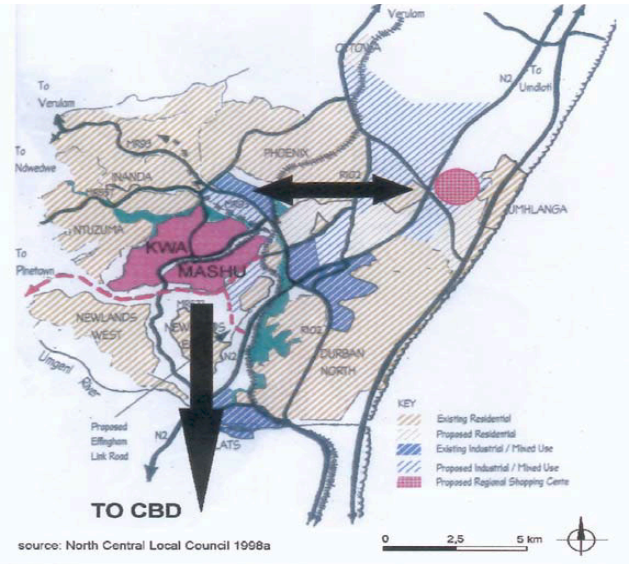
Individuals living in these communities have to travel beyond INK borders for their places of work, resulting in high transport costs (Department of Provincial and Local Government, n.d.). Approximately 47% of the residents, travel by public transport, this being rail (15%), bus (17%) and taxi (68%). There are spatial inefficiencies of the public transport network, with the majority of the Black population, on average, living far from a major highway (Schensul & Heller, 2011). With transport costs ranging between 17% − 35% of total monthly income, it is no surprise that, after all expenses, many of the households are going into debt, or are reliant on supplementary income from families to support themselves (Schensul & Heller, 2011). There are no active economic activities in these dwellings. Some 85% of the employed commute to Gateway, the city, and White residential areas where they are generally employed as patrons, domestic workers, and

construction workers (Department of Provincial and Local Government, n.d.). The formal economy remains extremely limited (Department of Provincial and Local Government, n.d.). In South Africa, half of Black Africans live in townships. The idea behind the establishment of dwellings for labourers was the supply of dormitories, including male-only hostels where "hands" would be available for work, but could still be invisible (Bond, 1996; Pernegger & Godehart, 2007).

Townships were placed by Apartheid to avail labour during the day, and for labourers to disappear into at night, shaped along racial and class-stratified lines (Schensul & Heller, 2011). Umlazi to the south, and Inanda, KwaMashu, Ntuzuma and KwaDabeka to the north, form the core of the urban African legacy neighbourhoods (Schensul & Heller, 2011). To understand the location of INK townships in relation to the CBD and adjacent areas of employment, below is the figure illustrated by Pernegger and Godehart (2007) before regional shopping centres existed (Gateway and Cornubia).

Figure 6

KwaMashu and INK location in relation to the CBD and areas of employment



Note. KwaMashu and INK location in relation to the CBD and areas of employment where regional shopping centres are now existing (Gateway and Cornubia). From *Townships in the South African geographic landscape: Physical and social legacies and challenges* (p. 8), by L. Pernegger and S. Godehart, Training for Township Renewal Initiative (TTRI) (http://www.treasury.gov.za/divisions/bo/ndp/TTRI/TTRI%20Oct%202007/Day%201%20-%2029%20Oct%202007/1a%20Keynote%20Address%20Li%20Pernegger%20Paper.pdf).

Even after Apartheid, restrictive macroeconomic conditions and neoliberal microeconomic policies kept the poor conditions consistent in townships (Bond, 1996). Unemployment rose from 22% to 43 % two years after democracy. Those confined to peripheral areas moved into areas with better services and better linkages (Schensul & Heller, 2011). Living conditions remain uncomfortable in most Black townships, where people crowd into shacks on the outskirts of the industrial, commercial, and economic centres of the country (Delport & Lephakga, 2016).

5.4.1 Sampling

Phenomenology uses a non-probability sampling, and for this research study purposive sampling was applied. According to Kruger (1988, as cited in Edwards et al., 2013), in order to understand a phenomenon, participants selected would "have had experiences relating to the phenomenon to be researched" (p. 9). This was a recruitment of a relatively homogeneous sample of participants based on the research topic (Hefferon & Rodriguez, 2011). This study recruited participants who, by their own admission, and confirmed by family members, were at one point addicted to whoonga, and had desisted. Perhaps one of the apprehensions about this research study, particularly at the research proposal phase, was whether it was going to be possible to find appropriate volunteers. The use of snowballing is apposite for finding such a sample. Recovering from addiction without institutional or medical recourse implies hidden populations. Although for those who employed opioid antagonists would come into contact with professionals, for example, the doctor and the pharmacist, addiction could be recorded, yet recovery cannot be assessed. Recovery means that victims would have minimal contact with institutions that would assess this progression to recovery. Research studies on addiction and recovery from drugs recruited participants who were associated with institutions. This excluded individuals who had recovered without recourse to medication, whether per professional or institutional assistance. There was a wish to include different pathways to recovery from whoonga.

Even though IPA uses a relatively small sample, the recruitment of participants, considering the expected difficulty in finding them, meant that recruitment processes had to be diversified. To achieve this, three strategies were used. The first strategy included recruiting an individual who had desisted from whoonga use. This individual would direct the researcher to another one, using the snowball effect to increase the sample. The first participant heard about this research study and spoke to the researcher about participating. He prided himself on having abstained independently and without recourse to medication. He also mentioned that a friend had also desisted from whoonga use. He had reservations about this friend. Since he had desisted from whoonga use through being arrested, he might not qualify as a suitable volunteer. His ideas were

that recovery made sense if it was directed internally. This participant did not want to vouch for his friend. He was uncertain whether the said friend had really desisted, despite the friend's presentation and behaviour that showed that he had desisted.

The second strategy was to recruit participants using referrals from the social service officials. The presupposition was that these officials are affiliated to the Department of Social Development (DSD), the main custodians of substance-abuse issues in South Africa. These officials, together with the police, would, in their daily encounter with the community executing their duties, particularly their involvement in substance abuse programmes, know individuals who had abstained from whoonga use.

The third strategy involved the placement of advertisements in both clinical and non-clinical settings. Clinical settings meant government clinics (health centres) within INK townships administered by the Department of Health. Police stations and shopping malls within these townships were thought to suffice as non-clinical settings that would expose the advertisement for recruitment to a wide variety of people. Although the idea of placing advertisements in the shopping malls promised possibility of engaging individuals who had recovered naturally, such an idea was rejected. Communication with two managers of two formal shopping malls (Bridge City and KwaMashu) indicated that the process of placing such an advertisement was costly. The acquisition of authority to do so was lengthy even for formal agencies within the marketing and advertising industry. For example, to place an advertisement, a bland A4 size paper was to be upgraded to an A1 gloss paper and in colour for an advert to be suitable for a commercial level accommodated by the malls.

Of course, there were false starts. In acquiring permission to be granted to conduct the research in these townships, senior police officials were to give consent. As already indicated, police could be referrals of participants to the study. As will be discussed under the ethics section below, this permission was also needed for the personal safety of the researcher upon data collection. The fear of reaction from drug dealers to someone acquiring information about issues involving their trade violated the Singapore agreement on the personal safety of the researcher. This concern had further pushed the project back, demanding the rethinking of the approach. Such led to the abandonment of initial efforts to approach this study using community models, particularly social action. But, as mentioned above, it was thought to be a given that the police and social service officials would come into contact with whoonga addicts and would assist with recruitment. A senior police officer approached for a consent had had contact with four youths who had requested to be arrested for fear that their return to the township was going to lead to them ingesting whoonga, from which they wanted to desist. These youths were referred to the

rehabilitation centre. Three of the four had successfully managed their relapse at that time. When ethical clearance was granted, in that six-month period, two had left the province; one had returned to the rural areas in the Eastern Cape, and the other had moved to Gauteng for employment. The third youth had tragically become a missing-persons case. His mother confirmed the report by the police who had given me her contact details, that he went to the shops one Saturday afternoon, and never returned home.

As already stated, the first two participants were recruited through the encounter with the first one. Several days later, the third participant responded to an advert that had been placed at the police station. After that, the participants dried out. In the placing of advertisements in clinics or health centres that had been delayed owing to commitments of the social service officers, I was on site. The woman who saw me place an advert approached me after reading it. She directed me to her friend, whose sister's grandson had stopped taking whoonga. The fourth participant was recruited through his grandmother's sister, directed to me by this lady, the participant's grandmother. The last two participants came via word of mouth. In informal conversations around these townships, I was directed to the fourth and fifth participants. A young man who told me that he knew someone who had quitted whoonga use, directed me to his house. The last participant was pointed out to me by a vendor who knew him. Recruitment was therefore largely achieved by me being on site and making some enquiries. Snowballing led to the recruitment of two participants. Advertisements on their own yielded one response. The word of mouth and being available in the community, actively seeking participants led to interviews with the last three participants.

5.4.1.1 Sample

This study recruited participants from INK townships who had desisted from ingesting whoonga. To recruit this main sample, snowballing and advertisements were used. The initial participant referred the researcher to a friend. One main participant responded to the advertisement placed at the police station. Other participants were referred by word of mouth, people who saw the advertisement, and by community members. Table 5.2 below summarises descriptions for each participant.

5.4.1.1.1 Participants

Participants were allocated pseudonyms that the researcher chose for them, drawing from South African boys' names in Nguni- and Sotho-speaking languages. Although participants were all born and brought up in KwaZulu/Natal, and were Zulu speakers, original names and surnames

indicated their origins. While all pseudonyms are positive in nature, some were chosen because they best suited the participant's demeanour. For example, Mandla is of Xhosa origin, and is applicable to both isiZulu and isiXhosa as a boy's name. The participant appeared athletic, presenting with a violent streak in his operations, and therefore this name seemed appropriate. The name chosen had to be short. The discussion of participants will outline participants' ages, living and family circumstances, education, duration of addiction, resumption of desistance, and methods or pathways used to recover.

Table 5.2

Sample Descriptives

	Age	Education	Employment	Recovery Pathway	Recovery Period	Length of Addiction
Sipho	26	Post-matric	Professional	Natural	Stable: 6 years	6.3 years*
Mandla	26	Matric +2	Semi-professional	Institution − arrest	Stable: 5.5 years	7.5 years**
Tshepo	33	Grade 6	Unemployed	Institution − rehabilitation	3.3 years	9.7 years**
Mondli	20	Grade 8	Unemployed	Natural/ aversive medication	6 months	8.3 years
Lunga	27	Grade 11	Semi-professional	Medication-assisted	2.8 years	11.3 years
Sizwe	29	Grade 9	Unemployed	Medication-assisted	6 months	11.5 years*

*excludes previous desistance; **excludes arrests

5.4.1.1.1.1 First Participant – Sipho

Sipho (26) heard about the research study in a conversation we had with him during the research proposal phase. I met him when I was enquiring about the ward divisions and the councillors, particularly the location of the offices of the local authority. I was anticipating local authority to be potential gatekeepers if the research study was to be conducted within INK townships. Sipho was at that time an engineering student at a local institution of higher learning.

What also came as a surprise was that he reported to have been addicted to whoonga for eight years. He volunteered as a participant in this study.

At the time of the interview, he lived at home, in a backroom he had shared with his late elder brother. Sipho was the third-born child. He also had a sister, who is employed. His parents were not employed at the time of the interview. They are now pensioners. Sipho offered that his first encounter with whoonga was as a seller for a dealer, a returning convict he befriended, admired, and spent time with. Sipho experimented with whoonga together with a group of friends. This dealer, who also smoked whoonga, remunerated them with whoonga. Sipho and friends sold whoonga for him. The dealer would go to the Durban CBD to buy more whoonga stock, packaged as straws at that time. The friends had already been smoking cannabis, and after some time, rather than selling their whoonga, they decided to experiment with it.

Sipho found that the whoonga high was more pleasurable than the cannabis high. He is the only participant who did not smoke Mandrax. However, later, he realised that it was difficult to live without the drug. Within a short time, he became addicted to whoonga. Whoonga required that Sipho have the morning "fix" to begin to function, as well as the afternoon fix that he could not sleep without. Sipho had to find the means of maintaining this growing habit. Sipho started by lying to neighbours, asking of them money that he said was for bread, and that his parents were going to pay upon their return from work. That changed when it was discovered that he smoked whoonga. Sipho began stealing from home as well as from the community, including adjacent neighbourhoods. The family and the community were vigilant whenever he was around. One day, when they were caught stealing, Sipho and his friends were severely beaten by the community members. After that, community members would speak to him sternly about his whoonga addiction. He was reminded that his family was a decent family, and that his whoonga addiction was a disgrace to them. Sipho resorted to selling scrap metal. He would scavenge for junk metals, and occasionally steal whatever he could lay his hands on. At this time, he would come and go whenever he wanted to, spending weeks away from home. He would spend most of his time hustling for a whoonga fix. Abandoning taking care of himself, he was mostly dirty. He had sold all his personal belongings, his clothes, shoes, devices like his cellphone and an iPod music player. At this time, the family wanted nothing to do with him.

Sipho spent most of his time in his room as he was forbidden from entering the main house. His return home was influenced by feeling lonely after the time he had been away. His recovery constituting natural recovery was characterised by dry detoxification. This is recovery without recourse to medication, professional, or institutional assistance. Events leading to desistance began by staying put at home. Desistance was instigated by a friend who visited Sipho. This friend had

acquired a huge block of a purer form of whoonga, that was not packaged in straws. To Sipho, this suggested that this version of whoonga had not been adulterated by bulking agents that local dealers would use. His friend acquired it directly from the CBD, from a Nigerian whom he said he knew as a dealer at the Point. After a three-day binge, the whoonga was depleted, and the friend left. Sipho ventured out to hustle on his own. People who saw him were intimidated by his pale, thin, and apparition-like appearance. Sipho returned to his room stressed, the possibility of overdose lingering at the back of his mind. In a case of instantaneous recovery, he ruminated over his predicament and made a decision not to take any more whoonga: Sipho suffered the full blow of withdrawal symptoms. Sipho described them as excruciating stomach cramps, coupled with a lack of bowel movement, followed by diarrhoea, that subsided after eight days. Sipho requested milk from his mother to mitigate this condition. He informed his mother that he was quitting whoonga use. To distract himself from pain and to induce sleep, Sipho smoked cannabis heavily, till his eyes burnt. Withdrawal from whoonga caused muscle and joint aches, restlessness, and the inability to find a comfortable sleeping position. At the height of the withdrawal, he further ventured outside with the intention of hustling for a fix. He was feeling weak, and he did not think he was going to manage. Therefore, he returned to his room and slept. Withdrawals subsided three weeks later, and he remained home. In venturing out to meet people again, Sipho joined his former friends who had not advanced to smoking whoonga. These friends hung around similar spots in which he used to hang around with them before whoonga. They did not trust his recovery, daring him incrementally; giving him dates by which they believed he was not going to last without whoonga use.

Sipho's education had been interrupted by whoonga; he was unable to finish matric. When it was confirmed that he had stopped using whoonga, his family invited him on outings, bought him new clothes, and he was enrolled at a Further Education and Training (FET) college. At the time of the interview, he was an apprentice with one of the electricity companies serving the local municipality. He is a father of a three-year old girl. After six years of desistance, he had achieved a stable level of sobriety. He laughed off the idea of relapse, claiming that it was unthinkable. This could have meant that his current self was far detached from the whoonga world. Perhaps after so much work and time had elapsed, the thought of smoking whoonga again had become distant. Sipho's recovery can be described as natural, in that Sipho did not attend any institution. He also did not use any medication to manage his withdrawal symptoms. Particular to his experience with whoonga addiction is the case of influence by an elder who availed whoonga to Sipho and his friends. During the initial experimenting with whoonga as a group of friends, they were already smoking cannabis. Before a decision to desist, argued to be prompted by the possibility of dying

lingering in his mind, Sipho seemed to float around at the mercy of friends, as an addict. Their choice of important others, particularly those who were addicts themselves, led to initiating whoonga use. Sipho embraced a subculture that went against who he is, as the community members seem to attest in reprimanding him. He was unwittingly drawn into drug use by buying into a certain masculine identity. Sipho represented stable recovery from whoonga, that after recovery reached functioning that was the closest to achieving citizenship.

5.4.1.1.1.2 Second Participant – Mandla

Mandla (25) was recruited to participate in this study by his friend, Sipho, the first participant. At about 14, Mandla moved to Phoenix, a neighbouring Indian township for a better education, when in Grade 9. Mandla travelled to school per minibus taxi; and he had to carry extra cash for his lunch. Unlike most people who report taking whoonga influenced by friends, Mandla reported to have himself sought whoonga, after hearing about it. Mandla heard that whoonga gave a good high compared with the cannabis he was already smoking. After taking whoonga, Mandla confirmed the high; and soon thereafter was addicted. Mandla stole from his classmates' cellphones, calculators, and other valuables; he was involved in fights, and he became generally troublesome. His grades subsequently dropped, causing his favourite teacher to approach him about his whoonga addiction. His behaviour had extended to missing school − he would simply not show up. However, Mandla succeeded in completing matric, despite a three-month arrest. But also because Mandla's addiction was funded, he was able to function. Mandla would opt to buy whoonga with his money for transport and lunch.

Mandla described his family situation as difficult. By this he meant both that the family members were quarrelsome and he suffered dire material conditions. Mandla is the last-born child of a family of seven siblings. Financially, this female-headed household was struggling: it was difficult for his mother to afford him education, and therefore Mandla considered himself fortunate. However, he claimed to have received maltreatment from his elder male siblings. Mandla was generally rowdy; and he describes this as anger outbursts. Mandla reports having struggled with this anger since childhood. He was angry with his father and did not want to relate to or create a relationship with him. He claims that the father was not there to protect him. According to Mandla, his father did not care to visit Mandla when he was arrested. His stepfather was, however, kind to him, living with his family in the same neighbourhood and caring for his children. Although Mandla stayed with his family, he remained in the old house they were moved from to occupy government houses. Mandla characterised his family as still feuding for various reasons.

When Mandla had completed matric and transport funds had subsided, Mandla took to stealing, house-breaking and entry, among other crimes. Particular to Mandla is that he presented with interpersonal violent behaviour. Mandla was subsequently arrested twice. He swore that he was innocent of his first arrest; he was framed for a crime he did not commit, because he was a known whoonga addict in the community. Mandla was exonerated of that crime, and he returned for revenge. In both arrests, while in prison, Mandla stopped taking whoonga. This is considered a coerced form of desisting or abstinence. When Mandla returned for the first time, he joined his friends again and resumed smoking whoonga, three months after desistance. Upon his second arrest, however, he was found guilty of the crime and sentenced to three years' imprisonment. Upon arrest, he was coerced to desist from taking whoonga. However, his sentence led to him witnessing his mother in tears over him.

Mandla desisted from taking whoonga because he was arrested. Although it was not his first arrest, the sentencing for the last arrest prompted him to renounce whoonga. In the strictest sense, his recovery was induced by an institution, even though dominant elements propose a natural recovery route. This route was inspired by a drastic change in his circumstances, that included acquiring a criminal record. Mandla did not take Methadone. Prison is not a drug rehabilitation institution. There are views that prisons are not suitable for drug rehabilitation. Mandla suffered full-blown dry detoxification. It was not for the first time, as this had happened during his two previous arrests. He would be arrested and cease ingesting whoonga because it was not available to him. He would resume whoonga use soon after discharge. Two participants in this study who had been arrested desisted from taking whoonga that way. Both returned to whoonga use upon discharge. However, this time, Mandla made a decision to stop taking whoonga. This resolution to change did not require him to face immediate withdrawal symptoms, he was partially remitted from whoonga use owing to being imprisoned. Since this decision, three months after the awaiting-trial imprisonment, he had been sober for five years. He is now employed in a semi-professional job. This suggests that Mandla is at a stable stage of recovery. He found whoonga to have wasted his time. Mandla mourned that his addiction did not allow him to improve his home situation that he described as difficult.

5.4.1.1.1.3 Third Participant – Tshepo

The third participant was Tshepo (33), a father of three children. Tshepo was recruited to the study by responding to an advertisement he saw at the local police station. Tshepo had been there to certify documents that he was using to seek employment. Tshepo had long since left school when he experimented with whoonga. He presented with both academic struggles as well as

truanting behaviour. He had taken to cannabis and graduated to mixing it with *indanda* or *iphilisi* (Mandrax pill), as his drug of choice. He did not like whoonga, experimenting with it at first. He said he was asked to pay by a group of friends he had asked for a smoke, something freely shared. This special joint of cannabis was whoonga, and when it was offered to him, it dried his mouth, made him feel dizzy and nauseated. He did not take whoonga for over two years, but then he tried it again, this time enticed to do so by a close friend. This time, he found the whoonga high to be exhilarating, and way more elevated than the Mandrax high. Tshepo was employed, he lived with his family, and spent time with his uncle who had helped him find a job at his workplace. Tshepo bought junk metal from sellers who brought it to the scrap yard.

As he took whoonga regularly, Tshepo started spending time with his friends, and was hardly at home. He reported that, at the height of his addiction, he would leave work to go to his friends and would return home in the mornings to prepare to go to work again. At work, he started stealing, increasing such as the binges increased. Afraid of arrest, he left work abruptly. Without income, he resorted to stealing at home, mugging people, house-breaking and entry; however, he claims to have never resorted to selling junk metal. He was arrested twice, as a result of his crimes. Like Mandla, Tshepo would be arrested, and be coerced into sobriety while in prison. Upon discharge, he would return to his friends and to whoonga. Leading up to his recovery, Tshepo had caused trouble in the original neighbourhood he had returned to after imprisonment. He saw the need to flee. Tshepo left to live with the mother of his children and her mother. In this household, as he did at home, he stole, beginning with items that were less visible, because not used often, and tucked away. His girlfriend learnt that he was smoking whoonga and tried her level best to provide whoonga for Tshepo, causing debt among neighbours. She used money reserved for the welfare of the family, particularly their children.

When his mother-in-law learned that he was smoking whoonga, afraid that he would steal from the community, she offered to help with essential morning and evening consumption. The mother-in-law had confronted Tshepo, who conceded that he was addicted whoonga. The two made a pact that, when Tshepo was ready, he was to inform her, whereupon he would be sent for rehabilitation. Tshepo recognised that he had abandoned his responsibilities as a father when he smoked whoonga. He was unable to improve his family situation, being further burdensome to the family that took care of his children for him. After three weeks, he approached his mother-in-law, and requested to be sent to a rehabilitation centre. His mother-in-law paid the admission fee and left him at the centre.

Tshepo was in this institution for three months. He reported that the institution was religious-based. Opioid substitution therapy was not administered at that time, although Tshepo

reported that three-and-a-half years back he had heard that Methadone was administered. Tshepo reported to have suffered dry detoxification. Symptoms included inability to sleep, feeling disjointed; joints and muscles felt painful. He also suffered excruciating stomach cramps. These symptoms were common among new intakes. The institution taught its patrons to pray, describing addiction as an evil that must be overcome. The institution further invited patrons to a public platform to testify about their recovery. This local radio station features a programme on overcoming whoonga addiction, extolling guests who are recovering whoonga addicts. In his interview, he thanked his mother-in-law and his girlfriend for the support they had given him. Tshepo also made it public that he had quitted whoonga use, and for Tshepo, this assisted him in reintegration into the community. The community welcomed him upon his return, trusting him that he had changed. At home, his mother and his siblings were vigilant at first, curtailing his access to the main house.

Tshepo's recovery was assisted, even though he was not treated in the strictest sense of the word. He never used medication; and the staff at the rehabilitation centre, that was privately owned, were not professionals. Nevertheless, his recovery was supported by his girlfriend and his mother, as well as by the institution. Tshepo had left school in Grade 6. More than three years after he returned from the rehabilitation centre, Tshepo is struggling to find employment. He lives at home with his unemployed mother. His sister, who is employed at the Gateway mall, is the sole breadwinner.

5.4.1.1.1.4 Fourth Participant – Mondli

Mondli, at 20, is the youngest participant, who left school in Grade 8. Mondli lives with three cousins at his grandmother's home, where his mother, and subsequently he was brought up. His mother lives within the township in her own home, with Mondli's two younger siblings. He would visit her frequently before the fallout. This was caused by the discovery that Mondli was stealing from the family and the community to feed his whoonga habit. When Mondli left school, he was already smoking whoonga. He could not endure remaining at school, because the cravings, as the addiction progressed, demanded a fix. Otherwise, he reported to have been doing well at school, academically. His mother and his grandmother discovered after a long time that he was no longer going to school. Approaching the school, they learnt that he had not been attending school for several months. Mondli was already smoking cannabis when he started experimenting with whoonga. Whoonga was one of the substances he had tried: he had smoked Mandrax as well as "rock". Whoonga was Mondli's drug of choice. When there was enough whoonga, Mondli would still smoke rock to ameliorate the nausea that came with whoonga binges. This alternating multi-

drug usage gave him a different high that he also enjoyed. In offsetting nausea that presented with whoonga binges, Mondli was able to continue smoking.

In initiating whoonga use, Mondli presented an indication that whoonga had aphrodisiac effects. Mondli and the other boys in the township would hang together smoking cannabis. They frequented a house where two siblings lived on their own. Parents had moved to a new house in the suburban area, while their two older boys remained in the township. The older boy smoked whoonga. Mondli reported that he took whoonga because he was told in discussions with boys that it was an aphrodisiac. As boys discussing girls and their sexual involvement, a subject of sexual difficulty in maintaining a lasting encounter were discussed. Mondli presented a story similar and pervasive at that time, which the media caught on to − that whoonga was an aphrodisiac. As will be elaborated on later, this became one of the novel issues that was pursued during interviews. Clarifications were sought from participants who were already interviewed about this issue. The discussion of this issue was further presented in subsequent interviews with other participants.

Mondli learnt that, as an addict, his non-addict friends, who had known him before whoonga, would try to talk him out of smoking, mostly in disparaging ways. At times, he wanted to quit smoking whoonga, but he could not. To maintain the habit, Mondli found some employment with a local "shebeen" (unauthorised drinking place) owner. Mondli's grandmother did not approve of this arrangement, claiming that it made Mondli steal, instructed by this employer. Mondli confirmed that he did certain jobs for this employer other than cleaning her yard, collecting bottles, sweeping, and being sent shopping. At different times, community members would threaten to burn down the grandmother's house to take revenge for Mondli's transgressions. Mondli had to flee at times to different places sometimes to stay with relatives. He would steal in that neighbourhood and flee again. As a whoonga addict, Mondli stole from his own house, and burgled houses in the neighbourhood. He applied his signature crowbar and window entry that suited his small stature.

Caregivers tried everything in the process of his addiction to whoonga to help him to desist and to evade damage from the drug. A case of accidental aversive medication assisted him to desist. Mondli's mother and his grandparent bought him Methadone, hoping to wean him off whoonga. In this particular case, when he was asked to buy Methadone, he used the money to buy whoonga. His friend gave him tablets which he said worked as well as Methadone. This friend was also being treated by his caregivers, who afforded professional treatment. The friend was prescribed Methadone, and he did not take it. He also did not take these pills, opting to give them to Mondli. This was a ploy to get the money for whoonga. The grandmother insisted on Mondli taking these pills this particular day, concerned that he was still smoking whoonga, despite

insisting that he did not. Mondli took the pills to please the grandmother. In about half an hour he felt nauseous and had stomach cramps. He requested to be given Methadone, gulping this down. Within a few minutes, he vomited. Mondli believed that it was whoonga he needed, and that it was going to alleviate his condition. His grandmother refused to buy him whoonga, opting to lock him up in his room. When he managed to burgle his way out, it was the early hours of the morning. Feeling weak and dehydrated, he gave up the idea of seeking whoonga, and went back to try to sleep. Like Sipho, Mondli felt sickly for two days. At the time of the interview, it had been six months since this incident, and Mondli had not taken whoonga again. He reported to still think about it, how to get money to get it; and finds himself walking in the direction where he scored his whoonga fix.

Six months after discontinuing whoonga, Mondli was in early sobriety, and was still fragile. His recovery can be regarded as assisted by caregivers and aversive medication. Mondli acknowledged the pain he encountered when initiating recovery to be a deterrent strong enough for him not to relapse. For Mondli, whoonga addiction reduced him to nothing (finished), a position he is still trying to fathom and grasp fully, as well as to recover from. He currently spends most of his time at home watching soap operas he had stopped watching as a whoonga addict. The interview took place in the middle of the year, and there were no discussions on whether and when his return to school would be.

5.4.1.1.1.5 Fifth Participant – Lunga

Lunga (27) was in Grade 11 when he was suspended for truancy and unruly behaviour at school in an adjoining Coloured township of Newlands. Lunga reported not to have been doing well academically. Lunga smoked cannabis and Mandrax with his friends at school. He started smoking whoonga in 2007 when he was in Grade 8; and left school three years later. Lunga took more to whoonga after his suspension. He did not inform his parents about this suspension, and since they were not living with him, his father having passed away, and his mother living away from the family, he chose not to return to school. As a dedicated whoonga smoker, Lunga made all possible efforts to hide his habit from his family so they would not know about it. This was despite the obvious company of friends he kept and spent time with, who were whoonga addicts. Lunga reported to have not stolen from his household or his neighbourhood. In adjacent neighbourhoods, he and his friends would break into houses and mug people. Despite that he was dirty and unkempt at times, he would leave home early in the morning to avoid detection that he was a smoker. In doing so, he further abandoned his home chores.

At the time of the interview, Lunga had desisted from whoonga use for over three years. Lunga was recommended for employment even though he was a whoonga smoker. He attributed that to keeping as clean as possible within his own household and the neighbourhood. As mentioned above, he did not steal from neighbours, and he confined his muggings to other neighbourhoods. Lunga was so trusted by his neighbourhood that the local tavern owner would send him and his son to buy his stock, trusting the youngsters with a great deal of cash. Although difficult at times, Lunga kept as physically clean as his whoonga hustle would allow, i.e., if he acquired enough money, he could wash. Lunga found it troubling that I could find him. He believes that the local person who directed me to him must have been a whoonga smoker himself. Lunga was convinced that anyone who would have known about this behaviour must have met him in a merchant's/whoonga seller's home. As far as Lunga can tell, no one in his neighbourhood knew that he was a smoker.

When Lunga found employment in a semi-professional job at the Durban CBD, he would function without a smoke for some time. When he received his payment, he smoked whoonga in higher doses. Lunga would take whoonga to smoke at work, signalling the ability to function despite being high. At the height of his addiction, like Tshepo, he would smoke whoonga till early in the morning, returning home to make preparations to go to work again. He returned from work, and spent time with whoonga-smoking friends, smoking whoonga. Smoking whoonga proved to be expensive. Lunga would run out of money to transport himself to work. He would request that people lend him money, thereby acquiring debt. Lunga also learnt that he could not afford to feed himself, let alone his family. He was troubled that he could not buy himself clothes, a sign that he was employed.

In deciding to quit, Lunga reported to have cut down the whoonga a little. Lunga approached a local doctor who prescribed Methadone for him. Lunga then bought Methadone from the pharmacy at a local mall. He took about four bottles of Methadone, while simultaneously cutting down on whoonga consumption. Lunga still hid from his family that the medication was for whoonga withdrawal. He was forced to reveal this, however, when his niece was given Methadone by her mother, thinking that it was cough syrup.

In recovery, Lunga reported to have adjusted his financial issues. Lunga is able to take care of his basic needs, like transport money, and family groceries. He enjoys drinking alcohol, something he did not enjoy as a whoonga addict. His recovery was from whoonga, it excluded other drugs, like cannabis and alcohol.

5.4.1.1.1.6 Sixth Participant – Sizwe

Sizwe (30) started smoking whoonga in 2007, soon after he was expelled from a township school in Grade 9. Sizwe attributed his suspension to rowdy behaviour, and he was not doing well academically. Sizwe smoked cannabis. As the only child, he lived with his mother, who rented a room about a kilometre from the grandparents' home. Like Mondli, Sizwe and his mother were born and brought up in this maternal home. His mother moved to a rented room. Since the grandparents had deceased, she had returned to this household with her three sisters and their children, Sizwe's nieces and nephews. Sizwe is the oldest of the youngsters; he had a backroom for his bedroom. Left to his own devices during the day, as a regular cannabis smoker, he socialised with friends who introduced him to whoonga. These friends allowed him to try something they described as giving a better high than cannabis. Sizwe experimented with whoonga, and found it enjoyable. He socialised with these friends more, having become hooked on whoonga. But as his addiction took hold, friends refused him "freebies". His friends informed him that he would need to hustle to get his fix.

As an addict, now requiring more than one fix a day, Sizwe started by shoplifting at local malls. This being a risky pursuit, with close brushes with arrests, he joined other whoonga-addicted friends, who hustled by conducting breaking-ins in the townships. At this time, when he could not hustle, Sizwe would return to the grandmother's home to demand money. He was abusive and used foul language to coerce his aunts, nieces, and nephews to give him money, including his mother and the neighbours. His mother grew tired of this behaviour, and moved to another rented house; leaving him on his own in the former house which she continued to rent. Living on his own, Sizwe's addiction was partially supported by money his mother sent him for groceries. His rented house became a den where his friends would come and smoke with him. Somehow, this further reduced his hustling, as those friends would share a smoke with him, as the result of affording them a venue to smoke. Sizwe finds that his unruly behaviour among his family members and the recognition as an *iphara* (a dedicated whoonga user) made him lose respect for other people and for himself. He also learned that people did not respect him. Sizwe tried to stop. He reported to have been able to abstain for a year and a half. He presented a situation where these initial withdrawals were easier, and a possibility that initial whoonga could be interrupted. In that period, Sizwe acquired a relationship, but the friend was not convinced of his abstinence. Whoonga smokers would visit Sizwe and this angered her. After she terminated the relationship, Sizwe says that he was hurt, and stressed, deciding to smoke whoonga again. This time, he says that his addiction became intense, such that he had to join whoonga addicts who sold scrap metal. He still lived on his own, and he visited his family less often. When the family learned that he was a

whoonga addict, his mother stopped renting the house, it being judged an enabler of his addiction, hoping he would return home.

Sizwe did not return to the grandmother's house for a year; he had returned eight months before the interview. He had lived with a couple, who were also whoonga smokers. In a fall-out that Sizwe attributes to not being able to hustle enough for all of them, he decided to return home. Sizwe made a resolution to stop, but he was unable to. Sizwe believes that this time he was deeply entrenched in smoking whoonga; stopping as he had done before, proved impossible. Sizwe knew about Methadone and requested that his aunt buy it for him. Sizwe was not trusted at first, with a remark made by one of his family friends that it was a waste of money to buy him Methadone. This family had spent money on their addicted son, who was not recovering. But after two months since his return home, Sizwe's aunt gave him money to buy Methadone. Sizwe used this family's prescription. He took Methadone for two weeks, initially taking a teaspoonful a day, and then taking it as he felt the cravings. When cravings subsided, like Sipho, he joined a new group of neighbourhood friends. But unlike Sipho, these new friends were not smoking cannabis, although they drank alcohol.

In recovery, Sizwe found that the community of friends in the neighbourhood welcomed him when they learnt about his quitting, offering him alcohol to drink. Now drinking, a sign that he was no longer smoking whoonga, he hung around them and actively avoided his former whoonga friends. Sizwe believed that he was still likely to use whoonga if he continued socialising with them, six months after desistance. In that period, Sizwe reported to have gained weight. Unfortunately, living home, mostly in his backroom doing nothing, produced boredom. Sizwe hopes to find employment, and hopefully a relationship. He was conscious that, at his age, he had not been employed before. He started smoking whoonga, and moved on to dedicate himself to it during his late teens. His recovery can be categorised as medication assisted. Leading to acquisition of Methadone, Sizwe, like Lunga, was slowly reducing his whoonga intake. Like Lunga, he took medication at home on his own, and both had been directed by professionals they acquired the medication from. In recovery, Sizwe had begun smoking whoonga while he was at school. He had not been employed before, and he did not have any particular skill. He was hopeful that he would find employment, on recommendation by employed friends.

5.5 Data Collection

Data collection began after ethical clearance had been granted by the REC. It began with setting appointments with health-centre managers and police officers in local police stations to discuss the placement of advertisements. The first participant was contacted and asked to schedule

an appointment. When placing the advertisement in one of the police stations, I enquired about the availability of youth they had reported to have sent to the rehabilitation centre. The police furnished me with the contact details of the mother of one of those youths. As discussed above, two youths had moved to the Eastern Cape and Gauteng provinces, and the last one was a case of a missing person. Two weeks after placing all the advertisements, a third participant called. He had seen an advertisement in a police station; and he wanted to volunteer for the study. There were no leads or responses from participants at this stage for the next two months. As I was working on transcriptions, it was deemed important to schedule an appointment with a social-work official to enquire on the leads they had regarding individuals they had successfully aided, and who were now former whoonga addicts.

A general worker within the health centre who had seen me placing an advertisement, approached me. She reported to have a fellow congregant who was excited that her sister's grandson had quitted whoonga use. She gave me the contact details of the fourth participant's grandmother. Considered word of mouth, the contact details and directions to the last two participants were given to me by individuals who saw the advertisement. These individuals, a young man of about 32 years of age and a middle-aged woman, called me and directed me to these participants. I approached these participants. As already mentioned, the fifth participant was shocked that he could be found, signalling that someone knew about his whoonga addiction. The third participant was directed to me by a local shop owner who had heard that the person she knew as a whoonga smoker had desisted.

5.5.1 Semi-structured interviews

After an initial appointment with the participant, time was scheduled for an interview. However, the last participant was available at home, therefore the interview commenced immediately. Phenomenological interviews are a social relationship for the exchange of information, and they are an entrance into the informants' world, giving access to their experiences as lived (Walker, 2007). This exchange of information between the participant and the researcher in a face-to-face interaction is guided by an interview schedule (Smith, 2015).

5.5.1.1 Interview schedule

The use of the interview schedule was to guide the interview, and particularly the researcher, to ensure the uniformity of questions among all participants. These questions were formulated to address the interests of this research study. Practically, the interview schedule was used as a prompt sheet. This is a checklist that reminded me to ascertain whether all the questions

had been answered, usually towards the end. In preparing the interview, the interview sheets itself had been copied on one A4 size paper, and the font magnified. Questions were not to be asked in a particular order. Generally, most questions were not asked at all, and could be deduced from narratives. In later interviews, when I was now familiar with interviewing, some questions were asked during the conversation addressing particular points in mind, also while the participant was narrating the aspects of the story around the research question. Clarifications, some emanating from previous interviews with other participants, were sought during the narration as I got used to the interview schedule. In taking notes, this further involved making ticks on issues participants had covered, the idea of a prompt sheet.

The interview schedule had eight open-ended questions. Six of these questions supported the overarching instruction. The first main question instructed participants to relate their experiences of addiction to whoonga from inception till desistance. These are stories of how drug use was initiated, what addiction was like for participants, turning points that prompted recovery, and how addicts initiated and maintained recovery. Questions were formulated with support from addiction and recovery literature. The conception for me draws from Best et al. (2010) who regard recovery models as extending from addiction theories. For example, ecological frameworks regard addiction as a physical disease. The struggle is when one dimension (being physical) is treated to the exclusion of other important factors influencing addiction in the matrix of being human. This is despite different outlooks.

The conception of drug addiction as a chronic relapse disease informed a question to participants to relate their experiences, going through relapses or episodes of relapses in their addiction lives. The question asked participants was whether they had ever tried to stop taking whoonga before their last successful attempt. Had this been the case, what had happened? The question on turning points included the motivation that guided the resolution to stop taking whoonga. This question asked participants why they had stopped taking whoonga. The question on how the participants remained sober till the time of the interview requested them to relate methods they used to avoid relapses; the maintenance of recovery. Two questions drawn from literature on recovery required participants to reflect on identity change, making comparisons between being-an-addict to being-in-recovery. Participants were asked to concretise this change by offering examples. These questions were mined from addiction literature, particularly the progression of the addiction process and metatheoretical model of change that presents steps individuals would undergo in ending the addiction process. Literature further proposed and presented evidence that constructed recovery as a profound change of identity that includes the change of the self.

The last two questions included what it took for participants to summon the courage to overcome whoonga addiction. They also enquired on external resources that supported or thwarted recovery, addressing the last two research questions. Therefore, how addicts were assisted to recover, as well as recovery pathways each participant took, answered the last two questions on the use of available support. What enabled addiction and thwarted recovery was drawn from experiences with addiction. What thwarted recovery were notions of what made quitting difficult. These last two questions addressed the main concerns of the study as well as the recovery capital. This included social and cultural resources critical to overcoming addiction (Lyons & Lurigio, 2010). For example, according to Lyons and Lurigio (2010), a "friend of a friend" who provides a job opportunity is a member of a social-capital network.

The seventh question was whether participants had any further questions. This question signalled the end of the interview. It also gave participants the opportunity of relating what they thought was important to them in light of the issues discussed in an interview, and which the participant thought had been left out. The last question invited participants to have counselling if they desired this. This invitation addressed the ethical obligation to give support, and to preserve the emotional well-being of participants. As noted under ethical considerations, the services of local social-support professionals had been elicited.

5.5.2 Conducting interviews

Interviews were conducted in participants' homes. Three participants reside in Inanda, one in Ntuzuma, and two in KwaMashu township. These phenomenological interviews were in-depth, averaging two hours and fifteen minutes. They were followed up for clarification. This section discusses how these interviews were conducted.

The main task of the researcher is to encourage participants to narrate their experiences freely on the phenomenon under study (Hycner, 1985). Participants were informed beforehand what the discussions would be about, reminding them during the initial meeting, and soon after the recording of the conversations began. In collecting data by conducting interviews, this meant travelling to the participants' homes. Travelling within these townships had started with the researcher seeking permission from gatekeepers. INK townships are my and participants' childhood townships where secondary education was received. I have some personal sentiments about the place. For example, the police station sign at Ntuzuma, a place that was a veld when I was a secondary student there, was pinned on clear sign underneath reading Kwa-Mashu. Therefore, this means that Ntuzuma was once Kwa-Mashu, an issue we chuckled about, given the postal address used.

Travelling it now, I was meeting participants who, as young men, addressed me as "baba", *"bhuti* Thabani" and even *"malume*"/uncle. This means that I could easily be the age group of participants' fathers, elder brothers, or their mothers and uncles. I am saying "even" uncle, because, with a particular objection raised against being considered uncle, a link to teenage pregnancy, uncle is not a term of endearment. It is not even respectful at times when it carries nuances in township lingo of a youngster approaching an older male to swindle him. I chose *mfowethu* to refer to participants, particularly during interviews. *"Ndodana"* (son), *"ntwana"* (young man) or *"mshana"* (nephew), would be too informal. What participants called me were names showing respect for an older person. There was a good and relaxed atmosphere in most interviews associated with the subject under discussion, conquering whoonga addiction. I suggest that it was relaxed for Mondli to freely initiate and discuss sex-related subjects. Some of the participants were good conversationalists, particularly Mondli, who described his experiences in engaging ways. Mondli told his story animatedly. Sipho and Lunga were the reserved kind, who related their stories slowly, and for Lunga, prompting was required at first, before he could relax.

At participants' homes, I was introduced to families. I explained to caregivers what the research study was about, and why I wanted to interview their son, younger brother, nephew, or guardian. Families were generally welcoming; some offered refreshments and assisted in preparing the venue. General conversations with family members before and after interviews ranged from questions to the researcher about whoonga addiction, to the Soweto derby soccer match coming over the weekend. From these conversations, a grave concern with whoonga addiction was established.

During interviews, participants would begin describing when they initiated whoonga addiction. They were encouraged to tell their stories by my active listening. I would take some notes usually on gestures, what I thought of what was being said; and I jotted down a follow-up question that was to be asked afterwards on an issue, to avoid interrupting participants' train of thought.

5.5.3 Clarifications

At the end of each interview, transcribing interviews, converting them into written text began. When completed, they were sent to each participant to assist with corrections. I was expecting comments around what was really said that I might have not heard correctly. For example, Mondli referred to himself before whoonga addiction as a *"supa dupa qubu*", which was heard by me as *"super super s'qubu*". The context of the word suggested a high-flyer, who is rated top on current presentation of trends. However, transcripts generated responses and additions from

some participants. For example, Sipho wrote a page and a half addition on issues that he thought had not been covered. In other cases, information and facts thought to be unclear in the interview were elaborated on. Communication was per WhatsApp messages with page references, to locate information on text. Only Sizwe, who did not have a phone, was visited at home for clarification. Mondli used his cousin's phone. Tshepo did not seem to have read the transcript. I also asked for clarification on some issues, including novel issues, as will be discussed in findings. For Smith (2007), clarifications provide a literal interpretative dialogue about the researcher's virtual interpretative dialogue.

5.5.4 Recording: interview setting, field notes, and recording equipment

Interviews were recorded using an audio-recording device. When approaching the participants at home, the researcher was assisted to ensure that the identified interview setting was free from background noise and interruptions (Edwards et al., 2013). Interviews were held indoors. In a township environment, this assisted the transcription of notes, but it also helps with avoiding intrusions and distractions, and assured confidentiality. Notes were taken during and after each interview (Edwards et al., 2013). These notes can be divided into observational notes – "what happened notes" deemed important enough for the researcher to make. Theoretical notes are "attempts to derive meaning" as the researcher thinks or reflects on experiences. Methodological notes are "reminders, instructions or critique" to oneself on the process; as well as analytical memos, the end-of-a-field-day summary, or progress reviews. Transcripts from audio-recordings were the object of analysis (Smith, 2011a). These notes are added in the left-hand margin as part of analysis on transcripts.

5.6 Data Analysis

The researcher admits a novice status in conducting a study using IPA; however, I hope to do the basics well (Smith, 2011b). IPA explores the sense that participants make of their personal and social worlds, while recognising the contribution of the researcher in delineating the participants' interpretations of their experiences (Reid et al., 2005; Wagstaff & Williams, 2014). Hermeneutic circling involves a process of situating experience and meaning as part of a larger whole, according to Daher et al. (2017), of the participants' life-world. The process of analysis began with the interviews, particularly after the first three, and ended with final submission. The conception is that analysis ends with writing-up. From my experience, conducting this study, there were several revisions that altered some conceptions made earlier. Earlier interviews brought forth the actuality of doing IPA interviews, and revisions and additions were made in subsequent

interviews. The first participant told his story in ways that suggested what it meant to him to undergo several stages from initiating whoonga to where he had now arrived. The participant has a post-matric education, and perhaps this was easier to deduce, his language being more descriptive than that of other participants. The next participant was also quite eloquent, using English to a greater degree than the other participants. However, upon transcribing these interviews, thinking about the research needs, I realised that I should have asked participants more of what they meant in most statements they made. This means that, as explained later, it would help a study that presents evidence from verbatim extracts. This would give me verbatim descriptions that would be usable, so that I can be true to participants' understanding of their experiences as they pronounce them. The technique known as funnelling seems odd at first, but it makes most sense when questions funnel reflections on what such meant to participants, the object of analysis. Therefore, the first two interviews made it clear to me that, in searching for meanings, interviewers should ask participants what it meant to them to act or behave the way they would/were explaining.

With regard to the following of a novel idea, the issue of whoonga addiction as enhancing sexual prowess had been presented by the media. This was brought up by the fourth participant. In seeking clarification, I returned to the first three participants to ask them about this phenomenon and whether they would elaborate on the point. Two participants answered the question directly. The first participant wrote me a two-page response that addressed other issues that he thought were important for me to know about. Subsequent interviews added these questions, timed to be questions I would ask towards the end of the interview. The findings and discussions on ploys to recruit whoonga addicts will elaborate on this piece in discussions below. Transcriptions supported analysis, bolstering the context of a discussion in adding the non-verbal expressions. Interviews give an overall story that is comparable with other stories by other participants. Transcripts repeat these; and help with a better grasp of these stories. But at this time, they are assisted by interviews in that when one is typing them, one is playing and replaying incremental snippets of interviews.

Transcribing was not assisting the analysis as much as I initially thought that it would. I had imagined that transcribing would negate the need for reading and rereading. When I was transcribing the fourth interview, I remembered the stories of previous participants, but I was so engrossed in transcriptions of later interviews that what exactly the individual had said was not at all clear or even important. The process of transcribing a concern with gaining verbatim words and expressions, resulted in understanding being secondary. In a period of three weeks between the third and the fourth participants, I gained the opportunity of looking at all the transcriptions together, and an attempt to analyse them began. That process had to be abandoned to make time for transcriptions of new interviews. At the end of interviews, notes made during this initial stage

assisted in linking to the ideas I already had. The process of analysis, for me, started with sending back completed transcripts to participants, for participants to read and make corrections where they thought the message was not clear, elaborating where necessary. Five participants did not make corrections but answered questions I had for them that I had picked up from transcripts. The questions were highlighted in the text or written at the back of my transcript. The township language could have changed from the time I was the participants' age. However, I think that, fundamentally, they have not shifted from the basics I understood. For example, the meaning of *ukuphotheka* has remained relatively the same. It could be that participants presented a language suitable for the "uncle", I sometimes was to participants.

Two hard copies of each transcript were printed. As mentioned above, the text was placed in margins that allowed for a space to make handwritten notes on both sides of the text. In free-hand, ideas that came as I was reading the text from the transcript of the first participant, some free-flowing others from literature, were scribbled on the left-hand side of the margin. It was inevitable that some ideas would come from what other participants had said. I had already interviewed all the participants and transcribed their interviews at this stage. Elaborations on previous notes were made and some were discarded in what I thought was improving the conception of that idea. Quite as much as one needs to consider each case independently, it was inevitable that ideas from certain participants would have influenced this initial coding process. It is not clear how this was useful in making comparisons at a later stage, but I thought that it would be useful. Some ideas were influenced by theories when I was making sense of what I was reading. These notes would elaborate on non-verbal communication I had added, and field notes I had made during the interview. Together with non-verbal expressions they were added onto transcripts, and these notes made sense of the participants and what they meant. Notes were either paraphrases, summaries, or translations. Notes were written in English.

I also decided to do the same initial coding on the other transcript, starting afresh, hoping to see things anew. This process added notes to the initial copy. Extra ideas about issues were also added. From the initial scripts, I wanted to condense codes by looking for connections. In a manuscript paper these ideas put in code encapsulate what they mean. Some of these codes clustered around pathways individuals took. Others were about emotional issues at each turning point. How they operated in the township in acquiring the next fix fell within actions people took to maintain their addiction. Some codes refused to fall into any categories. Others were clear that they belonged in this particular conception, later jumping out, and a few would ultimately influence later themes. I now had a list of words of 75 to 90. In checking for connections between these words, my target was to find at least 35 codes. Such coding renders translations largely into

English. Several words remained verbatim, that were compelling but could not be linked to codes without losing their context. The best technique here is to go back to the transcript to read the context of each code, seeing whether it may link with others or could join existing codes, changing them. In formulating themes, I was guided by three ideas. Themes should be referenced in the text; they should at best be able to put up a story about that issue; and I also focussed on what was particular to each participant. I thought that those stories linked to some theories would be common among participants. Themes that seemed peculiar to participants influence the formulation of each theme about that participant. For example, participants were opportunistic criminals, but one would not steal from home, and the other would not sell scrap metal. While all the participants stole, two had a violent streak in their *modus operandi* that would relate to muggings and a potential to cause physical harm to their victims.

For the first participant four themes were drawn: these themes largely influenced significant and pertinent issues. Detailed analytical treatment of each case was followed by the search for patterns across the cases (Smith, 2011b). At the core of analysis is the concept of double hermeneutics, or a dual interpretation process; both the researcher and the participant are perceived as intrinsically sense-making creatures (Finlay, 2009; Pietkiewicz & Smith, 2014). The participants make meaning of their worlds; and the researcher tries to decode that meaning to make sense of the participants' meaning-making (Pietkiewicz & Smith, 2014, citing Smith & Osborn, 2008). The close examination of the first case leads to the extraction of micro-experiential themes; and then a careful examination of patterning across the cases in the corpus (Finlay, 2009). The researcher will read and reread the transcripts (familiarization), making initial notes; both on meaning (pre-analysis) about the person, own ideas (preconceived and emerging), as well as a theory that could account for observations. Themes are derived by condensing ideas into a collective or representing idea. There are various techniques used to reduce data into themes. All these involve a systematic representation of meanings; the decision to collapse meanings and themes remains with the researcher as themes emerge. Eventually, these sub-themes are merged into a few themes that form the main themes, representative of the experiences of participants (Smith & Osborn, 2003). This is conducted first at an individual level, and then at the pool or group level.

5.6.1 Transcriptions

Recorded interviews were transcribed by the researcher. The process is lengthy and laborious, demanding many man hours. Some researchers using IPA propose that researchers must transcribe the interviews themselves. It is not definite how this could have assisted in this research.

I noticed, however, that it does not negate the need to read and reread before analysis. It perhaps assists to direct one to exact quotes. This means that I could locate relevant extracts in the pages that the two-hour conversation had been reduced to. What seemed important with regard to performing own transcripts is the addition of contextual notes. It helps to transcribe the exchange soon after interviews, when what happened during an interview is still fresh. Together with observation notes taken during the interview, this assisted to enter notes, including contextual notes, while they were still fresh in one's mind. Transcripts can be very long when they are outlines for analysis. To make handwritten notes to assist analysis, the document's margins were adjusted. This allowed space for left and right margins required for analysis (Smith & Osborn, 2003). The Microsoft Word function to format transcripts was placed on Moderate margins.

5.6.2 Interpretation

Interpretation in this study began with the interviews, listening to each story to make sense of what was said. Interviews required active listening and to be in the moment with participants. Other than scheduled questions, follow-up questions rely on attending closely to discussions, to probe for ideas that were novel, different or unexpected and for an elaboration. At this stage, I believe it would have been useful to ask participants further what they meant. This means asking them directly what they presented meant to them, without interrupting the flow of the discussions. In a study that focuses on how participants made sense of their world, and a particular focus on verbatim evidence, this strategy is strongly recommended. At the end of interviews, what had been clear were strategies used to desist whoonga use, what stages participants were with regard to achieving QoL. These were relationships between recovery level and functionality, what is described as citizenship. To a certain extent, the research study became a focus on success stories and for a long time, this directed much of my thinking. Such a focus was directly largely by the relief of finding volunteers in this study who doubted that they could really desist whoonga and would use dry detoxification. The focus of the study was readjusted with the direction of the supervisor, after the first draft, to a focus on making sense of what it meant to participants to undergo the addiction and recovery processes.

In doing that, how individual participants' stories related to one another was important. This means that part of making interpretations involves contrasting what individual participants brought to the story of addiction and recovery from whoonga in relation to the rest of the participants. It was to be expected that there would be similarities among participants, but the focus in IPA is also on excavating individual, particular, and ideographic nuances. Participants were all "in recovery", but at different stages; and how they desisted from whoonga use was individual-

specific even for participants who used medication to desist from whoonga use. It was also important to relate these findings to the real world of whoonga addiction as represented by literature on whoonga addiction in South Africa. It became important to draw on real-life interventions based on these experiences. For example, the quest for Methadone requires support for the advocacy for OST, but this should be juxtaposed in relation to treatment costs.

My ideas about addiction before this research study were firmly anchored in addiction treatment. I was convinced, as it seems clear with the approach assumed by researchers that approaching whoonga addiction would include extending addiction treatment to communities. This general understanding emanated from the amalgamation of literature and previous research, with findings to elaborate and make sense of the meaning. The understanding of dry detoxification expanded when a case of aversive reaction to medication was presented as a form of recovery that present hallmarks of medication-assistance, as well as dry detoxification. This term proved to have been used before in describing this phenomenon in relation to whoonga. As a method of desistance, it had been presented in ways that suggest that it would occur under conditions where it was forced, a case where people would be arrested, and as a result of lack of access to the drug, stop taking the drug. The pain that I associated with dry detoxification was such that it was not likely to be voluntary or that it could be coerced by non-law enforcement agencies, as findings in this study showed. In making sense of dry detoxification, my conception of the term, what literature provided and what participant directed had to be amalgamated in making sense of this phenomenon.

To make sense of what participants meant demanded thinking in terms of how the participant made sense of their world: this is a difficult undertaking. It demands that one think of their world from their shoes, what it would mean to me as a person. This undertaking will include ideas one has about the phenomenon. My ideas about drug addiction were firmly attached to addiction theories, as would be the case for most researchers, in light of its domination.

5.6.3 Writing up

In IPA, analysis ends ultimately when writing up, mainly because of the reiterative nature of the process. Few themes matched those of the interview schedule. However, some elements in superordinate themes matched elements in the interview schedule. This is largely directed by the research needs of this study, referencing the research questions. Writing up a report on a dissertation in phenomenological studies can reflect credibility and trustworthiness of the work being reported on. In this study, the presentation of this academic work can direct a reader by establishing a particular dialogic or educative presentation (Taylor-Powell, 1998) in the processes undergone in phenomenological enquiry. The way in which pre-ideas of the researcher morphed

during an encounter with participants, and how they could have influenced the establishment of codes and themes, is reported on. The researcher indicated and demonstrated how the hermeneutic circle occurred, the process of creating themes from transcripts. In analysis, the onus to take account of the context of those experiences is on researchers of such psychological investigations (Larkin & Griffiths, 2002).

5.7 Ethical Considerations

This section will discuss ethical requirements needed before data could be collected. The study involved human subjects: as a result, an ethical clearance was required before its commencement. This section will begin by discussing measures taken to ensure the voluntariness of participation and confidentiality, where how the privacy and the anonymity of participants were ensured.

5.7.1 Voluntariness

In human studies, voluntariness is a principle that ensures that participation was free from coercion and undue influence (Mkhize, 2006). As it will be discussed in the section on an informed consent below, participants were informed in detail, beforehand and in their own language what the study was about. Participants were provided appropriate information (Wassenaar & Mamotte, 2012). Therefore, participants volunteered in this study with full knowledge what the study expected from them. Participants consented to participating in this study by signing an informed consent. To further ensure voluntary participation, they were presented an option to withdraw from the study without ramifications. This voluntary withdrawal would have been contingent on their discomfort that would have arisen. None of the participants withdrew from the study. Participants were in the process of recovery, after desistance and free from drugs. For these participants, they were no longer addicted to whoonga. To be in that position, they had to make a life-changing and positive choice that their lives were going to take. Participants were considered to be capable of making choices. They were considered capable of understanding information provided, including their freedom to withdraw (Wassenaar & Mamotte, 2012).

5.7.2 Confidentiality

To ensure confidentiality, this study began by ensuring that interviews took place in a private room. Transcripts bearing participants' real names will be kept safely by the researcher. This is further communicated in the consent form. Confidentiality was explicitly outlined (see

Appendices 1 and 2), and it was easily accessible as the consent form was translated into participants' first language (Wassenaar & Mamotte, 2012).

5.7.2.1 Privacy and anonymity

The study interviewed a member of the family to triangulate findings. This was to find another source of information to confirming that participants had desisted whoonga use. In that space, consent to interview a family member was given by each participant. Each participant identified a family member. From stories of addiction and recovery from whoonga, participants' families knew about the recovery status of the participants. Participants were not minors, meaning that they did not necessarily need consent from their parents. Nevertheless, parents and caregivers gave verbal consent to the interviews (Mkhize, 2006). Participants were interviewed in their own homes and in their own rooms where possible, their natural environment, with full knowledge of their family members. In reporting, this study used pseudonyms.

5.7.3 Permission to conduct the study

In the humanities, research studies conducted at the University of KwaZulu-Natal are guided and granted ethical clearance by the Human Social Sciences Research Ethics Committee, as was this study (Research Protocol Number: HSS/016/019D) (see Appendix 2). Upon presenting the research proposal to the University's Committee of Higher Degrees, it was anticipated that consent from participants would be required. Stories of addiction and recovery from whoonga affect individuals in profound ways. Expectations to evoke emotional issues were anticipated. An arrangement with the local INK social services to assist with the debriefing of participants, should such a need arise, seemed sufficient. Permission to conduct the study was also requested within the police stations as well as with managers of health-care services. Advertisements recruiting participants in the study were placed strategically in these environments. As mentioned above, there was an indication that participants would be difficult to find, hence snowballing was preferred. However, to maximise the chance of recruiting participants that used diverse recovery pathways, advertisements seemed an appropriate recruiting strategy. It was not clear whether participants would volunteer considering that the study did not offer payments as an incentive. However, the hope was that individuals who had recovered would be willing to tell their stories. These stories were characterised by achieving relief for oneself. The idea of placing adverts at shopping malls had been discarded. It was considered too costly, and too protracted to achieve, for the purposes of this research study.

5.7.3.1 Gatekeepers

The Ethics Committee indicated the need to acquire permission from the DSD, the official custodians of substance abuse issues in South Africa. This was mainly because the utilization of their officials to assist with debriefings fell within this department's area of responsibility. This department requested a presentation to their provincial committee before granting permission. Permission to conduct this study, and the guidelines by the provincial head of this department, were granted (see Appendix 3). The Ethics Committee had further suggested that permission be acquired from the Department of Health (DoH), particularly to allow the placement of advertisements in their health centres and clinics. This department requested a research protocol, a condensed version of the research proposal, following a particular format of presenting research proposals in this brief manner. An eight-page document was compiled and co-signed by the supervisor, then e-mailed to this department. The provincial head of the research wing within this DoH granted permission to place adverts in health centres (see Appendix 4). The head stipulated that the research study should not disrupt the daily proceedings in these institutions. Both departments requested feedback on findings of the study.

The placement of adverts in these health centres was guided by the social service officials. Social services officials decided on which notice board the adverts should appear. In two cases, they assisted me in acquiring appropriate keys for notice boards. On substance-abuse issues, these departments (DoH and DSD) work together. Although social-work services consult other cases referred to them by the professionals within the health centre, their central role in the drug-abuse programme is to identify and to prepare suitable candidates for rehabilitation. Substance-abuse programmes in South Africa, as well as in INK townships, depend on this referral system. A presentation to these departments will be arranged after the completion of this study.

Permission to conduct the study was also requested from the police, particularly officers commanding three police stations within INK townships. These police officers were presented with a letter from the university and signed by my supervisor. This letter explained the aims of the research study, the participants required, the duration as well as anticipated time of completion of data collection for this research study. Police were to provide security, should there be a need. Permission was granted by these senior officers. I was to inform the police of my whereabouts within these townships, on first entering the community. Contact numbers of visible policing members were given to me to contact them should the need arise. There were, however, no incidents that warranted the attention of the police.

5.7.4 Debriefings

As discussed under data collection above, participants were requested to indicate whether they had a need to consult professional counsellors. The idea was that, if emotions evoked by relating their experiences were such that they required professional attention, they would indicate such to the researcher. An arrangement was made beforehand with two head social workers at Inanda "C" Clinic as well as KwaMashu; during the initial visit as well as when placing adverts, I presented to them permission from their provincial offices. One participant, Mandla, requested to consult a social worker. He reported that he had always struggled with anger and that he wanted to be assisted to deal with it. He also thought that his family situation which he had characterised as feuding required that he find ways of handling the anger he has shown against them. This request was not evoked by the interview − it can be perceived as the way the participant wanted to take care of himself. If it assisted his relationship with his siblings, and his father in particular, this intervention would help him mend these relationships.

Mandla was referred to Inanda "C" Health Centre − the social worker acknowledged receipt of the referral letter. Three sessions had been conducted at the time of writing this report. Upon follow-up with the participant, Mandla described the sessions as generally helpful, but he was still a work in progress.

5.7.5 Respect for persons

The principle of respect for persons applied in this research study. This is a universal principle that vouches for the treatment of individuals as free and autonomous subjects (Emanuel, et al., 2004). This principle values the autonomy and freedom of individuals to make their own choices. Participants in this study were former whoonga addicts undergoing various stages of a process of recovery. The effects of the drugs in incapacitating them to make a choice, could not be known, particularly for participants who had desisted whoonga use for six months. Nevertheless, even for two participants who had desisted from whoonga use for six months, these people were considered capable of making choices. The respect for participants began from the time they are approached, even had they refused to participate. In this study, none of the participants approached refused to participate. Lunga consented to participate after he had been assured by the researcher that the interview had no bearing on his former life as a whoonga addict. This study sought authorization from participants before formal interviews were conducted. A fully-informed voluntary consent was therefore acquired from all the participants (Carter & Malucio, 2003; Emanuel et al., 2004). This was done by constructing an informed-consent document, which participants had to sign before interviews.

5.7.5.1 Informed Consent

Informed consent was constructed using the guidelines set by the Research and Ethics Committee (REC) at the University of KwaZulu/Natal. Informed consent signed by participants explained what the research study was about, and the expectations it had for their participation. Upon recruitment, the selection criteria for recruitment of participants was verified. Participants had to be former whoonga addicts, which means that they would have desisted from whoonga use. Participants had to be youths between the ages of 18 and 35. After verifying that they met these criteria, a meeting was arranged. In this pre-arranged meeting, I explained to participants what the research study was about. This was made explicit and easy to understand (Wassenaar & Mamotte, 2012). To enhance accessibility, the informed consent was translated into isiZulu, the dominant language of the participants. Participants were told that the interviews were free discussions, and they could end such whenever they felt uncomfortable or unwilling to continue. In the process, I was to ask pertinent questions to seek clarity of issues presented.

For Emanuel et al. (2004), respect for persons includes the protection of their confidentiality, and the monitoring of their well-being, also motivated by principles of beneficence, and non-maleficence. To protect their confidentiality and privacy, participants were informed of the use of pseudonyms in reporting research findings. To further protect participants against potential risk in relating their recovery stories, as mentioned above, emotional support services were availed. These services were provided by the social-work officer. By its nature, the research study takes the direction of finding a means to support recovery. This is important for the welfare of participants and their compatriots beleaguered by whoonga addiction. Upon completion of the study, participants will be visited to discuss findings. Of practical value is that participants in this sample could assist the initiation of peer-driven recovery support initiatives.

In this research study, informed consent meant that participation was voluntary, as delineated in the informed-consent process. Participants could withdraw from the study if they so wished. Confidentiality was assured to participants that, when signing the informed consent, personal information was protected. Participants were treated with respect during the interviews. They were not interrupted, and were allowed to relate their experiences freely. As experts, they were being consulted: this is a superior position that acknowledges their worth.

5.7.6 Social and scientific value

The principle of value for research studies is consonant with the principle of non-maleficence, which refers to “a moral obligation to act for the benefit of others” (Emanuel, et al., 2000). Although not a national agenda, whoonga addiction is a subject of social interest. Whoonga

addiction is now considered an epidemic that ravages communities (Wessels, 2015). From the empirical review of literature, addiction professionals in South Africa are concerned with the increase of whoonga addiction, that includes a need to raise the scourge of whoonga addiction to a national agenda. In seeking interventions within addiction treatment, they are limited by the worldwide approach that has been dominant in this arena. The study presented an emergent need for alternative approaches, by introducing and engaging recovery in ways that do not alienate other efforts. Addiction professional are engaged in ways that make them consider other tactics of dealing with addictions in an African and a township setting. The need for collaboration suggests interests that should not be guided by securing professional relevance. Rather, recovery is guided by a need to employ a variety of ways to end addiction.

In revisiting the dislocation theory, the study inadvertently theorises on ending problematic addiction to drugs. The research study engaged people who were involved to assist those who had not yet recovered to consider recovery. By asking what it was like for them to undergo these processes, the study is further asking them to tell us how we can help others. Although the study cautions against the use of single-factor models, the research study further presents alternative approaches that are usable in a whoonga situation. In formulating a holistic and an integrative model, the ecological study of the addiction to whoonga is a concern with extracting usable interventions derived from the environment. The study presents alternative but compelling solutions to the problem. Participants in this study are an empirical evidence of the reality of desistance from whoonga addiction. The movement of recovering has a foundation in these strengths and assets. The study presents a valid reason to pursue a recovery movement that is sensitive and realistic to the context in which addictions to whoonga occur. This research is a case made to support recovering addicts to remain sober, helped by their community of peers, and the community in general. According to White (2010), recovery can be contagious, spreading the message that whoonga addiction can be overcome. According to Weegmann and Piwowoz-Hjort (2014), fellowship groups provide inspiring models of change. Addicts themselves can attempt to desist, spreading the movement.

An empathic understanding of whoonga addiction could soften those who are hostile, once they have understood, as humans, the journey of recovering and overcoming addiction, as experienced by those who were addicted. The recorded life of recoveries suggests that addiction to whoonga can be overcome, and that the addicts' lives can change, bringing hope. The research study explores alternative ways of reducing harm; and suggests ways for the creation of therapeutic communities that support addicts to recover. Communities are engaged, drawing from their ecological resources, to help prevent experimentation with drugs to occur in the first place. The

value of the research study is mainly to enable the general public to understand the issues and struggles that are involved in whoonga addiction, offering hope for changing the view of addicts. This applies particularly to difficulties with ceasing drug use, and hopefully, in gaining a certain level of understanding and empathy for the addicts to receive support. The message is that addicts need support to recover, to manage long-term abstinence.

5.7.7 Validity and trustworthiness

In evaluating the quality of this research study, criteria guiding qualitative research studies and those particular to IPA were used. Credibility in qualitative methods is stringent in its concerns with validity and trustworthiness. Yardley (2017) maintains that the reader who reads the narrative account must feel transported to the situation or the setting. This study presented a description of each participant in detail. Readers were introduced to the participants' home circumstances, how they initiated recovery, turning points, as well as the method of recovery that each participant used. In presenting findings, the research study used thick, rich descriptions. This meant that meanings were understood during the interview within the context they occurred. Discussions integrated the life situations in relation to findings. In qualitative studies, this assessment of credibility is established by what Creswell and Miller (2000) refer to as the lens of the reader's dimensions: sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance (Yardley, 2000, 2008, as cited in Yardley, 2017).

5.7.7.1 Sensitivity to context

The study is a focus on finding practical and alternative solutions guided by the context addictions to whoonga occur under. In using an ecological approach, one of the major strengths of this study is that it is a project foregrounding the context of whoonga addiction, not only as essential in understanding the phenomenon, but as essential in offering solutions. Going forward, IPA as a methodology, forecasts a focus on the context to define its alignment, that pays homage to its hermeneutical phenomenology roots. In evaluating the role of IPA, Smith (2011) agreed with a position by Todorova (2011), that the context will be the fundamental basis of future IPA studies. The study drew from the hermeneutics of empathy, but further presented contextualised understanding of experiences with whoonga addiction. The hermeneutics of suspicion, IPA balances with its empathic appeal: a separate paper that argued for ecological and recovery approaches in the context of whoonga addictions was presented. While that was important in developing from literature a rationale for such a route, it was important on this research report to expand on the issue and to present solutions. As a project within IPA, IPA studies would struggle

to present both the empathic angle that would include the context, but in this study, whose basis is an ecological approach, it became important and compelling.

The study paid close attention to the codes and the language used. Concepts were understood within the contexts they manifested in. As an act of interpreting text, a relevant understanding was made within the context of the discussions in both the research report and the interviews. A comparison with other participants in elaborating and expanding on meanings was also made. Relevant literature and implications in addiction treatment were inferred. Further understandings of the concepts and meanings were made by linking them to established literature. To pay close attention to language and its context, the extracts were presented in the original language they were spoken in, and interpreted into English. The main principle in IPA is to adhere as closely as possible to the utterances of the participants. In interpreting extracts into English, a clear understanding of how I made sense of the expressions is included. Therefore, discussions illuminated how I made sense of evidence and how interpretations unfolded. For example, in presenting how participants initiated whoonga use, I chose to incrementally include factors that culminated in a story that took into consideration all the factors presented. In choosing to use original codes, my interpretation was an effort to stay as close as possible to original utterances. This seems the best way to evoke the context of the emotions and cognitions associated with meanings. I used my understanding of the language as a first-language speaker to make sense of these concepts. I further grounded those conceptions within an understanding of dominant literature and previous research findings.

This research study is based on an understanding that decontextualised approaches result in poor success of addiction treatment. Chapter Four was included to involve the understanding of whoonga addictions within the African and the township settings, where they manifest. Whoonga addictions are a unique South African phenomenon, as researchers have noted. In understanding them, this aspect should be filtered in, and this is the fundamental basis of this study. Parallels with *krokodil* are differences in pharmacological and symptomatic presentations of such heroin-variant substrates. Similarities are that they occur in a wave and among youth largely of impoverished communities. Otherwise, they occur in two disparate communities − one in Europe and the other in Africa. To ground an understanding of whoonga addiction within the context it presents itself is fundamental to understanding and curbing it. This is the major advantage of using IPA, the focus on the context that informs the manifestation of phenomena. The study is based on a presupposition that context-relevant solutions are to be sought in a fight against addictions, including whoonga addiction.

As an IPA project, the strength of this study lied upon providing rich and detailed portrayal of personal experience (Smith, 2011a). This study demonstrated sensitivity to context by showing awareness of the participants' perspectives and setting, the sociocultural and linguistic context of the research, and how these may influence both what participants say and how this is interpreted by the researcher (Yardley, 2017). This study accomplished this not by imposing pre-conceived categories on the data, but by carefully considering the meanings generated by the participants (Yardley, 2017).

5.7.7.2 Commitment and rigour

In presenting how data was collected and evidence of how interpretations were derived, this study demonstrated commitment and rigour. In this study, the focus on the idiographic, and the important component in IPA was achieved through the engagement with each individual case in detail. This was done in presenting findings, where convergences and divergences that highlighted both the particular element and commonalities among participants were delineated (Smith, 2011a). This study demonstrated according to Larkin et al. (2006), commitment to understand the participants' lifeworld.

The processes of data collection were delineated. This included the struggles that were presented to the researcher in the field, and how they were overcome. The processes of requesting clarifications, and using family members to confirm desistance, ensured not only triangulation of data sources; it further assured validity of findings. In presenting the findings, the study demonstrated an in-depth engagement with the topic, including thorough data collection (Yardley, 2017). Skills in the methods employed were detailed (Yardley, 2017); although novice, they adhered to the fundamentals of the methodology used. Themes were demonstrated by the appropriate use of extracts to make claims, referencing them as data to achieve transparency (Yardley, 2017). Commentary and analysis of findings were presented with a reflexive component (what I thought about the issue) and contextual detail (of extracts, participants, and the study). To make sense of findings, theories were used. Findings presented what was particular to or divergent among participants. This is a balance between what was particular to, the idiographic component and "what was shared" by participants (Larkin & Thompson, 2012).

5.7.7.3 Transparency and coherence

This research report demonstrated processes that the researcher went through from collecting data, transcriptions, interpretation and analysis, as well as writing up. The theoretical stance that drove the project was delineated, indicating the drive informing a concern with how

we can bring about solutions. I was able to transmit that these are concerns that touch my personal contribution and conviction as a member of the African family. It is a concern with bringing about ways that make sense of whoonga addiction as a predicament that is derailing the economic and social emancipation of Black South Africans. I find my drive in using available tools, and a determination to end whoonga use. In the study I tried to demonstrate processes that I went through in collecting data. In making sense of findings, the reader was taken through how themes manifested, guided by the research aims. It was inevitable that themes would be guided by the processes involved. Intrinsic to this study is that these processes from addiction to recovery are by nature linear and would be best presented in a linear fashion. This is an order that represents the evolutionary process of recovery, that must include addiction to whoonga.

5.7.7.4 Impact and importance

This research study interrogates whoonga addiction, seeking real life, relevant, and compelling solutions to this problem. This focus foregrounds whoonga addictions as an issue worthy of discussions, making this concern with the rampant increase of whoonga addictions visible. As part of efforts to curb whoonga addictions, a compelling argument for the use of alternative and "other" approaches is made. The study finds a complementary role, despite divergent aims to prevailing strategies under the harm-reduction measures. In that way, the study does not alienate addiction professionals in a call for the use of methods that would work to support long-term recovery. The study demonstrated how support assisted recovery, but importantly, how embracing recovery can develop into a movement that supports the initiation and maintenance of long-term recovery. Youth movements include support that is shaped in ways that support prevention. The guide that will inform youth development was suggested and was linked to participants' Africanness. It is not clear how a serious approach to ending or ameliorating whoonga addictions would ignore a support for such initiatives. These initiatives heed a multi-sectorial call with focuses on empowering available strengths and resources − the community. In looking for context-specific responses to drug addictions, this knowledge is important in informing deliberations over whoonga as the issue that awaits the approval of a formal strategy. Such deliberations may want to filter environmental factors that influence the rampant increase of whoonga addictions − poverty, youth unemployment, inter alia − in a drug prevention policy. The research study took place before the formal promulgation of strategies to curb whoonga addictions, and therefore would benefit deliberations. The study cautions against treating communities as patients and consumers, presenting solutions that are context-specific. The study included the context of whoonga addictions, the communities it affects, filtering in unemployment, socio-

economic depression and other conditions of the very context that formulated and makes township life; the context of whoonga addictions.

The focus on maintaining recovery, life after desistance suggests that collaborated efforts should be geared towards empowering the communities in ways that allow them to establish bonds. Recovery encourages innovative ways of engaging the community in dealing with drug addiction, presenting a welcoming environment and the atmosphere conducive to recovery. It is important to bolster prevention by seeking ways to insulate youth against experimenting with drug use. This study, its findings and recommendations will be difficult to ignore.

5.7.8 Fair subject selection

Fair subject selection is a principle that protects the exploitation of vulnerable groups (Emanuel et al., 2000). INK townships generally comprise impoverished and historically marginalised communities, people considered vulnerable. The sole criterion for selecting participants in this study was that they had to have had experience with whoonga addiction. These participants had abstained from its use and were in the process of recovering from it (corroborated by the family members and neighbours). In its aims, the study discriminated against whoonga addicts, choosing to interview those who are "in recovery". This is not considered an unfair discrimination. It is guided by the research needs. Recommendations in this study include the needs of those who are still addicted to whoonga, encouraging them to desist; giving them and the community hope that desistance is possible. The study addresses what addicts will need to do when they choose to desist. The basis of the findings are real situations of people who are in recovery.

5.8 Conclusion

Within a qualitative framework, this study made sense of addiction and recovery from whoonga as construed by people who were involved, related and understood under the context these phenomena occurred. IPA directs how studies using this methodology are conducted, though not prescriptive. This chapter presented why IPA was appropriate for the use in this study, the focus on bodily, emotive, cognitive and contextual experience with the phenomenon. The chapter presented ethical considerations required in studies investigating human experience. This further included the discussions on how the quality of the study was ensured.

CHAPTER SIX
FINDINGS: ADDICTION TO WHOONGA

6.1 Introduction

This chapter on findings explores what it was like for participants to be addicted to whoonga. These are descriptions of the developments of dedicated use of whoonga that include accompanying thoughts, feelings, and self-identity. This chapter begins with how whoonga use was initiated, to the state of *iphara* being realised. Participants' experiences with addiction to whoonga are discussed as third-order experiential meanings concerned with how participants made sense of their experiences as events that occurred in their daily lives. Guided by IPA, interpretations discuss meaning, cognition, affect, and action, in superordinate themes. Interpretation develops descriptions of the commonalities of these experiences, while interrogating differences and nuances in such experiences from particular, divergent, and idiographic experiences. Interpretation is a focus on making sense of pre-reflective understanding, to interpret and to explain findings, evidenced by direct extracts. Analysis will draw from my own conceptions of the subject matter or the issue, giving thick descriptions − reflecting on both the contexts of the extracts, and that of discussions during interviews, including established understanding from literature.

In presenting findings, the following section is a discussion of two superordinate themes: Becoming an *iphara,* − describing a process of becoming an addict − and being *iphara* − describing intricacies of dedicated whoonga use. These themes encapsulating addiction to whoonga show the use of whoonga as a progression from smoking cannabis and other softer drugs, particularly Mandrax. Whoonga was easily available in the community, and easily accessed by participants. The whoonga high was advertised and tested in the company of cannabis-smoking friends and peers who wanted to try whoonga. Others were offered whoonga by those who were already smoking it. Boredom was identified as the most influential pushing factor, and the pulling factor was associated with curiosity. Participants wanted to taste the drug, seeking novel experiences from the drug that was taking hold in townships at that time. In becoming addicts, participants took the drug on an occasional basis, realising when withdrawals had set in and criminality had ensued, that they "needed" whoonga to function, and were now becoming addicted. Addiction to whoonga is an undertaking characterised by essential ingestion, via smoking, i.e., in the mornings and in the afternoons, both to function and to sleep. However, as the addiction progresses, an increased number of hits or fixes is needed. Participants would binge on whoonga if it became available and plentiful, inadvertently increasing dosages and cementing the addiction. Since most

participants were unemployed, to obtain money for these fixes, *ukuphanta* or to hustle, involves largely stealing, although violent crime would not be excluded. Some participants were arrested. Most faced the threat of violence in which the community would retaliate; such would put their livelihoods and their families in danger. At the height of addiction, participants characteristically did not wash. In this *iphara* or junkie status they were not wanted, ostracised by the community, and to varying degrees, by their families. Whoonga addiction presents as a busy life. At different times, participants would leave their homes for lengthy periods, ranging from weeks to months, and for one participant, a year.

6.2 Themes

Themes discussed in this chapter draw from experiences that prompted whoonga use, an initial encounter with the drug. Themes will further include the intake of the drug as a turning point leading to a state of dedicated whoonga use. The second theme − being *iphara* − describes dedicated whoonga use, its basic and common elements as experienced by individual participants. Particular experiences associated with this development are revealed. Despite the popular use, the source of the word *iphara* remains unclear. However, it is firmly linked to the description of people who are addicted to whoonga. Media descriptions of the term have attached it to behaviour, personal appearance, and a sense of general disapproval of this state of being.

6.2.1 Becoming an iphara

Insight into how people become *amaphara* begins with how participants started smoking whoonga and progressed to what they considered an addicted state. This state was characterised by a constant need for a fix that had increased since initial ingestion; then occasional use that led to a state of dedicated use.

6.2.1.1 Experimenting with whoonga

For Sizwe, becoming a whoonga addict was propelled by boredom, and was facilitated by peers. Addiction began with Sizwe's suspension from a township school when he was in Grade 9. At school, Sizwe presented with conduct-related cases of truancy. To orientate the reader to the symbols used in verbatim extracts, Table 6.1 below describes them and provides examples.

Table 6.1

Transcriptions Symbols

Symbol	Meaning	Examples
[ ]	Words between these parentheses describe non-verbal communication during interviews, added by the author to transcripts.	[Demonstrating Head Banging]
SIZWE:	Name of the participant indicates the speaker of the utterances in extracts.	SIZWE: "You would find that I was bored. Friends would say, 'No, you must taste how this thing is like,' you see?"
...	Interjection or a pause in a speech will indicate breaks in the speech and pauses. It will appear before and after the speech that was removed.	MANDLA: "I know exactly that for other people, one would begin to smoke just for fun … pressured by their friends, pressure and stuff …"
" "	Quotations marks indicate verbatim extracts.	MANDLA: "I chose it because I was escaping from a lot of issues".
"... '...' ".	Like quotations marks above, will indicate the verbatim extract as well as quotation marks for direct quotations uttered by other people within the verbatim extracts.	MANDLA: "It is really hard to live a life like, no one believes in you no matter what you try to do because I can tell you … my neighbours … there was thing as I was growing up that; 'this one is rude', but not knowing what I was going through at home".
" " and *"... '...' "*.	Quotations marks (*italicised*) indicate verbatim extracts in isiZulu.	*"Uthole ukuthi nami ngiphothekile, bathi, 'hhayi, awuyizwe lento injani' "*.

Sizwe also admitted having not been doing well academically, and that he smoked cannabis. After a suspension hearing, he chose not to return to school, and stayed at home in the township. He did not inform his mother whom he lived with in a rented room, of this suspension. Left to his own devices in the township, with nothing to occupy him, Sizwe joined friends to smoke cannabis.

Extract 1:

SIZWE: *"Uthole ukuthi nami ngiphothekile, bathi, 'hhayi, awuyizwe lento injani', yabo?"*	SIZWE: "You would find that I was bored. Friends would say, 'No, you must taste how this thing is like,' you see?"

As he described in the extract (1), Sizwe attributed his initiation into whoonga to boredom, that he described as *ukuphotheka*. I find a close association with the meaning of to saunter. In this description, there is a sense that boredom was pervasive. Sizwe had decided to leave school: this would involve meandering about with nothing occupying him. He inhabited a back room in the

house his mother rented. On one hand, it was an escape from boredom that propelled Sizwe towards joining townships friends who were not employed, and were not going to any school, smoking cannabis with them. According to Sizwe, initiation into smoking whoonga was via an invitation by friends to experiment with a whoonga high. In relating this experience, Sizwe acknowledged that a chance to take whoonga resulted from seeking the company of these friends. The friends Sizwe joined were neither going to school nor employed and they smoked whoonga. Whoonga addiction therefore accelerated his outlier existence.

On the other hand, in a sequence of events leading to this encounter with whoonga, Sizwe had left a school that had provided structure, and something to do. In leaving school, he left structure and adult authority, opening his world to other possibilities. Sizwe presented with both behavioural and academic difficulties. It can also be contended that the school did not follow up. Sizwe fell through the proverbial cracks, and it is noteworthy that he could also have needed extra help with his academic work. Sizwe said that he was on his own during the day; it would be difficult for a youngster who remained home unsupervised. Since his mother was employed, she could not monitor his school attendance. As a single parent, his mother was involved in generating income for the family. In her working day, she left before Sizwe would have to go to school; and his mother returned after he should have returned from school. As a result, Sizwe's mother did not notice that Sizwe was no longer going to school. Sizwe did not confess to this; his mother discovered much later that he had long since left school as the year progressed. Away from the extended family members, living on their own in a rented house, there was no adult supervision for Sizwe by day.

Lunga confirmed that addiction to whoonga is driven by boredom. While for Sizwe this meant having nothing to do, for Lunga it was an act of seeking something novel or exciting to do. Lunga was still at school at a neighbouring township, outside his own township, and he began smoking whoonga with his cannabis-smoking friends because they wanted to taste whoonga.

Extract 2:

LUNGA: *"Yabo ukubhema, ngaba iaddict for mhlampe 3 years noma 2 years ngibhema ngiganga, ngilokhu ngibhema ngalelo langa ngiganga, kwaze kwahamba kwahamba kwagcina kwiyi-habit, kodwa nje ngaqala kanjalo. Wazi ukuthi, okay, mhlampe ngalelo langa uma ngizibhorekele simane sihlanganise sithenge, sihlale sibheme kwaba kanjalo, kanjalo, kanjalo".*	LUNGA: "You see, smoking (whoonga), I became an addict maybe 3 or 2 years after I had experimented with it. I would smoke it occasionally, just playing. As the time went on it became a habit, that is how I started. You would know that, okay, maybe on that day you are bored, and we put money together and buy. We would sit and smoke and that is how it became a habit".

Lunga described experimenting with whoonga and continuing to smoke it as *"ukuganga"*. This innocent, child-like pursuit of a drug was a reference to both the initial and the ensuing casual experimenting with whoonga. Although *ukuganga* describes behaviour that would include serious transgressions, given its use by other participants, the emphasis in this case is on characterising experimenting and initiating whoonga use as encouraged by child-like naiveté. Boys in the township would make mischief and commit petty wrongs.

Unlike Sizwe, Tshepo and Mondli were offered whoonga by friends who were already smoking whoonga. Lunga and Sipho, experimented while in a group of cannabis-smoking friends who were not smoking whoonga. As with Sizwe, Lunga and his friends at school and in the township were smoking cannabis, as with all the participants. However, unlike Sipho, when participants were experimenting with whoonga, they had already started sprinkling their cannabis joint with Mandrax. From this angle, initiation into whoonga use by a group of township boys involved boys who had smoked Mandrax. Thus, this experimenting would be searching for a different and maybe even a better high. Whoonga presented a different high, and its availability in the community initiated and propelled its use, through word of mouth.

For Tshepo, smoking whoonga was initiated by a promise of an enduring high. In his initial encounter with the drug, Tshepo joined a different group of neighbourhood boys. Like Sizwe, Tshepo joined them to smoke cannabis. These boys were smoking what he thought was cannabis; however, this was in fact "an exclusive joint" of cannabis. When Tshepo requested that the friends share the joint with him, these friends demanded that he paid. He was astounded by this response − a type of a joint that one had to pay for. In his experience with smoking cannabis among friends in the township, the joint was shared freely among cannabis smokers. In my reporting "boys" and "youngsters" will be my distant reference to what participants called "friends", and where the use of friends is not limited to a closed group, rather presented as fluid among boys in the township.

Extract 3:

TSHEPO: *"Shuthi ngelinye ilanga bagcine bengichazelile ukuthi, 'yazini yeka lento yakho oyidlayo, le esiyibhemayo iyaphuza ukuphela egazini".*	TSHEPO: "Then one day they explained to me that, 'You know what, stop smoking what you are taking, what we are smoking takes time to get out of your system".

The friends refused Tshepo the smoke at first, but as he mentioned in the extract, they eventually explained to him what the joint was. To Tshepo, whoonga was presented as a different drug, that, compared with the Mandrax Tshepo was already smoking, gave a better high that lasted longer.

Therefore, in trying whoonga for the first time, Tshepo was pursuing a lasting or an enduring high. Tshepo forms a group of participants whose first encounter with the drug was facilitated by joining a group of friends to smoke cannabis, only to find that they were smoking whoonga.

For some participants, for example Lunga and Sipho, the decision to experiment with whoonga was facilitated by the company of friends − a group of boys who were smoking cannabis, who wanted to experiment with whoonga. However, unlike Lunga, smoking whoonga for Sipho and his group was enabled by a third party. An elderly individual, a drug dealer facilitated this initiation into whoonga, by availing the drug. A returning convict sold whoonga upon discharge from prison to make a living. Sipho and his friends kept the company of this older male out of veneration of his convict status and to listen to prison stories. At different times, when this older male would go to buy bulk whoonga in town, Sipho and friends sold whoonga for him. He remunerated the youngsters by giving them two stashes to sell for themselves. As he mentioned in the extract, when they sold these stashes, they would keep the money. In experimenting with whoonga, Sipho and his friends started by smoking a bit of this share.

Extract 4:

SIPHO: *"Sidayise imali kube eyethu, lo obekowethu sathi akesi-test-e ngawo sike sizwe ngawo ukuthi injani lento le. Injani nje i-taste yayo mawuyibhema u-feel-a kanjani. Hhayi ngelinye ilanga sigange ngawoke lo-2 siwubheme; sizwe ukuthi hayi i-right iyashayana".*	SIPHO: "We sold some (whoonga) and the money was ours, we decided to test the stash that was a means to be our finding what this thing was like, how it tasted when you smoked it and how you would feel. Therefore, one day, we decided to smoke both stashes and we learnt that what we had been told was right − it gives a good high".

Sipho implied that they were driven by curiosity, but clearly this was because whoonga was also made available. This was described as a need to test whoonga, to find out what it tasted like, and how it made one feel. From initial experimenting with whoonga they learned, and as Sipho confirmed, whoonga *"iyashayana*", the high was authentic and highly pleasurable.

Both Sipho and Lunga experimented with whoonga within a group of friends who wanted to taste the drug. Unlike Sipho, where the drug was made available by a third party, Lunga and his friends went out to seek the drug. Lunga said that they had heard about whoonga and as boys, bored in the townships, went out to look for something exciting to do. This suggests that, unlike Sizwe who described being bored as lacking something to do, for Lunga and his friends being bored suggested that they lacked something exciting to do. But like Tshepo, Lunga and his friends were looking for a different or an exciting high with implications that, in suggesting that they were

bored, the cannabis high from cannabis the boys were already smoking no longer produced a desirable high. Both participants confessed that experimenting with whoonga was facilitated by being part of a group of friends, and they both described this phenomenon as *ukuganga*. This implies that experimenting with whoonga was that the boys were engaging in child-like behaviour, being "naughty" and taking a risk. While smoking whoonga was experimenting by a group of friends who wanted to try a different drug experience, the drug was readily available. At this stage in the township, it seems as though the drug had further proven to be a source of income for locals; selling the drug provided a source of living for a returning ex-prisoner.

On a commentary about a third party involved in assisting participant with the initiation of whoonga use, and where an elderly man availed whoonga to a participant and his friends, a sense of disapproval was communicated. As Sipho and his friends began to smoke their stashes, as opposed to selling them, Sipho described a situation when the dealer, who was also a smoker, noticed that the boys were smoking. In the dealer responding in nonchalant and encouraging ways, even though he was a smoker himself, Sipho repudiates and disapproves of such behaviour. Sipho passes a negative judgement on an older person who availed whoonga to youngsters. This means that, in many ways, as an older person relating his story of addiction to whoonga, Sipho finds fault that a person who is expected to guide and model exemplary behaviour by sheer virtue of being an adult, led the youngsters astray on this behaviour.

Extract 5:

SIPHO: *"Uma esibamba-ke lobhuti wakwamakhelwane avesane angabi nankinga. Sivele sibheme naye, cabanga. Asinike imali yokuthi sithi ...* [gesture to indicate smoking]*, sibuye, sobhema naye la endlini kulokhu-ke kuhamba kanjalo-ke, kuhamba kanjalo-ke kusa-right, uyabo? Kanti nabantu abakaboni ukuthi sesiyabhema".*	SIPHO: "When this brother from the neighbourhood caught us, he did not have a problem. We smoked with him together, think about it? He gave us money so that we can … [gesture to indicate smoking], and we would come back and smoke in his room with him, and that is how it went, and it went like that still all right, you see. And people had not noticed that we were smoking".

In the extract, Sipho related that the older man caught them smoking whoonga, and that he did not seem to care. Rather, he did not have a problem with it: they smoked together. This older man encouraged smoking, in that he would, when he had run out of stock, give the youngsters money to buy whoonga. The boys then returned to smoke with him in his room. In adding, "*cabanga*/think about it", he found it now to have been untoward and immoral that an elder would be indifferent, encouraging youngsters to smoke whoonga. The veneration of a man who provided fascinating

prison stories, and who had been "made" in jail – belonging to a gang, was repudiated by the older Sipho. At this early stage of smoking whoonga, Sipho related that the community had not yet discovered that they were smoking. However, as the addiction progressed, they ventured into new ways of acquiring money in different groups of friends who were smoking whoonga. Whoonga addiction was encouraged by a misguided individual, a role model to gang subculture.

While for Tshepo, whoonga was presented as an enduring high, for Mondli, it was touted as an aphrodisiac. In describing his initiation into whoonga, Mondli was persuaded by an experience of those who smoked whoonga. Mondli and his friends would visit them as a group of boys who enjoyed smoking cannabis together. These friends lived in their former family home, the parents having moved to a suburban house they had bought, taking the younger children with them. The older brother, one of these two siblings who were Mondli's friends smoked whoonga. He said that this friend and other whoonga smokers told him that whoonga improved their sexual performance. He wanted to try whoonga because he had suffered what he described to be premature ejaculation. It must be noted that Mondli, the youngest participant smoked whoonga at 14; and Mondli described himself before whoonga addiction as a *super dupa qubu*, a description that connotes that he regarded himself as a ladies' man. In the extract (6), Mondli offered that, as boys, this promise of excellent sexual performance whoonga brings emerged in their conversation about girls. Mondli vouched that whoonga ingestion enhanced his sexual prowess, at least at first when girls would still consider greeting him at all, not later, however, when they lectured him for letting himself go.

Extract 6:

MONDLI: *"Oh shuthi uma sixoxa nabo labafwethu, sihlezi sixoxa ngamantombazane ukuthi heyi kade engachami. Uyaphuza ukuchama; ngangena nje kanjalo. Mina nganginenkinga yokuthi uma ngilala nomuntu wesifazane ngiyashesha ukuchama; ngicasukiswa yileyonto ukuthi ngiyashesha ukuchama angisa-enjoy-".*	MONDLI: "Oh, when we chat to these guys, we always spoke about girls, saying that he did not come. It takes time for one to come, and that is how I began. I have a problem that when I was with a woman, I would come off quickly; and that irritated me that I would come quick and I am not enjoying".

In the extract (6), Mondli explained that their talk about girls led to discussions about premature ejaculation, a condition that annoyed him. This did not fit with his notion of being an impressive "stud". Mondli attributed his initiation into whoonga as driven by a need to prolong his sexual encounter. He emphasised this point, drawing from examples of people he said he knew, some older and professionals who would smoke whoonga for its aphrodisiacal properties. However, as

he described later in the interview, as a whoonga addict, he learnt that girls would admonish him for letting himself go. Despite giving him pain, he ignored these calls for him to quit whoonga. As Tshepo confirmed, while whoonga might have given him sexual prowess, as the addiction progressed, the chances of a sexual encounter were remote for an *iphara*.

Extract 7:

TSHEPO: *"Zona ezinjengalezo bengihlala naye kodwa ngingasenzi lutho, yabo leyonto, ukwazi kwakho sesihlala engathi manje sabandawonye, yabo leyonto?"*	TSHEPO: "Stuff like that, we stayed together, and we did nothing, can you see that, you keep it to yourself, we stayed together like we were siblings, can you see that?"

Tshepo reported being embarrassed to talk about his sex life as a whoonga addict. He found discussing it something to keep to himself. He said that he lived with his girlfriend without any sexual contact, a situation he equated to a relationship of siblings (Extract 7). At the height of addiction, a desire for a sexual encounter was derailed by an all-consuming nature of the dedicated use to whoonga. Nevertheless, Mondli admitted having enticed people he recruited to smoking whoonga, citing the aphrodisiac effect as the "benefit" of smoking whoonga.

It is important to note that Mondli was the fourth participant. The sexual issue had not arisen in the three previous interviews. Therefore, in clarifications I sought afterwards, I asked the three previous participants whether they had had this experience. I also asked the next two participants about their knowledge of this issue. Whoonga addiction as providing sexual adequacy was presented in the media at that time. All the participants had heard about these assertions; but only two related experiences that illuminated these claims.

To understand the idea of this "recruitment strategy", and perhaps even a ploy based on a myth, this section gives a brief overview of findings on this issue. Lunga believed that any drug, including alcohol, particularly whisky, would give one an urge for a sexual encounter. This means that such a reaction is not particular to whoonga. Tshepo maintains that, at initial stages, whoonga improves one's sexual performance. As the addiction progresses, however, sexual interaction becomes remote. Tshepo evidenced this by making an example of his love life. Despite living with his girlfriend, at the height of whoonga addiction, there was no sexual contact.

Mandla made a presentation that addiction to whoonga could be a solo effort that was not influenced by anyone. According to Mandla, the influence of peers in initiating whoonga use was not limited to handing the participant whoonga, as in the case with Sizwe, Mondli, and Tshepo who were initiated into whoonga use by joining a group of whoonga-smoking friends. Neither was it limited to Sipho and Lunga, who were with a group of friends who wanted to try whoonga.

Mandla reported to have sought whoonga himself. In the extract below (Extract 8), Mandla reported that he was not assisted in initiating whoonga use by peers or friends. He presented addiction to whoonga to have emanated from his own volition, a voluntary experimenting with a drug. He began by refuting claims that people would be forced to take whoonga. Mandla presented ownership an individual must take for his addiction to be able to recover. He further affirmed that addiction to whoonga, by all participants was not coerced.

Extract 8:

MANDLA: *"I won't lie and say khona umuntu owangidonsa ngenkani - it's something engayifuna ngayithola".*	MANDLA: "I won't lie and say someone pulled and forced it on me – it's something I looked for and I found it".

In the extract (8), located earlier in the interview, Mandla made a case for initiating whoonga use as a solo effort, mentioning that no one pulled him or forced him to smoke whoonga, rather, he looked for it, and found it. In looking for whoonga, he mentioned that he did not take it for fun as most people would do, refuting claims that he started smoking whoonga driven by seeking pleasure. On the contrary, as he insisted in the extracts (10 and 11), he was driven by difficult home situations.

Extract 9:

MANDLA: *"I know exactly ukuthi abanye abantu, uyayithatha omunye just for fun ... ehlohlwa abangani bakhe, pressure and stuff ...*"	MANDLA: "I know exactly that for other people, one would begin to smoke just for fun … pressured by their friends, pressure and stuff …"

In the extract (9), he found it to be a concession that people who get addicted to whoonga would smoke it to have fun, others succumbing to the influence of peers and peer pressure. In using the word "*ukuhlohla*", Mandla further adds an idea that this was group involvement and perhaps a childish and short-sighted thing to do. Other than arguing that, for him, there were other reasons for initiating smoking whoonga, he confirms that he was solely responsible for taking whoonga. Like Lunga, Mandla is confirming that smoking whoonga was a voluntary act that is not forced or imposed over a person. But unlike other participants, Mandla reported that his pursuit for whoonga was not intended to have fun, driven by pleasure seeking.

Extract 10:

MANDLA: *"Therefore, ngaliqala njengomuntu oli-test-ayo to escape izinto that was happening".*	MANDLA: "Therefore, I started it as someone who is testing it to escape things that were happening".

Mandla was self-driven. Mandla said that drug-taking was an escape for him, suggesting that it was the way he dealt with the difficult conditions he was experiencing (Extract 10).

Extract 11:

MANDLA: *"Ngayikhetha because I was escaping from izinto eziningi".*	MANDLA: "I chose it because I was escaping from a lot of issues".

For him, smoking whoonga was driven by grim personal and family-related concerns that he was trying to escape (Extract 11).

For Mandla, initiating whoonga use was a response to a sense of not belonging at home as well as a situation he described as difficult. Mandla reported that he chose to smoke whoonga to deal with animosity at home and emotional struggles that he said had been ongoing since childhood. Mandla had no relationship with his biological father, and had fallen out with some of his elder siblings.

Extract 12:

MANDLA: *"It's really hard to live a life like, no one believes in you no matter what you try to do because mina I can tell you ... my neighbours ... bekunalento yokuthi since ngikhula; 'uhlaza lo', but not knowing ukuthi what I'm going through ekhaya".*	MANDLA: "It is really hard to live a life like, no one believes in you no matter what you try to do because I can tell you … my neighbours … there was thing as I was growing up that; 'this one is rude', but not knowing what I was going through at home".

Mandla refused to connect with his biological father despite the insistence to do so by his mother. He said that he found his father to have neglected them as a family. He characterised his family as having many arguments, where he had had some confrontations with his elder brothers, who in his view were step-siblings. He connected with his biological sister. She and his mother were people who seemed to care about him. He mentioned that he had a relationship with his step-father who was in his life for some time, but also disappeared. Mandla described his home situation as difficult, an intimation of indigence.

Mandla presented reasons for initiating whoonga use that showed that drug addiction links to a difficult family situation, interpersonal difficulties, personality factors and difficult family

background characterised by squalid family conditions including poverty. Mandla said that it was difficult for him to find someone who believed in him. His father would not visit him even when he was arrested. Mandla also related to have presented with difficulty in managing interpersonal relationships that started when he was young. He claimed that his home situation accounts for his using whoonga. Mandla was described by his neighbours as rude (Extract 12). Mandla conceded that this description was a pattern since childhood: he presented as angry. He believes that neighbours did not know the difficulties he experienced at home. In seeking drugs and whoonga, in particular, Mandla was escaping difficulties at home but he was also presenting as a difficult child to deal with.

In attributing his initiation into whoonga use to his own efforts alone, Mandla refuses to blame friends for initiating him into whoonga. As discussed in a section on recovery, the main point Mandla wanted to make was that people who blame others for their initiation into whoonga deny their responsibility to recover; assuming a victim role. He believes that these people do not take responsibility for their addiction; and would, as a result, find it difficult to quit. In what he considered the "fear to commit" (extract 29, Chapter Seven), he later suggested that to recover meant that people had to take responsibility for their lives. However, in elaborating on the idea that he looked for and found the drug, the impression that it was his solo effort is confounded. He conceded, when he was reflecting on his whoonga addiction later, towards the end of the interview, that he took the drug because whoonga was available; but also, that he was in the company of people who were smoking whoonga. Although these people did not give whoonga to him, as in the case of the other participant, in indirect ways they advertised its high. It was touted as an enduring high for Tshepo, and an aphrodisiac for Mondli. Mandla affirmed that at this stage, whoonga was readily available in the township and it became increasingly known.

Extract 13:

MANDLA: *"So i-whoonga was easy target and ngihlala nabantu abayibhemayo, so ... until ngiyifuna nami, so yabanjaloke i-life ngaphuma".*	MANDLA: "Therefore, whoonga was an easy target and I stay with people who were smoking it, so … until I wanted to try it, so life was like that, I got out".

For Mandla, whoonga was a drug that he looked for and had known about and wanted to try. He said that it became an "easy target", implying that it could have been any other drug, but that whoonga was readily available, now being smoked by people he lived with. Reflecting on this contradiction on whoonga initiation as a solo effort, in the extract from reflections and conclusions

he made towards the end of the interview, Mandla mentioned that his peers and their influence were deeply involved in his drug addiction.

Extract 14:

MANDLA: *"I did that, nga-please-a ama-friends wami nga-moan-a; so I'm no more going to do that".*	MANDLA: "I did that, pleased my friends and I moaned, I so I am no more going to do that".

Mandla further implicated friends in relapses, where their influence made it difficult to recover. He said that his addiction life revolved around pleasing his friends. Mandla was remorseful about this, bemoaning lost opportunities (Extract 14). This highlighted reflection in explaining his relapses, including his criminal acts and conduct, was that they did so as a group of whoonga-smoking friends. At this stage, when participants smoked whoonga, there were fewer whoonga addicts, and its most visible effects had not yet become noteworthy. However, Lunga had noticed, even at that time, that whoonga rendered people as *amaphara*, a state he was loathe to enter. It could have been the fear of a need for constant fixes that signalled to him that whoonga was not worth the effort. However, it could have been fear induced by observing the effects of whoonga on those who were "hooked" – *abasebegxilile* (Extract 15 below). In the evolution of whoonga addictions, an increasing number of people who were getting hooked on whoonga helped propagate whoonga use in the townships.

6.2.1.2 Sinking into addiction – losing control

After experimenting with whoonga, participants found that the whoonga high was pleasurable. Participants described it as "*iyashayana*", a feeling that it was exhilarating, and a confirmation that it was a "better" high than that of Mandrax and cannabis. Participants abandoned smoking Mandrax after smoking whoonga. Only Mondli found "rock" to function as an alternative to off-set the whoonga high. Unlike other participants, Mondli could satiate from whoonga, when there were whoonga binges and the drugs were plentiful. From the initial encounter to the realization that he was unable to function without a drug, Lunga and his friends had continued smoking whoonga, enjoying its high. While he related to have been oblivious to the potential damage of their habit at first, signs and a concern of potential negative effects were lurking in the background, and signs were ignored.

Extract 15:

LUNGA: *"Ngilokhu-ke ngithi, 'hhayi ngizobhema …' ngilokhu nginganaki, uyabo? Ngithi, 'hhayi vele angigxilile kuyona' angithi bona babesebegxilile sebe-addicted, yabo?"*	LUNGA: "I was saying, 'I would just smoke …', I was not aware, you see? I was saying, 'no, I am not hooked on it' you see those that were already deeply hooked, and they were addicted, you see?"

In this extract above (15), Lunga reported to have continued whoonga use because, when he compared himself with those who were "deeply hooked", he was not yet there. He said that he ignored signs − *enganaki*, meaning that there was at the back of his mind a subtle warning that he ignored. The high was enticing, and in comparing it to possible danger, the sense that the high was enjoyable and might have driven continuous use is transmitted. Lunga believes that he was not yet addicted. At this stage, it was the pull of the drug that promoted its continuous use and further entrenched the drug use. The turning point happened when the reality of addiction struck. When Lunga learnt that, as this innocent pursuit continued, he found himself taking whoonga not to get a high but to avoid pain.

Extract 16:

LUNGA: *"Hmm… manje nami ngizitshela ukuthi mhlampe ngiyagula. Kuthiwe, 'hhayi yilento okade uyibhema; fanele uphinde uyibheme futhi ukuze izophela leyonto …"*	LUNGA: "Hmm… now, I was also telling myself that maybe I was ill. They said, no, it is what you were smoking; you must smoke it again so that what you are feeling will go away …"

In becoming an addict, Lunga learned that it was no longer a pursuit of a high he and his friends would occasionally seek, pitching in money among themselves to smoke together and to enjoy it. Now, it was the evasion of painful withdrawals that encouraged him to continue to smoke. Most participants linked withdrawals to a feeling of being sick, described within the meaning of the term of *ukugula*, evoking an idea that it could have been a condition similar to an illness or a health problem (Extract 16). Lunga's friends told him that this feeling of being sick was the effect of withdrawing from whoonga that could only be relieved or "cured" by a whoonga fix.

Extract 17:

SIZWE: *"Ngoba ngizamile ukuthi ngiyiyeke, ngagula, kwaphoqa ukuthi ngibuyele kuyona".*	SIZWE: "Because I tried to stop, I got sick, and it was forcing for me to go back to whoonga".

In the extract (17), Sizwe further related, it was this feeling that caused relapses. At the early stages, when he realised that he was "ill", suggesting that he was now getting addicted, he tried to stop. He was unable to stop, a feeling that he felt helpless against withdrawals and the drug; he said that he felt he was "forced" to return to smoking whoonga. Now a victim to the drug, and under its spell, he was about to unleash havoc on the family and the community, stealing from them to obtain the next fix. This was not a loss of control over whoonga: this was a loss of control of his inhibitions. Lunga would commit criminal acts knowingly, to gain the next fix. The subsequent effects of the drug and its pursuit began, with devastating effects on his body.

Perhaps in a dramatic way, Mondli gave a vivid description of this transition to addiction enforced by withdrawals. Mondli, like Lunga and his friends, started by smoking whoonga casually, enjoying the high. In the extract, Mondli says that he started by "stealing" it, meaning that it was secretive, and before participants were hooked, there was clear understanding that in many ways, smoking whoonga was a violation of some sort.

Extract 18:

MONDLI: *"Silokhu siqala ngokuyitshontsha sibheme sibuye siyiyeke sithi hhayi ngeke sisoze siqaleke, sibheme sibuye siyiyeke, sagcina siqaleka-ke sesiyibhema. Suxakeka ukuthi ebusuku ungalali, uma muthi uthi hhayi othi ngingayibhemi namhlanje, uma uthi uyalala eyi akulaleki uyaphenduka. Awukakayiqalekeli kakhulu ngoba nawe awukakwazi ukuthi kwenzakalani, kodwa nje usuke uthi: 'why ngingayitholi i-position yokulala?' Ngiyapaquza, ngiyaqhwisha embhedeni uthole ukuthi ngathi ngingazilahla, uqwishe, uqwishe, uqwishe; uma ubhema ngakusasa ulalisa okwengane encane".*	MONDLI: "We started by smoking by stealing casual moments to smoke and we would stop, thinking that we would never get cravings. We would smoke and stop, and we ended up having cravings. Now you would be confused that you are unable to sleep at night. When you had decided that you are not going to smoke on that day: you wanted to sleep, but you are unable to sleep; you keep tossing and turning. At this stage, you are not yet craving for whoonga deeply. You do not know what is happening, and you ask yourself, 'Why am I not able to find a comfortable position to sleep?' You are tossing and turning, kicking and kicking in bed, and you get the feeling of throwing yourself, kicking, and kicking and kicking; but when you smoke again the next day, you would sleep like a baby".

In the extract (18), Mondli explained that he started smoking whoonga by "stealing" whoonga; this means that he did not want people to know about it. Like Lunga, the progression to the experience of withdrawals began with a continuous use of the drug, driven largely by the enjoyment of these initial highs. In his mind, he also thought that he was not going to have

cravings. At night he found that he was unable to sleep without smoking whoonga, not knowing about cravings at this stage.

Mondli explained that, at that time, cravings, as he got to know them afterwards, had not set in. An inability to sleep, however, came first. He found that he was unable to find a comfortable position to sleep in bed. Mondli would be restless, twisting and turning, kicking and wishing to throw himself on the floor. Perhaps similar to the feelings of disjointedness described by Tshepo, this was an uncomfortable experience that only whoonga could cure. Mondli mentioned that, the following day, when he smoked, he would "sleep like a baby". For Mondli, the realization that addiction had set in started with insomnia, accompanied by restlessness and discomfort. Now, the drug was no longer a casual enterprise: the addition was entrenched, it began to be painful. I make a contention that the broader view of whoonga addiction life, the scarcity of the drug and the increasing needs for highs as the drug addiction progresses, compels constant hustling for it. This seems to characterise addiction lives in dominant ways, that perhaps, this is the stage where enjoying the drug at all, might possibly end.

When participants realised that they had become addicted to whoonga, they wanted to stop taking the drug, but found that withdrawals had set in. The addict identity that had ensued was rooting itself. Reflecting on this progression, Lunga found that an innocent, pleasurable engagement had led to an addiction that was difficult to reverse. In the extract (19) below, Lunga related that he could no longer smoke as casually as he had once done. He had thought that he was in control, and could stop whenever he wished, unlike those he saw to have been already "addicted".

Extract 19:

LUNGA: *"Ngaqala ngokuganga ngagcine… ngithi ngiyayeka ngingasakwazi uku-maintain-a, ngashawa ama-withdrawal symptoms, ay emumva kwalokho kwahlukana. Yah ukwiqala lokho, kwakuyinto ekanjalo nje…"*	LUNGA: "I started by playing and I ended … I was trying to stop but I could not keep up. I was hit by withdrawal symptoms, ay after that everything became disjointed. Yah, that is how I restarted, it was something like that …"

In a summary of this transition, Lunga discovered that when withdrawals had set in, he was hooked (Extract 19). These feelings are described as "disjointedness" (*ukwahlukana*). Unlike Tshepo, who confined such a feeling to bodily joints, to describe an overall feeling of withdrawal from whoonga, Lunga generalised such a feeling to the experience of life as a druggie. Symbolically, this was an overall tribute to a chaotic life that smoking whoonga had initiated, and as a turning

point, that they had now entered. Lunga seemed to relate this to the overall description of loss of control over a drug; life going haywire.

6.2.1.3 *Ukuphanta* as criminality

After ingesting whoonga, the complete manifestation of whoonga addiction characterising the most outstanding factor in whoonga addiction careers is an indictment to criminality. Whoonga identity is tied to stealing and involvement in criminal behaviour to obtain the next fix. After tasting whoonga, participants discovered that they wanted more of the drug. At this stage, for Sizwe, friends who initiated him to the drug by offering him a taste told him in no uncertain terms that he needed to find his own whoonga. Sizwe found that smoking whoonga involves not only needing more of the drug, which meant that he had to find more of it − it also meant finding a means of obtaining money for the next fix.

Extract 20:

SIZWE: *"Angithi lento iyaphantelwa? Imali, ukuze ukwazi ukubhema, fanele uhambe uyophanta phela. Ngoba baqale bakunike mahhala, yabo?"*	SIZWE: "You know that you have to hustle for this thing? Money, so that you can smoke, you must go and hustle for it. Because initially, they will give it to you for free, you see?"

In the extract (20), Sizwe described that whoonga addiction involved hustling that he termed *ukuphanta* (to punt). While the term seems to originate from gambling in horse-racing, in this context, it refers to efforts and means of making money for the next whoonga fix. In some ways, it is a perversion of a virtue that promotes self-efficacy, the tendency to "lift oneself by own bootstraps", that is dearly prized in such a township environment. In similar situations this is the virtue of making something of oneself and rising above the often dismal existence in the township. Such an encouragement can also include taking such a rise at all costs. It can therefore be used to justify criminal tendencies, for example, selling whoonga.

For Sizwe, the friends he said initiated him into whoonga use, refused him the next fix that he now desperately needed. They were no longer providing for him, and they had informed him that he needed to find his own whoonga. For him, this meant that addiction started with what he referred to as "flops", that he committed in the community.

Extract 21:

SIZWE: *"Uqale-ke ama-flop yabo la elokishini, uqale uma uya ezitolo u-shoplift-e, ukuze sithole phela imali yabo ngoba umuntu akasebenzi, yabo leyonto?"*	SIZWE: "Now you are to start to commit flops in the township, you see, you begin to shoplift from shops, so that we can get money, you see, because one is unemployed, you can see that?"

"Flops" derives meaning from "conspicuous acts" of misdeeds, transgressions including unacceptable and untoward behaviour, mostly criminal. The word gives a sense of disapproval of own behaviour as a whoonga addict, a kind of a failure to maintain an upright behaviour, linking to an inability to lead an upright and acceptable life. Unemployed, Sizwe did not have an income to maintain this habit. Unable to stop taking whoonga, Sizwe had to find a means of making money. This was giving in to the control of whoonga: criminality started by his shoplifting in nearby malls. For Sizwe, as he related in the extract (22) below, the signal that he was now addicted was the criminal acts he committed to obtain the next fix. Sizwe mentioned that he was not discriminate, becoming troublesome in the township.

Extract 22:

SIZWE: *"Ngangena kanjalo-ke; ngaqala nami ngahlupha elokishini, kungasayekeki, yabo?"*	SIZWE: "That is how I got addicted, I started being troublesome in the township, I cannot stop, you see?"

The commission of flops did not end in malls − it involved stealing from the neighbours and the community in his township (Extract 22). For Sizwe, whoonga addiction further included unruly behaviour. He was rude to his own family whenever they could not provide money for him. He would use unacceptable language, screaming and damning them whenever he could not hustle. Sizwe was forced to resort to his family for "assistance".

When addiction had set in, participants stole from their families, and this led to a variety of confrontations. As with Sizwe, Sipho's addiction life became unacceptable to him when he started stealing everything in his household that was portable. This led to the family sanctioning him from entering the main house.

Extract 23:

SIPHO: *"Nasekhaya sebeyaqala sebeyabona ukuthi 'hhayibo nangumuntu bo' ekhaya mhlampe usutshontshe imali. Ngaqala ngatshontsha-ke izimali kowallet lapho, ngatshontsha ama-phone ekhaya, ama-ring oSisi bami, ama-chain ubucwebe nje, amacici. Ngintshontsha nje yonkinto ethathekayo ama-hairdryer, ... ngithathe ngihambe ngiyodayisa".*	SIPHO: "Even at home, they could see now that 'no this person, no', maybe I had stolen money. I started stealing money from wallets, I stole cellphones at home, my sister's ring, jewellery, earrings. I stole everything, whatever could be stolen (portable) like hairdryers, … I would take items and sell them".

In the extract (23), Sipho mentioned that these were cellphones, earrings, and hairdryers that he stole from his siblings with the intention of selling them for money for the next whoonga fix. The need for the next fix, now compelling, stealing started within his household. For Sipho, stealing from the family happened after he had sold his own valuables, his clothes, shoes, cellphone, etc. He related that he was left with tattered clothes on his back. Now that the family was being vigilant whenever he was around, stealing progressed to the neighbours and the community.

For Mandla, his addiction could be managed at first. When he described how he was indiscriminate in his criminality, Mandla said that such had intensified when he completed matric and he was not receiving a fare to travel to school. Therefore, the source of money for buying whoonga had vanished; it became difficult for him to smoke whoonga.

Extract 24:

MANDLA: *"So yayisi-challenge-a manje ukuthi (ngibheme) I must go and find ... doing that kwakuba ukuganga emphakathini sishise unyazi siyogqekeza khona senze zonke lezozinto. Ekugcineni, into esasiyifuna uku-satisfy-a i-craving esasinayo at that time, so saqhubeka-ke ukwenza lokho, siganga emphakathini".*	MANDLA: "Therefore, it was a challenge now (to smoke) I must go and find … doing that meant being trouble to the community, being quick like lightning we would commit burglaries in the community and do all those things. At the end, what we wanted was to satisfy the craving we had at that time, so we continued causing trouble in the community".

In the extract (24), Mandla mentioned that he then moved to stealing from the community. Among crimes he committed as means of obtaining money for the next fix, were house-breakings, that he described as "*ukuganga*". Mandla described his criminal activities as "*ukushisa unyazi*" − directly translated, meaning to "hit the lightning". This is a reference to the speed at which the addicts carried out their stealing, mainly break-ins and entry, to avoid detection. Being quick is an

enduring characteristic of whoonga addicts, prompting a possible reference to their name *iphara* to emanate from parallels drawn with the speed at which "paramedics" move.

But it also means that they were indiscriminate in their criminal acts, giving the impression that they did whatever it took to get the next fix. Although the imagery of lightning may reflect a violent streak, it is not a main feature, although it is not excluded. Muggings, by their nature, involve the use of violence, when taking belongings from a person by force. Both Mandla and Tshepo acknowledged their use of this violent way. Both were arrested twice for such criminal acts.

Only Tshepo was employed when he began to smoke whoonga. When he noticed that he was hooked, whoonga being deeply ingrained into his system, he tried to stop, became ill, and was forced to return to its use again.

Extract 25:

TSHEPO: *"Sengiyibhema, ithe isingingene kahle nje, sengiyibhema ngisho emsebenzini-ke manje. Sengiyiphatha ngisho emsebenzini la ekade ngisebenza khona".*	TSHEPO: "When I was now smoking, and when it had become a habit, I began smoking it even at work now. I will bring it even at work where I was employed".

As the cravings continued, and it was now settled that he was a whoonga addict, as a turning point, Tshepo started bringing whoonga to work. Before, he was able to spend the whole day at work without smoking whoonga (Extract 25). When he could not bring whoonga to work, there were some dealers close to the gate at work. This means that, at first, Tshepo could maintain some semblance of normal functioning without constant whoonga fixes. However, later on, Tshepo learned that he needed whoonga to function. At this stage, people around Tshepo began to notice his change of behaviour. Tshepo began to distance himself from colleagues at work. He was no longer spending lunch time with them. He kept his distance to smoke on his own − he avoided any form of detection that could result in them knowing about his addiction. Other than shame, he was also worried that his employer would discover his addiction.

In becoming a whoonga addict, for Sizwe, dabbling with whoonga always leads to addiction. For him, addiction will force you to commit unsavoury criminal acts, and the community will disavow and disrespect you.

Extract 26:

SIZWE: *"Hhayi ngingasho ukuthi hheyi iwhoonga yona uyayibhema yona uyibheme. Ekugcineni, uyathanda, awuthandi, uzogcina usuwenza amacala la elokishini abantu bengasakuhloniphi…"*	SIZWE: "No, I can say that hey you can smoke whoonga and you smoke it. At the end, you may like it or not, you will end up committing crimes in the township and people will disrespect you…"

In the extract (26) above, Sizwe sums it up that experimenting with whoonga could be enjoyable at first. However, should you continue, you are bound to commit criminal acts to feed your habit. For Sizwe, such always ends with the community disrespecting you. The realization, for participants, that their addiction to whoonga had become irreversible, came with losing control over its intake. Taking whoonga requires regular fixes. As the addiction progresses, more fixes are required. Such, for Sizwe, became the issue of acquiring money for the next fix, leading to criminal behaviour and disavowal by family and the community.

6.2.2 Being amaphara

To be an *iphara* (pl. *amaphara*), a state of dedicated whoonga use, involves a preoccupation with and a commitment to smoking the drug, that revolves around the acquisition of money to get the next fix. The sole aim is to smoke whoonga, and to continue to smoke it in bouts of binge-smoking. For Tshepo, becoming an *iphara* began when he returned from work and went straight to the smoking "den", a place where he smoked whoonga with his friends.

6.2.2.1 Abandoning care for oneself and others

Home became a pit stop to work; like Lunga, Tshepo returned in the early hours of the morning to sleep, and to wake up to go back to work. He would have been smoking whoonga the rest of the night with his friends. This means that he was no longer interacting with his family as their member, and he got to see his uncle only at work. This uncle had found him work where he was also employed. Before whoonga, Tshepo would drink with him after work at home. Tshepo preferred whoonga to alcohol. Smoking whoonga meant that he was spending less time with the uncle, and he preferred whoonga over alcohol. Two major signs that he was slipping towards an *iphara*, was that he started eating less, and his personal hygiene began to deteriorate. Tshepo mentioned that he was no longer having dinners or even breakfast at home. Tshepo began to wash only his face when he went to work.

Extract 27:

TSHEPO: *"Uma ngiqala i-whoonga, ngibuya emsebenzini ngingasehli ekhaya ngo-6 ntambama. Angisehli esitobhini sasekhaya, ngehla ngala engizoyithola ngakhona, ngifika ekhaya ebusuku ngifika sengizolala. Ekuseni ngiyavuka ngiya emsebenzini, kushuthi kade ngibhema ebusuku kwaze kwayoshaya o-12, o-1. Angisadli endlini, ngivuka ekuseni ngisule ubuso ngiye emsebenzini".*	TSHEPO: "When I started whoonga, I would come back from work and not get off at my home stop at about 6.00pm. I am no longer getting off at the home taxi stop, I am getting off where I am going to score, I will arrive at home at night just to get to bed to sleep. In the morning I would wake up and go to work, that means that I have been smoking at night till 12, or 1 am. I am not having breakfast or supper, I would wake up in the morning, wash my face and go to work".

In the extract (27), Tshepo mentioned that home became a pit stop en route to work. Tshepo returned in the early hours of the morning to sleep, to wake up, to go back to work. Two major signs that he was slipping towards becoming an *iphara*, was that Tshepo started eating less; and his personal hygiene began to deteriorate. This partial washing of his body presented as the beginning of being *iphara*. It was prompted, as participants will later explain, by a preoccupation with the drug that included being busy hustling for whoonga.

Lunga did not want his family to know that he was a whoonga smoker. In hiding such, Lunga reported to have tried to behave normally. However, a give-away that he was a whoonga smoker were the friends he was seen with; these friends were also not washing. Lunga related that, at his home, his mother was strict, raising them to wash before they slept (Extract 28).

Extract 28:

LUNGA: *"Eyi ekhaya ku-strict, yabo ekhaya, ngiyolala ngingagezile, ngifika njalo nje sengiqondile. Uthole ukuthi the day ebusuku mhlampe ngihambile ngibuya nemali, ngifike ngigeze ngiyishiye".*	LUNGA: "Ey, they are strict at home, you see at home, sleeping without washing, I would always come behaved. You will find that on a day when I returned at night and I had brought some money, I would wash and leave some money".

Therefore, to appear normal, as a whoonga addict, he would wake up in the morning, and, like Tshepo, wash his face before leaving. He did not want to be detected as dirty; that would have meant that he was a whoonga smoker, an identity he tried hard to deny. Lunga also abandoned his chores. From a family whose mother prioritised cleanliness of her children, including bathing, the pressure to be clean worked against Lunga's state as a whoonga addict. To be clean was associated with being well-disciplined, according to Lunga, who described coming home clean as

"*ukuqonda*", doing things right, and behaving in an acceptable way. As a whoonga addict, however, this was not sustainable. Lunga would go for some days without washing, while out there hustling. Lunga conceded that washing or taking a bath, as a whoonga addict, was a problem. However, from the emergence of this behaviour in conditions where participants were not yet busy, as in the case with Tshepo, he was still employed when not taking a full bath began. Perhaps not taking a bath is an intrinsic characteristic of addiction to heroin, a part of being a junkie derived from effects of the drug. The general conception from media reports and the community was that intrinsic in the whoonga addict was that addiction repelled water.

Extract 29:

LUNGA: *"(E)sokugeza, hhayi ukuthi khona into eyinkinga ngamanzi, hhayi awanayo inkinga amanzi".*	LUNGA: "Time to wash, not that there is a problem with water, there is no problem with water".

For Lunga, such an explanation would be insufficient; he claimed that not taking a bath and appearing dirty was a result of hustling (Extract 29 and 30). In the course of his addiction career, Sizwe confirmed Lunga's position in reporting that he washed only occasionally, and would at times go two or three days without washing. Participants propose the idea that not washing was related to spending most of their time hustling. From a distant reflection by Sizwe in the extract above, Sizwe confirmed that the signature characteristic of an *iphara* is being dirty.

Extract 30:

SIZWE: *"Mhlampe ukuba addicted kakhulu isikhathi awusitholi, uyahamba uyobhema. Angithi phela awusaceli sekufanele uhambe uyoziphantela, ngiyoze ngigeze ngalesosikhathi, bekuphela ngisho u-2 days 3 days. Abanyeke nje hayi abayingeni indaba yokugeza…"*	SIZWE: "Maybe when you are deeply addicted, you will not find time, you would go and smoke. You are now no longer pleading for smokes: you have to go and hustle for yourself. You will bath at that time: you will go 2 or 3 days without taking a bath. Others, no, they are just not interested in washing …"

He said that he would go for days without washing. Sizwe related to this in connection to being busy hustling. In the extract (31) below, other than causing chaos in the community, Sizwe reflected that, when he had stopped taking whoonga, he realised that part of being an *iphara* includes being dirty. When he saw another *iphara* like him, a laughing-stock of the community, the person was an *iphara* because he was dirty (*ungcolile*), characterised by dirty heels.

Extract 31:

SIZWE: *"Kodwa mase uyekile kuhambe kuhambe ubone ukuthi, 'hheyi ama-flop engiwashayile, akanje kanje'. Uyabona uma kudlula elinye iphara, mhlampe bamuhleka ukuthi ungcolile amaqakala anjani!"*	SIZWE: "But, when you have stopped, as the time went on, you could see that, 'hey I am causing flops, which are like this and like that.' You would see another *iphara*, maybe they are laughing at him that he is dirty, and you can look at the ankles!"

Heels and ankles relate to the hind part of the foot and the heel adjoining the lower limb, an anatomical or physiological area. In locating the whole characterization of not being clean to dirty heels, as the most noteworthy effect of being a whoonga addict, this relates to the original characterization in an isiZulu proverb, *ukushaya ingqakala*. This means bathing, that involves the whole body, and not necessarily the heels. It explains why heels would characterise being dirty.

However, what Sizwe was also saying was that, as a whoonga addict, his appearing dirty was not the main preoccupation. It perturbed Sizwe that *amaphara* were a laughingstock. He noticed when he had stopped taking whoonga that this constituted part of the *iphara* state-of-being. He imagined that they had laughed at him when he was an *iphara* too. Sizwe reflected that, to him, such constituted disrespect. Although Sizwe reflected that it was deserved, it was however, no less humiliating to him. Being filthy, as a whoonga addict, involves being a laughingstock to community members.

Sipho, who would go for three weeks without washing, said that his hands and the soles of his feet would be so dirty they would turn black. This confirms the most pervasive portrayal of whoonga addicts in the minds of the public. However, Sipho referred to *izithende*, heels of the feet, as opposed to ankles: Sizwe used heels to convey the same idea. In this extract (32), Sipho had been away from home for a long time. This accounts for why he did not have a place to take a bath. Other than facilities, he also did not have toiletries for bathing. Now being an *iphara*, he was afraid to go home. He was living with a friend who, like him, a whoonga addict, was also not washing. Sipho would go for weeks without washing. In reflecting on such, Sipho attributed this, like Sizwe, to not having time; however, he added that, even had he had time, he did not have facilities to take a bath.

Extract 32:

SIPHO: *"Izandla sezimnyama, izithende sezimnyama, anginayo into yokugqoka mina. Angisahlali ekhaya, amanzi nje yinto engingasayazi, kuphela o-3 weeks. Ngizogezaphi? Ngigeze ngani? Kanjani? Ngiyasaba ukuya ekhaya, ngihlala nomngani wami naye akagezi siyazifanela nje".*	SIPHO: "My hands are black, the heels are black, I do not even have clothes to wear. I am no longer staying at home, and bathing (water) is something I have not had, shunning water, for 3 weeks. Where am I going to take a bath? What am I going to use to bath? How? I am scared to go back home, I am staying with my friend and he is also not bathing, we are just the same".

At this time, Sipho was not living at home: he did not have facilities to take a bath, having sold most of his belongings. The idea of not washing was also encouraged by the friend he was living with, also a whoonga addict: this friend did not wash (Extract 32).

Extract 33:

SIPHO: *"Sengisholo nje ukuthi mekuthiwa ngiyageza manje angazi ngizoshintsha ngigqokeni, anginalutho sengadayisa yonkinto".*	SIPHO: "I was just saying that even if I wanted to wash, I am washing now, I do not know what I am going to wear after I have bathed, I have nothing, I have sold everything".

In a hypothetical case, in which Sipho would have considered washing, he did not have fresh clothes to change into, now that he had sold all his personal belongings (Extract 33). Lunga adds that his appearance changed when he became a whoonga addict. Lunga's skin complexion darkened; and he said that he looked different. Unlike not finding time or not having facilities to wash, Lunga thought that his appearance had changed because he was always exposed to the sun.

Extract 34:

LUNGA: *"I-complexion yami nje ukuthi okay yabo, ngashintsha ngahluka. Kwaba nalento ekhombisayo ukuthi yabo manje, noma uhleli elangeni, noma ubhema uhlezi uselangeni uyasha. Ibala lakho lishintshe kuba izinto ezikanjalo…"*	LUNGA: "My complexion just that okay, you see, I changed and I was different. There is thing that shows that you see now, even when you are in the sun, even when you are smoking you are in the sun, getting burnt. Even your colour changes, it's things like those …"

Other than feet and hands that were darker, Lunga introduced exposure to the sun as contributing to the darkening of the skin and his consequent different appearance. Hustling and acquiring scrap metal exposed participants to the elements. The look was unmistakably dirty, dark, and dishevelled; a characteristic that Mondli finds a tell-tale sign of being a whoonga addict. However,

Mondli, reported to have found sleeping after taking a bath pleasant and enjoyable. But he mentioned that, in the morning, while he was still living at home, he could not bath before he smoked. Before he left home, he was able to bath, and to mask his whoonga smoking. While he thought that he could escape detention by keeping clean, he could not escape it. He found that his behaviour gave him away as a whoonga addict.

6.2.2.2 Preoccupation with smoking whoonga

As a whoonga addict, the preoccupation with the drug comes before eating and bathing. For Mondli, taking a bath would be considered after the acquisition of a morning smoke. Both these morning and afternoon smokes were essential smokes that an addict would "need". In the evolution of dedicated whoonga use one of the most enforcing processes marking an ascension to dependence and tolerance, involves the idea of a compelling need to smoke whoonga in the mornings and in the evenings. This process, as elaborated on later, marks the beginning of a state where participants realised losing control over their drug intake. The stage encourages bingeing, where chasing the dragon presents an idea that participants would be forced to smoke more of a drug to find that initial high. The "need" for whoonga signals a stage where drug progression is enforced by avoiding pain than chasing the high. In understanding this phenomenon, one has the feeling that this is when whoonga addiction ceases to be an enjoyment and begins to become a life of pain and anxiety for the next high. It makes sense that individuals would be in perpetual motion, busy seeking whoonga.

Extract 35:

MONDLI: "*Kodwa nje zashaya izikhathi zasekuseni lapho angikaze ngidle; zashaya ezasemini, hhayi u-arosta uyangibulala-ke manje; ngiyajuluka, ngiyanuka. Lapho-ke mina ngangingagezi ngingakaqaqi; ukugeza bengingenayo inkinga because even mangihlala la ekhaya. Babengangiboni ngokugeza ukuthi, 'hhayi, useyabhema' ngoba ngangikwazi ukugeza… Babengibona nje ngendlela esenza ngayo izinto ukuthi, 'hhayi useyabhema'; ngibuya ebusuku kakhulu, mhlampe ngingadli".*	MONDLI: "But, when morning came, and I have not eaten; and noon came, no, *arosta* is killing me now, I am sweating, I stink. By then, I cannot even wash when I have not had my morning smoke. I did not have a problem with washing because even when I was still staying here at home, they could not see that since I was not taking a bath that, 'no this one is now smoking' because I could wash … They only detected the way I was behaving and how I did things that, 'no, this one is now smoking'; coming back late at night, and sometimes not eating".

As Mondli mentioned in the above extract (35), the afternoon smoke allows an individual to sleep comfortably. Known as *ukuqaqa*, this means to release or to unfasten. The morning smoke is essential for whoonga addicts to be able to function. When he could not obtain his morning smoke, withdrawals, which he called *arosta*, would be intense; Mondli would remain dirty and smelling bad, but he would not wash before he smoked. Participants gave the impression that this morning smoke presented withdrawals that increased in intensity as the whoonga addiction progressed. However, whoonga addicts do not need whoonga only for this morning fix. They would also need it as often as possible. At the height of addiction, the preoccupation is so intense that it leaves no time to bath, even after an addict has had his morning fix. Obtaining a fix meant being free to function, and such requires one to hustle for more whoonga.

However, most participants, including Mondli, also found that, at the height of addiction, the need to smoke became insatiable. Other than a need to have the morning and the afternoon fixes, Mondli was preoccupied with the next fix even before the current one had waned. In describing this compulsion, Lunga thought that money and whoonga were the primary preoccupations in his life as a whoonga addict. Expressing this preoccupation with whoonga, Tshepo concluded that whoonga was a jealous drug. When communicating about his whoonga addiction, Tshepo described this to his mother-in-law as "*isilingo*", a vexation. As with most participants, Tshepo was expressing the intensity of his preoccupation with the drug. The drug was not letting go, such that, even after smoking whoonga, participants would be thinking about hustling for the next fix. In the extract (36) below, Lunga posits that whoonga addiction is a preoccupation with money and the next fix. For Lunga, this emerging burden whoonga was becoming made him consider stopping at a stage when the pull, manifesting with physical withdrawals, was intense. Craving for whoonga is the most burdensome feature in whoonga addiction.

Extract 36:

LUNGA: *"Ukubhema, ayikho into oyicabangayo, njalo imali ayikho enyinto iyona kuphela empilweni, ayikho enyinto, imali, ukubhema, imali, ukubhema. Ngoba wawuze ubone, hhayi ukuthi ngeke ugxile kuthina…"*	LUNGA: "Smoking, there is nothing else you are thinking about, money is scarce and that is most important thing in life, nothing else, money, smoking, money, smoking. Because you could see, no this is not going to be intense …"

This concern with the next fix comprised the avoidance of withdrawals in the morning and the afternoon. The preoccupation was with the next fix, even while smoking, as the addiction

intensified: washing became secondary. For Mandla, addicts forget to eat, they are so busy hustling and smoking. In the extract (37) below, Mandla found that they would also not sleep. In the cover of darkness, at night, they would steal scrap metal. They would then sell it to scrap yards. This spared the day for smoking. It also spared them from detection and the prying eyes of the community. Even when they were selling scrap metal, they had to steal it, and whatever else they could find when the opportunity arose.

Extract 37:

MANDLA: *"Singalali sihambe siyozitshontsha izinsimbi, sizisa la ezidayiswa khona and during the day siyabhema because iyona into eyayibalulekile, sasize sikhohlwe yinawukudla ngoba iyona into eyayibalulekile to satisfy that need".*	MANDLA: "We would not sleep. We would go and steal junk metal, take it where it was sold, and during the day, we smoked. That was the most important thing; we even forgot to eat because the most important thing was to satisfy that need".

Acquiring and selling scrap metal, among other occupations addicts engage in to make money, is dubbed by the media the whoonga economy. Such kept addicts occupied in ways that would make them forget to eat, smoking whoonga being the most important objective. Collecting scrap metal during the day yielded very little money for someone successfully to purchase fixes. While scrap metal collecting is a safer way of acquiring money, it takes time and it is laborious. Taking metal to the scrap yard is also a manual job. When whoonga addicts spend their wakeful lives chasing the next fix, it is not only washing that subsides, the urge for other basic needs falls away. Whoonga addicts report to go on for days without food.

Perhaps from going for days without food, Sipho confirmed that both the urinary and the bowel movement seemed halted.

Extract 38:

SIPHO: *"Mawubhema lento-ke awuphiswa ukuchama. Sibona ngoba usushaywa i-arosta - usuqalekile, awuphiswa ukuya ethoyilethi".*	SIPHO: "When you smoke this thing, you do not get the urge to pass urine. You will only notice when *arosta* is hitting that you are now craving; you do not have the urge to go to the toilet".

When you smoke whoonga, Sipho reports (Extract 38) that there is no urge to pass urine or to go to the toilet. He would, however, experience cravings, described as *arosta* that were a dominant urge propelling their behaviour. Mondli could not eat or wash before smoking; and Lunga confirmed that it was when he had enough money that he would get time to bath. As far as

participants were concerned, their sole focus was on a means of making money and buying whoonga. In the extract (39), Lunga, like Mondli, found that he would be able to consider taking a bath when he was settled that the next fix was secured. This would be when he had enough money acquired from his hustle to smoke. This would give him time to eat. Lunga might even find time to wash. Therefore, washing, according to Lunga, would be secondary to eating. However, if he had not smoked, Lunga could not consider either; and he indicated that he could not even function, making only efforts to gain the next fix.

Extract 39:

LUNGA: *"Uzoze uqale umake wabhema, uzokwazi ukudla, uthi mawunemali kahle iningi, uyakwazi ngisho ukuthola isikhathi uhambe uyogeza. Kodwa uma ungabhemile ngeke wenze lutho, akukho ozokwenza …"*	LUNGA: "You will only start when you have smoked, you will be able to eat, and when you have a lot of money, you can even get time to wash. But if you have not smoked, you will do nothing, there is nothing you can do …"

Lunga put a number of "pre-conditions" that one would need to fulfil to be able to take a bath. This made taking a bath a secondary "luxury" they could not afford, when addiction to whoonga involved hustling for a mere fix. Not eating could lead to weight loss, a characteristic of addiction to whoonga. Whoonga addicts appear skinny and emaciated. Sizwe reflected on his weight gain after desistance. He found that six months after quitting, he was able to bath, but the most noticeable difference six months into recovery, was weight gain (Extract 40).

Extract 40:

SIZWE: *"Ngingathi umehluko emzimbeni ngibuyile, ngiyazi ukuthi nje ngiyageza futhi, uyayibona leyonto?"*	SIZWE: "I can say that the difference physically is that I have gained some weight, and I know that I also wash, you see that thing?"

Being in recovery involves being able to wash. Sizwe, now that he was eating properly, had also gained some weight. Losing a great deal of weight during his whoonga bingeing, Sipho concluded that facing his demise had prompted recovery. After a three-day binge of whoonga, Sipho did not go out, even to the toilet. When he went out of the room, people noticed that he was thin and pale. Sipho associated this ghostly look to not eating. Continuous intake of whoonga limits food and liquid intake, and consequently, addicts lose weight.

Other than physical appearances, for Mandla, whoonga controls one's life. Asked to elaborate, Mandla mentioned that whoonga use forces you, knowingly, to do despicable things

against your wishes and your own better judgement (Extract 41). In explaining this, Mandla mentioned that he would steal even when he knew that it was causing grief for the owner. As with Mandla, Mondli felt helpless against the commands of whoonga. Mondli personifies whoonga as someone instructing him to go home and steal the phone he saw left in the charger. Mondli concludes that it was the way he was going to be able to obtain whoonga.

Extract 41:

MANDLA: *"Mangithi i-whoonga it's controlling, ngithi mina i-whoonga iyakuthuma ukuthi njengamanje. As unale-craving osuke unayo, i-craving yakho iyakuthuma ukuthi leya phone elapha ekhaya ehleli e-charge-eni hamboyithatha. Yabo mungayithatha uyidaiyse leya-phone uzongithola ebese uyangibhema i-whoonga …"*	MANDLA: "When I am saying whoonga is controlling, I am saying that whoonga will send you right now. Because you have the craving you have, the craving sends you to go home and get the phone from the charger, go and take it. 'You see if you steal the phone and you sell the phone, you will find me, and you will smoke me as whoonga…"

In describing the nature of whoonga addiction to young men, Mandla found that whoonga is a woman in a romantic tale that requires the protagonist to take up the gauntlet to be able to be rewarded by claiming her. Mandla portrays whoonga as commanding, implying that it left no room for refusal, only acquiescence and submission. Cravings made Mandla steal as though it were an instruction he had to abide by. Whoonga is perceived as a living animated force that rules over addiction lives.

From narratives of addiction to whoonga by this sample, participants in this study became dedicated whoonga addicts, *amaphara* being a term in reference to themselves as whoonga addicts. Participants were initially seeking a better, different, and more intense high; as well as the (novel and imagined) experience whoonga promised or was advertised to produce. Most participants were invited and enticed by peers. This could happen in the company of cannabis-smoking boys in the townships who wanted to try something different. There might, however, be implicit and explicit appreciation of the drug by those who were already ingesting whoonga. In one case, a whoonga-smoking friend led the participant through the initial steps. In another, by availing a drug, an older male, a dealer, inadvertently facilitated the initiation. Participants had begun by smoking cigarettes and other "softer" drugs, mostly cannabis. With the exception of Sipho, most participants had graduated to mixing the cannabis joint with other powdery substances like Mandrax. Such are elements of a progression to trying other novel drugs, a trajectory that most participants were already taking. Therefore, whoonga addiction was an addition of an intense powder to their

cannabis joint when some had already started adding other less intense powders. Cannabis smoking would be a progression from cigarette smoking; and participants continued to smoke cigarettes even after recovery. Whoonga seems to evolve from cannabis smoking. Therefore, while cannabis may not be the gateway drug to whoonga, since not all of its smokers graduate to smoking it, in this study it was nevertheless a precursor to whoonga addiction.

Findings in this study confirm that people addicted to whoonga are identifiable by their personal appearance: they are dirty and unkempt. The need to work quickly in carrying out their activities, usually criminal in nature − Mandla described this as *ukushisa unyazi*, meaning lightning quickness − included the need to avoid detection. However, a need for swiftness in chasing the next high at the peak of addiction, was described by Mondli as like being in movies; a sense of perpetual activity, where something always has to happen. While whoonga addiction is largely associated with discrimination, results in this study found this to encompass a general disapproval of such an existence by families and the community at large. Whoonga addiction pushes addicts away from their families. To be an *iphara* involves a feeling of isolation. Sipho described this as *awusenamuntu*, as a sense that nobody cared. The community was hostile and vengeful: to be an *iphara* involves being a suspect when there was stealing in the community. To save oneself, lying becomes the main instrument, and a way of surviving accusations; and could also assist the hustle in finding money to buy whoonga. Whoonga addicts are difficult to trust. As will be discussed later, addicts are also difficult to assist as it becomes difficult to trust them. For Mondli, this state of an *iphara*, characterised by dedicated use of whoonga, involves being "finished". This describes a desolate existence of anxiety, constant physical pain, uncertainty, deceit, giving up − a brutal life, fear, grimness, and ostracization.

6.3 Conclusion

This chapter described emotions and thoughts participants attributed to their actions and experiences in the early phases of whoonga addiction. Addiction began with initiation into whoonga use, progressing to dedicated use. Overall, experimenting with whoonga might have been a hedonistic pursuit, driven by curiosity, boredom, seeking novel experience, or avoiding emotional pain. However, experimenting soon slipped to horrendous pain driven by physical withdrawals and cravings that increased in frequency and intensity as the addiction progressed. Such feelings were so intense and unbearable, they led to the commission of criminal acts to achieve the next high. Addicts felt helpless against the drug that enticed and commanded them to acquire money at all costs. Whoonga addiction was so consuming that the basic needs became secondary concerns, in which personal hygiene, feeding, sexual needs, and any drive outside

acquiring whoonga was negated. Criminal acts involved largely stealing, but for other participants, it also included criminal behaviour with aspects of interpersonal violence. Smoking whoonga was a sign of a lack of respect for oneself that included acts that disrespected addicts' families, and the community.

CHAPTER SEVEN
FINDINGS: RECOVERY FROM WHOONGA ADDICTION

7.1 Introduction

This chapter is a continuation of the discussions of results, focusing on making sense of experiences with recovery from whoonga addiction. This is a discussion of how recovery from whoonga addiction was achieved, that further addresses what prompted and sustained it. The study recruited individuals who had desisted from whoonga use, and none of the participants was on OST. Participants outlined their recovery from whoonga, as beginning with abstaining from ingesting whoonga. Desistance became the main hurdle in the step towards recovery; it presented physical pain and psychological discomfort. Pathways to recovery describe ways participants achieved sustained desistance from whoonga. However, for most participants, neither the pain of withdrawal, nor negative encounters like arrests or being beaten up by the community, are seen as strong enough reasons for ceasing the ingesting of whoonga. For participants, it takes an inner "resolve", a decision by the person, described as coming from within. Such an inner "resolve" is driven by sound "reasons" that include fear of overdose, a deeper reflection that is a concern with one's future and well-being, the welfare of significant others, with some indications of "maturing out of the drug". However, for one participant, desistance, and by extension recovery, was coerced. For this participant, the role of a concerned family member was crucial in initiating recovery by facilitating desistance. For other participants, recovery from whoonga involved support that included presenting safer conditions for ingesting whoonga, acquiring medication to ameliorate pain. In initiating recovery, moral and psychological support was given, including enrolling a participant in a rehabilitation institution.

Sustained sobriety involved avoiding relapses, making amends with the family, peers, and the community, as well as finding new ways of being. The urge to reuse whoonga, and the fear that one would relapse, were major features challenging sustained sobriety, particularly for participants who were at early stages of recovery. Participants had to move away from the whoonga scene, divorcing themselves from situations and behaviour that reminded them of smoking whoonga, and that constituted their former whoonga life. Participants removed themselves from the environment by shunning former whoonga-smoking friends. They stopped smoking cannabis, opting to stay put at home, and acquiring a new set of non-whoonga smoking friends. Life after desistance further involved dealing with conditions, which for some, drove participants to use whoonga in the first place, including boredom: whoonga addiction kept participants busy. Life after desistance included frustration with finding employment and dealing

with difficult family relations, that, for some, could derail the recovery process. Participants took to whoonga while they were in their early teens, had not completed matric, and had no particular skill or job experience; sobriety involved a need for re-orientation, that would involve professional assistance to deal with trauma and difficulties addiction life presented; as well as reskilling that would include further education. Addiction to whoonga, despite recovery being achieved, fostered a sense of guilt, and it was difficult to shake off former feelings associated with addiction, and linked to stigma. Recovery from whoonga addiction had lasting emotional effects that were difficult to deal with; however, recovery was largely exciting, offering a sense of relief. Recovery was supported and positively rewarded by families, who assisted participants at a stable stage of recovery. Communities and non-whoonga smoking peers allowed recoverees to share communal life.

In discussions on recovery from whoonga, two themes will be presented, viz., curative confrontations (becoming human) and nurturing potentials (approximating citizenship). The first theme discusses experiences of events that prompted recovery, the circumstances that drove a consideration for desistance, including how desistance was carried out.

7.2 Curative Confrontations (Becoming Human)

While this theme draws in the turning points that prompted recovery, confrontations were also helpful to nudge participants to consider and to attempt desistance. In many ways, experiences leading to addiction meant confronting their state of being *iphara*, largely defined by battles that involved physical and emotional pain, dissatisfaction with the way they were leading their lives, including evaluating where whoonga had led them. Thought processes defining an option to quit whoonga are oriented towards seeking better lives for themselves and those close to them. This began with a realistic and honest evaluation that was "sobering", defined within the understanding of processes that govern a reality check. Participants described their addiction lives as that of an animals' life. The zoomorphism of this existence was displayed by the use of terms such as, *"sengiyisilwane*" or "I was an animal", a "monster". These included descriptions of behaviour that was regarded as "not human". Participants further described whoonga as "not fit for human consumption" to denote that being "finished", a state of being a whoonga addict, included not being human. Participants express that the non-addict identity was being *umuntu*, reflecting behaviour that was regarded as human. This involves care for their own welfare and well-being, as well as those of others, considered to be "normal", *njengabanye abafana* - "doing what normal boys do, and that which is right", including behaviour the community approves of.

In discussing this theme, perhaps it is important to start with a caveat that participants presented that cannot be overlooked. Recovery from whoonga addiction could be portrayed as a courageous act of self-preservation. However, Sipho believed that there were pharmacological reasons that could have contributed to managing desistance from whoonga use without professional help. In making sense of this, Sipho was explaining his previous relapse after three months of desistance in 2009/10. Sipho believed that the deeper one is in the process of addiction to whoonga, the more difficult it would be to desist from ingesting the substance. Sipho desisted from whoonga use through dry detoxification. In explaining how dry detoxification would be possible, he was attributing his ability to stop with relative ease during one of the early breaks when he could summon the strength to quit whoonga use. Although short-lived, the desistance was possible because the withdrawals then were not yet as severe as in the previous successful desistance. In the extract (1), Sipho was explaining that desistance depended on where the person was in the process of the progression towards addiction to whoonga. This includes the intensity that would involve the frequency of drug use. Such meant how much one had been smoking, suggesting that the heavier one smoked whoonga, the harder it would be to desist from its use. Desistance also involved the administration method. Sipho further added that he thought that recovery was also facilitated by the strength of the drug, which included how it was ingested.

Extract 1:

SIPHO: *"Kahle kahle ... lento iyangokujwayela ukuthi ubhema kangakanani, ngoba khona esasijwayele ukuhlala nabo ababebhema ngenye indlela, thina sasiyibhema ngenye indlela".*	SIPHO: "In actual fact, … this thing depends on habituation, how much you had been smoking because there are people, we used to hang around with who smoked it differently, and we were smoking it differently".

This becomes pertinent in Sipho's reflection on the previous relapse he had had after he had been smoking whoonga for two and a half years.

Extract 2:

SIPHO: *"Thina sasishuka ugwayi wesiZulu siyifaka. Sifike siwugoqeke ngo-Rizzler mase siyayivuvuzela. Laba abanye bathatha i-foil bathele la lemvuthu phezulu, ipayipi la emlomeni balayithe ngezansi, badonse leso smoke, baya-chase-a. Bayayi-chase-a, kahle kahle bona, kwaku-weak kahle kahle ukubhema ngoba yayingafani. Yabo ngezikhathi zethu kwakukhona nezi-(s)traw. Yayivaliwe yafakwa kwi-straw, yayingekho strong kakhulu leyo; kuzoba ile yamaqhubu iyonake lestrong…"*	SIPHO: "We crushed the Zulu tobacco and we would put it. We would roll it with a Rizzler paper, and we sprinkle it. Other would take the aluminium foil and would pour the powder on top. The pipe in the mouth and they would light underneath, and inhale the smoke, they are chasing. They are chasing, actually they, it was weak smoking because the ways we smoked were different. You see, during our times there were straws. It was sealed and put in straw it was not that strong; then the one that came in solid form is the strongest…"

This period coincided with the two to three years Lunga attributed to casual use of whoonga (Extract 3, previous chapter). An idea that it had been a lighter use of whoonga is, however, transmitted in both cases. What had prompted the need for Sipho to consider desistance at that time is that Sipho's close friends were arrested in large numbers. Whoonga addiction involves engaging in crime, and Sipho was part of this group. Afraid that he was going to follow, in what was conceived as the 2010 World Cup crackdown on crime, he made an attempt to stop.

Other than the short duration of his life as an addict to whoonga at that time, Sipho further attributed the light use of whoonga to the type of whoonga they smoked and how they smoked it. This is a comparison with how others in his group were already smoking whoonga then, that has now become widespread. Sipho believed that smoking the whoonga in straws was less intense than in the current version. He also thought that, because they sprinkled whoonga on a cannabis joint, its effects were lighter than *uku-chaser*, a reference to "chasing [the dragon]", as he called it. His cohort began smoking whoonga in its initial stages. Whoonga was then packaged in straws, not sealed – meaning that it was open to being adulterated further by the local dealer. The administration method was limited to sprinkling it on cannabis (*ugwayi wesiZulu*/Zulu tobacco) joint, and smoking it as a joint. This confirms evidence that this heroin-variant drug was largely smoked at least upon its inception, or in early phases.

Sipho confirmed anecdotal evidence that whoonga is now smoked in ways similar to how heroin is smoked worldwide. This is a commentary on the progression of whoonga consumption in South Africa since its inception, that involves the quality of the drug available. The idea is that it would be difficult for people to "chase" and to inject heroin with all the adulterants it is reported to contain. Nevertheless, the emergence of particular medical conditions associated with ingesting whoonga could emanate from the intravenous use that includes adulterants. Since none of the

participants changed their administration method in progressing towards dedicated use, participants in this study can be argued to belong in this first era of whoonga addiction − the so-called "straws era" − as whoonga was known then.

The straws era would, according to Lunga, end when whoonga packaging changed to capsules. Most participants began smoking whoonga around the mid-2000s. Lunga started around 2005, although he could have begun two or three years earlier (2002/3).

Extract 3:

LUNGA: "Eyi, anginayo isure, in Grade 8 yah, 11 yah, mhlampe 2005".	LUNGA: "Ey, I am not sure, in Grade 8, yah, 11, yah maybe 2005".

In the extract (3), Lunga was not sure which grade he had been in at that time. It can be concluded that, for Lunga, who thought that addiction began for him when he could not control its ingestion, a transition from occasional use would have started in 2005. For Sizwe, the addiction started for him when he became involved in what he referred to as "*ama-flops"* in the township; and for him, this was in 2000.

Extract 4:

SIZWE: *"Uma ngikhumbula kahle since 2000 and ba ...? Bayaphezulu, yabo?"*	SIZWE: "If I remember well since 2000 and they …? They went up, you see?"

In the extract (4), Sizwe was explaining that his addiction had started when he had to hustle for whoonga himself, after initiation. Therefore, for both Lunga and Sizwe, whoonga use started in the early 2000s. But for Mandla, who reported to have started whoonga use in 2007, it further makes sense that he would have looked for it; by then it was a commonly available drug among his cohorts.

Extract 5:

MANDLA: *"Therefore, 2007 ngiqala ukuthatha amadrugs - I started ukubhema insangu ngo-2004 ... ukubhema insangu. But, 2007 ngingena kwi-whoonga".*	MANDLA: "Therefore, 2007 when I started taking drugs – I started by smoking cannabis, in 2004 … it was smoking cannabis. But, 2007 I got into whoonga".

As Mandla confirmed in the extract (5), participants started smoking cannabis then moved on to smoke whoonga. For Sipho, cannabis is traditional tobacco; he claimed the right to use it, linking it to a form of cultural expression. Only Sipho reported not to have used Mandrax before whoonga

− most participants were smoking Mandrax when they took to whoonga. Sipho had a relapse in 2009/10, estimated to be two and a half years after he was initiated into whoonga use. Mondli and Tshepo both began whoonga use around 2011 and 2012, after the straw era. At the time before desistance, Lunga witnessed that whoonga had become packaged in capsules. Lunga further mentioned that there was a period when "good" whoonga was not available, accounting to some extent for the use of ARVs at that time. Concluding this caveat, participants proposed that the current version of the whoonga drug would be more difficult to recover from because of the intensity of withdrawals. For Sipho, this was a stronger and more potent heroin smoked via the chasing the dragon method.

The idea of confrontations in approaching recovery is best encapsulated by the reasons and predicaments that caused participants to choose recovery, and the extent they had to go to, to realise recovery, as presented by a choice of a recovery pathway. In the case of dry detoxification, turning points are situations in which the gains of sobriety outweigh the potential future losses. This adds an element that suggests that recovery is prompted by an evaluation of present circumstances against future gains and losses. In the case of Sipho, the need to quit whoonga was a compelling act to evade his potential demise, having faced the possibility of overdose. Sipho related that he was home in his backroom when his friend, who had acquired some money, went to town to buy purer heroin in block form. As discussed above, this presentation of whoonga suggested for Sipho that the local "straw" type did not produce as strong a high as this one. The friends smoked this whoonga for three consecutive days, with occasional sorties for supplies, such as the rolling paper, cigarettes, cannabis, and occasionally some snacks. Sipho had remained indoors. As established in the previous theme, whoonga consumption negates eating and personal hygiene: addicts would eat only occasionally. This means that Sipho did not have to go out to the bathroom.

However, after three days, when the whoonga had all been ingested and the friend who had bought it had also left, Sipho had to go out to hustle for his own fix. When he went outside, he met people who were alarmed at his emaciated and pale state. This shocked him in ways that made him wonder whether he was going to die of an overdose.

Extract 6:

SIPHO: *"Kulezinsuku nje lezi eziwu-3 ngingaphumi ngibhema nje kuphela la endlini. Ngaphuma ngimpofu ngizacile kwathiwa 'hhayi bo' ngavele ngaqhubeka, ngavele ngaqhubeka-ke lapho ngasale sengihlala la endlini-ke".*	SIPHO: "In these 3 days not venturing outside only smoking here in the room. I got outside pale and thin and people said 'haibo' and I just continued, I just continued from there and decided to stay indoors in this room".

To describe how people reacted to his pale and thin appearance, Sipho seemed lost for words, and the exclamation of surprise "*hhayi bo*" seemed to suffice to explain the shock (Extract 6). It is still surprising him, so it seemed, even when reflecting on it almost six years after desistance. Sipho had a double shock; this objective observation as a reaction by other people stunned him too. Perhaps to avoid it being confirmed by more people, Sipho decided to stay indoors. This reaction could also have made him become conscious of his appearance, and possibly his potential demise. He reported to have stayed indoors and that he was "stressing" about it. Sipho knew that he had to stop taking whoonga, and exit this state, it seems at all costs.

Extract 7:

SIPHO: *"Ngiqede usuku lokuqala nje sengizitshelile manje ukuthi ngiyayiyeka i-whoonga".*	SIPHO: "At the end of the first day I had told myself that now I am going to quit whoonga".

After the first stay, having stayed put indoors, Sipho said that this was when he made a resolution to quit whoonga (Extract 7). He described this resolution as coming from "stress" from the people's reaction, and that he was "over thinking" about it.

Sipho and Mondli, both desisting from whoonga with no recourse to medication to manage withdrawals, endured cases of dry detoxification, and aversive reaction to medication or medications, respectively. While Sipho seemed to have presented his choice to desist whoonga use as something compelling, "something he had to do", Mondli highlighted pain in recovery; presenting it as an essential deterrent to relapses. Mondli was coerced by his grandmother to take a pill, which, although it could not be confirmed was medication intended to induce an aversive reaction, it had that effect. To induce an aversive reaction to end drug use, the medication will produce negative and painful effects. These effects would be associated with the drug ingestion, and such an association will have a repelling effect, causing an individual to end taking that drug per negative reinforcement. For example, Antabuse is a medication used to induce a negative effect of alcohol on the subject, helping the problematic drinker quit. In relating how he took the pill,

Mondli said that, despite all the medication assisting him against taking whoonga, he had taken them, but continued to smoke. Mondli acquired pills from a friend; he told his grandmother that they worked as well as Methadone, but he did not take them.

Extract 8:

MONDLI: *"... so ngiyabhema mina ngenza yonkinto ngiphuza nalawa. Lawa angikaze ngiwaphuze la engibanjwa khona ukuthi hhayi lo akakayeki, ingale-date uGogo ethi 'wena awukaze uphuza lawa, phuza naleli' ngabona nami ukuthi, ngoba [friend's name] uthe lifana ne-Methadone".*	MONDLI: "… Therefore, I still smoke and I'm doing everything and I also drink other pills. I had not taken those, and this is when I got caught that, 'no, this one has not stopped.' This is the day Gogo said, 'you have not taken these, drink this one too' and I could see that, because [friend's name] said it worked like Methadone".

Mondli would take Methadone, and still smoke whoonga. For Mondli, the Methadone high was not enough. In the extract (8), he said that after he had been caught, he had not quitted, because he had not taken all his pills. His grandmother insisted that he take them. Mondli took them to appease the insistent grandmother, yet not expecting any reaction.

The uncertainty about the effects this medication produced first comes from the fact that he was given this medication by another whoonga smoker. This medication was prescribed to him by a doctor Mondli's friend had consulted for his whoonga addiction. This friend's prescription further assisted Mondli in acquiring Methadone. Mondli noted that this friend did not know what the medication was, presumably because, like Mondli, this friend had never used it. Nevertheless, he had insisted that it was like Methadone that Mondli had drunk to no effect.

Extract 9:

MONDLI: *"Naye wayengazi vele, wathi ifana njenge-Methadone, eyi ngiphuze kungenzeki lutho yabo? Ngaliphuza, 30 minutes njengoba kade ngisho, ngashintsha same time".*	MONDLI: "Even him, he also did not know, he said it was like Methadone that I would drink, and nothing would happen, you see? I drank it, 30 minutes and as I have just explained, I changed same time".

This gave Mondli confidence to drink the pill, but after thirty minutes, its effects were immediate and drastic. Mondli took gulps of Methadone to alleviate pain, and which he reported having vomited up soon afterwards. His pleadings to acquire whoonga were turned down by his grandmother who opted to lock him up in his room.

Extract 10:

MONDLI: *"Hhayi ke shuthi uGogo umuntu ongakholelwa kanjalo wathi, 'Ayikho leyonto njengoba kwenzeka kanje shuthi uba-right. Ngeke ngikunike imali mina ngithi zibulale'; ngoba ngangigula that day".*	MONDLI: "No Gogo is someone who does not believe that, she said, 'There is nothing like that, as this is happening to you it means that you are coming right. I am not going to give you money and say, 'kill yourself'"; because I was really sick that day".

In the extract, Mondli says that his grandmother did not buy whoonga as a solution to his pain and suffering. She told him that the symptoms meant that he was getting better, and she was not going to give him money to kill himself. Whoonga, according to the grandmother, was responsible for these effects: she was adamant that this was a cure. Mondli described that he was feeling very ill. When he was able to make his way out of the room, he was in too weakened a state to attempt to buy whoonga to smoke, even had he had money to do so. Hustling to get money at 3h30 am was out of the question, so he returned to his messy room. The reaction he suffered was as a result of the pill or the combination of the pill, Methadone, and a whoonga high.

In desisting from whoonga, both Sipho and Mondli suffered extreme pain. In the middle of an aversive reaction to the medication, Mondli seemed prepared to do whatever it took to end the pain and suffering. In the extract, he related that he attempted to hang himself. He was unable to hang the rope to strangle himself.

Extract 11:

MONDLI: *"Ngazama ukuzihenga ngizwa ukuthi yabo le-pain ngeke manje, ngcono vele ngife. Ngivele ngizame ukuzihenga ngithi…nginkinyeke, ngivele ngibone ukuthi, 'ayi ngizibulale' .... i-whoonga futhi .... Ngivele ngiyigqashule ngiyibeke phansi yabo, ngizishaye ikhanda kanje ...* [Demonstrating Head Banging] *ukuthi ngiquleke at least".*	MONDLI: "I tried to hang myself, feeling that this pain, no now, it is better that I die. I must just try to hang myself … get strangled, and I could that, 'no let me kill myself' …because whoonga …. I decided to just cut the rope and put it down, and started banging my hand like this … [Demonstrating Head Banging] so that I can faint, at least".

Mondli seemed to find it ridiculous in an amusing way, reflecting during the interview that whoonga made him do that. However, he cut the rope, and decided against the idea. Like Sipho, who wanted to throw himself on the floor, Mondli banged his head against the wall, hoping to faint. He imagined and hoped that, as he banged his head against the wall, he would inflict injury to himself, killing himself. Mondli contemplated suicide to avoid the pain he was suffering.

For Tshepo, curative confrontations started with a confrontation with his mother-in-law when she had heard that he smoked whoonga. Tshepo fled the neighbourhood he had lived in after release from prison. He reverted to whoonga use upon release, and to feed whoonga addiction Tshepo took to crime. His girlfriend and the mother of their three children knew that Tshepo smoked. In the extract (12), he mentioned that the girlfriend kept it a secret from her mother. She tried to provide for Tshepo as much as she could. She could not resist Tshepo's pleadings for money, and she would give him money that was meant for emergencies. These emergencies included the welfare of their three children.

Extract 12:

TSHEPO: *"U-Ma wengane shuthi wayesazi ukuthi ngiyabhema, kade engabatsheli. Shuthi la endlini kukhona imali ebekelwe ukuthi uma kugula ingane, uma kwenzeka ukuthi ingane ayiphathekile. Lemali, izonikezwa mina ukuthi kubheme mina ngoba manje ngikhalela yena la endlini ukuthi ngiyafa ukuqaleka, yabo?*"	TSHEPO: "The mother of my children already knew that I was smoking, but he was not telling them. Therefore, in this house, there would be money spared for cases when the child is sick, or in case the child is not well. The money will be given to me to smoke because I am now pleading with her in the house that I was dying of cravings, you see?"

Despite her efforts to provide whoonga for Tshepo, he started stealing from this household and from the neighbourhood. The community members had communicated their suspicions to his mother-in-law, and she saw the need to ask him about their suspicions.

Extract 13:

TSHEPO: *"Shuthi uMa wakhona ukhona-ke lapho-ke, uma esezwile; wasuka wangibiza nje, wase eyangichazela ukuthi uzwa kuthiwa. Ngase ngithi mina, 'No, baqinisile labo abasho njalo ngangena kulesosilingo', mase ethi uMa 'angisho ukuthi ngiku-support-a njengengane yami, uma usu-ready usuzitshelile ukuthi usufuna ukuyeka, ngitshele, yabo? Ngathi mina, 'Okay Ma' ".*	TSHEPO: "So when my mother-in-law was also there, and when she heard about it, she came and just called me, and she explained that she people say. And I said, 'No, people who are telling you that are telling the truth, I got myself into that vexation'. And then the mother-in-law said, 'I must say that I must support you as my child when you are ready and you have told yourself that you are going to stop, you must tell me,' you see? And I said, 'Okay Ma' ".

In the extract, Tshepo mentioned that his mother-in-law had heard that he was smoking whoonga. She called him and asked him about these allegations. He admitted to using whoonga, calling it a vexation. In calling whoonga addiction a vexation, he was admitting to being helpless and had lost

control over the drug. His mother-in-law promised to support him; and made him promise that, when he was ready, he should tell her. She subsequently provided for Tshepo essential morning and afternoon fixes. As the father of her three grandchildren, Tshepo was his mother-in-law's child. The mother-in-law believed that he deserved her support.

Extract 14:

TSHEPO: *"Angisayi phela ukuyophanta njengoba elokhu enginikeza lemali le ukuthi ngingaphumeli ngaphandle".*	TSHEPO: "I am not longer going to hustle now because she gives me money so that I do not have to venture outside".

Tshepo's mother-in-law was further concerned that, without money to feed his habit, Tshepo was bound to steal from the community. She was therefore protecting him, and possibly from him embarrassing the family. In the extract (12) above, for Tshepo, this meant that he did not have to hustle. But this came with a snag. Tshepo felt that he was now a burden to the family who supported him and his children.

Extract 15:

TSHEPO: *"Ngaleyondlela inhliziyo yakhe eyayikhululeka ngayo ngagcine sengishiyeka mina ukuthi la ngondlelwa izingane, mina ngalana ngithola nemali yokubhema amadrugs, yabo? Therefore, ngelinye ilanga kwafika into yokuthi, 'no lento isiyangihlukumeza, angisakhululekile, sengizihlalela endlini', yabo?"*	TSHEPO: "In that way her heart was free and the way she was understanding I ended up feel uncomfortable that they are raising my children up for me, on the other hand, I also get money to smoke drugs, you see? Therefore, one day, this thing that says, 'no this thing is devouring me, I am not longer free, I just stay in the house', you see?"

In the extract (15), Tshepo found it unbearable that he was burdensome to the family who took over his responsibilities. Tshepo felt irresponsible that they further provided money for him to use on drugs. He was removing money from the children he was supposed to provide for. As elaborated on in the next theme, ruminating over these issues caused a conflict between his responsibilities as a father, and the demands of whoonga addiction. These thoughts worried him, making him feel uncomfortable and not free. Tshepo stayed at home most of the time, which could compound this sense of lack of comfort and freedom. But it also could mean that as he was always at home, this discomfort was made to him, there was no hide-out or a break from this pressure.

Like Sipho, Sizwe had been away from home for a year when a fallout with the couple he lived with nudged him towards recovery − it prompted him to go home. Sizwe was unable to hustle

for all of them since the couple also smoked. The obligation to provide fell more on him, and on one day that he could not provide whoonga, the so-called friends chased him away.

Extract 16:

SIZWE: *"Uma ngibuya ekhaya almost last year unyaka waphela ngingahlali ekhaya, mhlampe kwasiza ukuthi ngibuyele ekhaya, this year…"*	SIZWE: "When I returned home almost last year, it had been a year away from home. Perhaps it helped that I return home, this year…"

At the time of the interview, Sizwe had been home for eight months: he had been away from home for a year. He returned home where he had been brought up. His mother had stopped renting the room Sizwe had lived in. His mother had moved to a new house, but was within the same township although in a different neighbourhood. When Sizwe was a whoonga addict, he mentioned that he was not able to spend time with his family. In the extract (17), he said that he would be irritable and short-tempered.

Extract 17:

SIZWE: *"Ngibuye manje uthole ukuthi nginenhliziyo encane yabo nje angisakwazi nje ukuhlala ne-family yami…"*	SIZWE: "And I would, now you find that I am short-tempered, you see, and I am not be able to stay with my family …"

Other than mood changes, Sizwe reflected on his change after desistance, in that he was disrespectful and quarrelsome with his family members. In the extract (18), he believed that he was out of control, and would always feel guilty about this afterwards.

Extract 18:

SIZWE: *"Ngisabhema, kuqala bengingenayo inhlonipho, even nala ekhaya angikaze ngithole ukuthi angixabani nabantu. Nami angizenzi ngixabana noMa mhlampe yinanoma ubani la ekhaya, uthole ukuthi sengibhemile sengiyazisola, yabo leyonto?"*	SIZWE: "When I was smoking, firstly I was not respectful, even here at home I have not fought people. I could not help it. I am fighting even my mother and perhaps whoever is here at home, and you find that when I have smoked, I regret it, you see that thing?"

But this return home, still a whoonga addict, meant that he had to face the family he had been rude to and would quarrel with. He reported having approached the family by explaining to them that he was willing to quit using whoonga. His aunt, who could afford to buy him Methadone as she was employed, responded by asking him what he thought needed to be done.

Extract 19:

SIZWE: *"Athi, 'yini esingayenza?' ngamutshela ukuthi khona umuthi ekuthiwa i-Methadone, uyaphuzwa lomuthi, uyabo? Ngikwazi ukuyiyeka lento…"*	SIZWE: "And she said, 'what can we do?' and I told her that there is a medication called Methadone, that you drink, you see? So that I can be able to quit this thing …"

In the extract, he says that he told his aunt that he needed to take medication, Methadone. He told her that this medication was going to assist him to desist from whoonga use. At first, the aunt wanted to confirm with a relative/neighbour whose younger brother was a whoonga smoker, if indeed Methadone worked. The family relative brought suspicion over such a request, presenting evidence of several bottles of Methadone they had bought for their brother, to no avail. Confronted with a possibility that this could be a ploy that her brother concocted to obtain money, the aunt opted to buy Methadone somewhere in the Pinetown area. However, since she worked in the Durban area, it became difficult for her to acquire the medication. It could also have been that she wanted to confirm Sizwe's intentions to desist, perhaps by observing his behaviour over time.

Extract 20:

SIZWE: *"Waqala wangangithemba wathi, 'ngeke akwazi ukunginika imali ngizoziyela'. Lapho mhlampe yaphela inyanga engibuka; yaphela inyanga futhi wathi, uzothumela omunye umuntu wala e-Pinetown la edayiswa khona. Wagcina ethi uya kuloyomuntu, 'hhayi nami…' bagcine sebenika mina imali befuna ukungibona ukuthi, 'hhayi u-serious'. Banginika ngaya lana eBridge City ngayithola ngo-R130…"*	SIZWE: "She did not trust me at first and she said, 'no, I cannot give you money, I will go there myself'. At that, maybe it took a month she was watching me; and another month again she said, she was going to send someone from Pinetown where this medication was sold. She ended up saying she was going to that person, 'no and I …' and they ended up giving me money to see if I was, 'no, he is serious'. They gave me and I went to Bridge City and I bought it for R130 …"

In the extract (20), Sizwe reported that his aunt did not trust that he was serious about quitting. She wanted to purchase the medication herself, therefore she did not give Sizwe money that he could divert to whoonga. For a month, she said nothing to Sizwe about whoonga, and a suggestion to Sizwe was that she was watching him, ascertaining whether he was serious. Being serious was proved by him staying at home. Sizwe began to wash, but he did not stop taking whoonga. This continuation of use seems to disturb him. It is implied in the extract when he says, "no and I …" Sizwe seemed to struggle to mention the use of whoonga. Perhaps he found it contrary that he continued to take whoonga. However, since he needed medication, he took the drug, so that he did not have to deal with withdrawal symptoms. It is not always clear what participants mean by

friends. Friends could be simply any group of whoonga addicts or, as mentioned above, a group of boys in the township. But Sizwe reported that he now spent more of his time with friends within the neighbourhood.

When the aunt eventually gave him the money, two months after the initial request, Sizwe went to Bridge City, a shopping mall nearby, to buy this medication. On his way back from the mall, he went to his friends with medication in hand to smoke whoonga for what was, according to Sizwe, going to be the last time.

Extract 21:

SIZWE: *"Hmm, ngiyiphethe kanje; ngiphethe lo-R100, ngithi, 'ngibhema okokugcina, lalela ukuthi ngithini, ngibhema okukugcina mina bafwethu …"*	SIZWE: "Hmm, I am holding the money like this, I have R100, and I am saying, 'I am smoking for the last time, listen to what I am saying, I am smoking for the last time, my brothers …"

In the extract, he said that, as he was holding the money, he announced to his friends that he was smoking for the last time. This announcement did not serve as a victory parade. He was excited that he had eventually got medication, but it also served as self-affirmation and reassurance that he was going to quit. These friends he spoke to would also serve to monitor whether he was serious about quitting.

Lunga did not have to wait for an aunt to acquire his medication since he was employed. But in deciding to get medication from a local doctor, and to desist from whoonga use, he was dissatisfied with how he spent his finances.

Extract 22:

LUNGA: *"Ngiyaspana, ngiyabhema, ngisebenzela ukuthi ngiyabhema ngabona lokho ukuthi hhawu njengoba bengibona abantu ngiyavuka ekuseni ngiyahamba. Ngisizwa ngemali yokugibela, kodwa ngiyasebenza anginaso ngisho isinkwa, yabo?"*	LUNGA: "I have a job, I smoke, and I worked so that I can smoke and I saw that, hhawu, as people see me wake up in the morning and leaving. I need to be assisted with fares, but I am employed and I do not even have bread, you see?"

In the extract (22), Lunga believed that employment for him only served his addiction. Employed, he found it difficult to comprehend that he was unable to meet his personal basic needs like transport fares in the morning, borrowing such from people. Lunga was particularly concerned about the image he presented to people. He tried to be careful about his whoonga addiction,

keeping it a secret from his family and the neighbourhood. He explained that being known as a whoonga addict was problematic. Lunga wished to avoid the stigma that being a whoonga addict attracts. In the extract, Lunga said that people would disparage you when they learn that you are a whoonga addict.

Extract 23:

LUNGA: *"Khona uma ezothi ethola ukuthi uyabhema akuthathe kancane ... ukuthi uyabhema, ngiyazi ukuthi ngiyabhema, kodwa ngimu-disappoint-e ngezenzo zami ngingakhombisi ukuthi ngiyabhema".*	LUNGA: "There is someone who would when they learn that you smoke undermine you … that you smoke, I know that I smoke, but I would rather disappoint you by what I behave than to show that I smoke".

For Lunga, he would rather disappoint a person by his behaviour than be known as a whoonga addict. At different times during his addiction, Lunga was suspected to be smoking, giving clear signs of this from his dirty appearance to the people he spent time with. Lunga always denied smoking when confronted with an accusation. In the extract (24), Lunga was relating an incident wherein which he had to hide the medication he took. The name of the medication would give away to his family that he was a whoonga smoker.

Extract 24:

LUNGA: *"Nakhona angibatsheli, bayasho ukuthi: 'iyona lento le oyiphuzayo, lomuthi wakho wokuyeka ukubhema,' yabo. Ngoba nayo ngafika ngayihebula ngisho iphepha ngemumva ngalisusa yasala i-barcode kuphela. Abazi ngisho igama lawo ukuthi yini bazi ukuthi kwak' umuthi, ngoba ngangingabatsheli, ngangingafuni ukuthi bazi ukuthi okay, 'Hah uyabhema'. Yinto engangiyifihlile nje leyo ngangyiyifihlile totally…"*	LUNGA: "Even then I am not telling them, and they were saying, 'it is this thing you are drinking, your medication to stop smoking, you see? Because when I brought it, I removed even the label behind, I removed it, leaving only the barcode. They did not even know what it was called or what it was. It was just medication because I was not telling them, I did not even want them to know that 'okay, hah he is smoking.' It was something I hid totally …"

Lunga said that he never told his family what the medication was, but they suspected that it was medication to quit whoonga. Three-and-a-half years before the interviews, in 2019, the rampant nature of whoonga in townships warranted that the participant's family members would have heard of Methadone. Therefore, he removed the label on the bottle to avoid it being identified as such medication by his family members. Nevertheless, according to Lunga, Methadone tastes like

normal cough syrup. Therefore, his sister administered it to one of his nieces, and Lunga had to explain that the child had to be taken to the doctor.

Extract 25:

LUNGA: *"Angithi bona bazi ukuthi vele ngithenga umuthi womkhuhlane, ngathatha umuthi wami wokukhwehlela; ngawubeka ... kanti zizokhwehlela izingane, bazithatha baziphuzisa i-Methadone".*	LUNGA: "You see, they only knew that I am buying medication for flu, and I took my cough medication; and stored it … but then the children caught the flu, and they gave them Methadone to drink".

In the extract, Lunga says that, because Methadone presents as cough syrup, he was able to make his family believe that it was cough medication. He did not know what effects the medication will have on the child. Lunga went to some lengths to hide that he was a whoonga addict. He succeeded to the degree that they entrusted him with a job that he acquired when he was still a smoker. Lunga also was able to function, masking that he was a whoonga smoker, and perhaps confirming Mondli's ideas that a financed whoonga addiction can assemble normal appearance and functioning. Lunga found Methadone to have a high similar to whoonga.

In quitting whoonga, Mandla was arrested, this being his second arrest. He had been arrested before for a case he considers a false accusation, being acquitted.

Extract 26:

MANDLA: *"Yabo ngosuku inkantolo eyasho ngayo ngikugweba 3 years in imprisonment; ngayitshela ukuthi it's because of i-whoonga and angisoze. Since that day angikaze ngiyibheme from the day engangena ngalo. I've been clean since 2012 till ngize ngiphuma until namuhlanje iwhoonga angikaze ngize ngiyithinte".*	MANDLA: "You see the day the court said, 'I am sentencing you to 3 years in imprisonment', I told myself that it's because of whoonga and I will never. Since that day, I have never smoked whoonga from the day I entered prison. I have been clean since 2012 till the day I was released until today, I have never touched whoonga".

Mandla's decision to desist from whoonga came with a court handing down a sentence. In this second instance, a case of house-breaking and entry, Mandla was found guilty, and sentenced to three years. In total, including pre-trial arrest, he served eighteen months.

In the extract, Mandla explained that he had not smoked whoonga since he entered prison after his second arrest. In both arrests, Mandla, like Tshepo, who was also arrested, would quit taking whoonga upon entry. Both participants would resume taking whoonga upon release from prison. When the court handed down the sentence, his mother who was present, wept. This touched

Mandla very deeply. He was sad, blaming whoonga for these effects. In the extract, his avowal to desist was motivated by this pain that he had caused his mother. Mandla's resolution to desist upon release from prison was associated with the cause of his circumstances.

Extract 27:

MANDLA: *"Ngaphuma with a hope yokuthi i-life yami ishintshile and ngaphuma nginalento yokuthi; okay right I will never ever make my mom cry. I did that, nga-please-a amafriends wami nga-mourn-a; so I'm no more going to do that".*	MANDLA: "When I was released, I had hope that my life has changed, I had the thing that says, 'okay right, I will never ever make my mom cry again. I did that and pleased my friends and I mourned, so I'm no more going to do that".

In the extract (27), a reflection on previous relapses, Mandla believed that smoking whoonga was something he did to please his friends, and this had caused him pain. When he made a decision to end his whoonga smoking career, he did not have to face immediate withdrawals. He had been arrested for three months at this time of the sentence, Mandla suffered intense withdrawals upon entry. But it is also imaginable that Mandla would easily make such a commitment, because three months after the arrests, he did not have to face the immediate consequences of such a decision. Participants who chose to desist without medical recourse suffered severe withdrawals. At this stage, Mandla was free from withdrawal symptoms as he had suffered them upon entry into prison. This resolve to smoke whoonga could easily be derailed by relapses upon discharge as happened at the end of the previous arrest. In his decision to desist from whoonga use, Mandla had to reflect on what he was going to do when he was discharged. This included making a conscious decision not to fall into the same trap.

Pain from withdrawal features as a major concern and a difficult hurdle that thwarts recovery by encouraging relapses. Reflecting on pain as part of desisting from whoonga, Mondli believes that it should be a logical and common understanding among smokers that, in order to quit, one must suffer withdrawals. For people wishing to desist from whoonga use, the underlying idea is that they should focus on getting well, that includes suffering withdrawals first. In his reasoning, Mondli finds that pain should be expected.

Extract 28:

MONDLI: *"Ungabi nandaba nokungalali ukuthi, 'angilali ngeke, ngeke ngingalali mina ikhona into engazi ukuthi ngingayibhema ngizilalele kahle nje'. Hmm... ngeke ufike ubheme i-whoonga unyaka wonke malume; njalo wena ulala nge-drug mase ucabanga ukuthi ngosuku lwesithathu usuyalala buthebelele…ukade ulala nge-drug for unyaka wonke".*	MONDLI: "You should not worry about not sleeping that, 'I am not sleeping, never, there is no way I am not sleeping when there is something, I know that I can smoke and sleep normally.' Hmmm … you cannot start by smoking whoonga the whole year and that you think that by the third day you will sleep comfortably… you have been sleeping using a drug the whole year".

Mondli did not believe that, when ceasing to take something that made him sleep at night, this would be comfortable or magical. In proposing that recovery was not going to happen on the "third day" he further implied that withdrawal was going to be a process. In confronting the situations that led to desistance, most participants resolved to end their addiction careers by abstaining from whoonga use. To do so means facing pains from withdrawals, and Mandla stresses that it becomes difficult because it requires commitment.

Extract 29:

MANDLA: *"... because abantu be-whoonga into abayisabayo uku-commit-a".*	MANDLA: "… because the thing whoonga smokers are afraid of is to commit".

The idea of commitment for both Mandla and Mondli above, comes with pain. The pain is not limited to situations that lead to desistance or realising sobriety. Participants resolved to end their addiction careers by abstaining from whoonga use. But years of whoonga addiction were not over for them. In avoiding relapse, participants had to manage their withdrawal and a pull to use again. In the case of Sizwe, the circumstances associated with initiating whoonga use had not abated. Dealing with them by using whoonga did not make them go away or change. For Sizwe, such a realisation came when he reflected about why individuals may not be motivated to desist, or become frustrated after quitting whoonga use.

Extract 30:

SIZWE: *"Uyabo leyonto abanye basho njalo phela ngoba yabo uma usandakuyiyeka unokuzitshela ukuthi uma ungasabhemi kuyabhora. Ngibatshela, 'kodwa bafwethu okusalayo ukubhora akugulisi'. Kugulisa into yesikhashana, ngeke uze uguliswe ukuthi uyabhoreka …"*	SIZWE: "You see that things, to some who say that, they say that because if you had just stopped, you would tell yourself that if you are not smoking, you will be bored. I tell them, 'but friends at the end, being bored does not make you sick.' You would be sick for a short time, and you would not get sick because you get bored …"

Sizwe said that most people would be afraid of boredom, having occupied much of their adult life smoking whoonga as something all-consuming to do. As established above, Sizwe attributed his initiation into whoonga use to boredom. Sizwe reflected that boredom, however, did not come with possibilities of withdrawals. Sizwe's preoccupation with boredom suggests that, even after desistance, his life did not provide him with occupation.

Part of managing the pull to use again involves the abandonment of former whoonga-smoking friends who would instigate and prompt the need to use again. The non-addict identity includes removing oneself from the company of those the participants used to smoke with, and who continued to smoke.

Extract 31:

TSHEPO: *"Ngihlala endlini, ..., bengingayi ngisho esitolo, yabo leyonto, because ngibuyelwa ukuthi ngizobonwa ilabafwethu ekade sibhema nabo".*	TSHEPO: "I stayed in the house, … I did not even go to shops, you see that thing because it comes to me that I was going to be seen by the brothers I had been smoking with".

Tshepo remained in his house after returning from the rehabilitation centre. As established in the above (Extract 31), Tshepo reported having chosen the company of his immediate family. This extract is used to highlight that Tshepo remained indoors, not even going to the shops, because he was trying to avoid his former whoonga-smoking friends who might have seen him. Mandla had similarly blamed his relapse on appeasing friends, after desistance, owing to imprisonment. Tshepo argued that the reason for this relapse was that he returned to the same set of friends that he had been smoking with before he was arrested.

Extract 32:

TSHEPO: *"Into eyangenza ukuthi ngiqalele phansi ukungashintshi abantu ohlala nabo. Ngavele ngabuyela ku-same bantu esasibhema, senza yonke leyonto, ngabuya ngahlala nabo, ngazwana nabo".*	TSHEPO: "What made me start all over again was to not change people you stay with. I just went back to the same people we smoked with, doing all those things, I came back and stay with them, befriending them".

In accounting for the previous relapse, Tshepo, like Mandla, attributed smoking whoonga again to friends who presented a familiar environment for smoking whoonga. These friends were a pull to use again. Cautious in his early recovery stage, Tshepo avoided the former friends he used to smoke whoonga with.

Extract 33:

SIZWE: *"Ngahlehla futhi kubona ngoba njalo ngiyazi ngeke ngiqhubekele phambili uma ngisahlala nabo. Ngizophinde ngiyihalele ngiphinde ngiyibheme…"*	SIZWE: "I pulled back from them because all the time I know that I am not going to progress and move forward in like if I hang around them. I am going to wish to smoke and smoke again …"

This caution for Sizwe in his early recovery demanded an acquisition of a different set of friends after desisting from whoonga. In the extract, Sizwe mentioned that these friends were not smoking whoonga and that he ensured that he also avoided them.

Extract 34:

SIZWE: *"Yah, abangani sengibashintshile sengihlala nabantu abangabhemi, ngenza sure futhi ..."*	SIZWE: "Yah, I have changed my friends, I spend time with people who do not smoke, and I definitely make sure …"

For Sizwe, who would meet these former friends on the township streets, he said that he would only greet them. However, he would not consider spending time with them.

Extract 35:

SIZWE: *"Abangani bami nje ngiyabona ukuthi bayangithanda laba abangabhemi and ngenza sure ukuthi angifuni ukuhlala nalaba ababhemayo. Nalapho sigcina ngokubingelelana emgwaqeni, ukuyohlala nabo hhayi ..."*	SIZWE: "I can see that my friends love me those that are not smoking and I make sure that I do not stay with those who are smoking. The only contact ends with greeting each other on the street, to stay with them, no …"

When Tshepo was discharged from the rehabilitation centre, he was advised to avoid people who had been his friends while he was an addict. Tshepo found it prudent to stay at home in the company of his female companion and his children. He said that people thought that he was employed and away at work. To sever ties with drug-using friends, either as a temptation to use again, would avoid any place presenting cues to the drug-seeking and drug-consuming environment.

Extract 36:

TSHEPO: *"Ususuka lana awuzame ukushintsha abantu,' nabo babona nje ngabuya ngashintsha; ngashintsha indlela engiphila ngayo.' Into engazama ukuyenza; abantu engabenza abangani bami mina ngenza abangani bami izingane zami, mase kuba abangani bami-ke. Ngihlala endlini, kwaba umuntu wesifazane umngani wami, ngihlala endlini nje kanje".*	TSHEPO: "When you are leaving here, you must try to change people,' they could also see that then I returned, I changed, I changed the way I was leaving. What I tried to do; people who I made my friends, I made children to be my friends, those were now my friends. I stayed indoors, and it was my woman friend who is my friend, I would stay in the house as we are doing now".

Former whoonga addicts seem to be treating whoonga addicts as pariahs, much as they were once treated when they were smoking themselves. This seemed to perpetuate the marginalization and the ostracization of people addicted to whoonga by people who once suffered as whoonga addicts. However, for those who had recently recovered, this was self-preservation. Remaining in the house and keeping minimal contact with former friends who were whoonga addicts is pervasive among participants, particularly in the early stages of sobriety. For Tshepo in the extract above (36), this was encouraged at the rehabilitating institution.

For Mandla, such feelings of empathy towards whoonga addicts were compelling, based on his understanding how they were feeling, an experience he had had before. This could create suspicions that he might not have stopped. The company participants kept when on whoonga gave away their status as whoonga addicts. Whoonga addicts support one another, increasing the likelihood that participants would smoke even without an intensive hustle. Mandla thought that he understood whoonga addicts' pain.

Extract 37:

MANDLA: *"Kufike ku-knock-e lo, 'hheyi mfwethu othi uR20', 'hheyi mfwethu othi uR10'. Bonke ngiyabanika unless ngingenawo ngalesosikhathi uzowuthola kusasa mekukuthi uzowuthola kusasa khona uR2 kodwa because nginalento yokuthi ngiyabazi ukuthi Uma sebeyifuna leyanto babanjani, wenzani, what he's capable of doing mase esefuna le-whoonga yakhe angayitholi, yini angayenza?"*	MANDLA: "Someone would come and knock, 'hey my brother give me a R20', 'hey my brother give me R10.' I will give all of them unless I do not have it at that time the person would get it tomorrow if he will get it tomorrow even a R2 because I have this that says I know that if they want that thing how they become, and what they do, what he's capable of doing when he wants his whoonga and he cannot find it, what he can do?"

In the extract, Mandla indicated that he cared about the addicts' welfare. And he mentioned that they would come to his room and ask him for some money. If he had it, he would give it to them. He reported that he did this because he understood what cravings were like and what addicts would do if they could not find the next fix.

For Tshepo, after some time, he was able to walk freely around the township. When he met the whoonga smokers, he was not as understanding as Mandla. Tshepo mentioned that he would tease them for still smoking whoonga. But initially, his fear of relapses made him remain indoors, avoiding addicts who were his friends; and he stopped smoking cannabis.

Extract 38:

TSHEPO: *"Kubalula ukuthi abuyele back kuleyanto mina ngabuya ngayeka ngisho ugwayi ohlaza because ngalesis'khathi ubhema ikukhumbuza yona lento, ngesikhathi ubhema ugwayi ohlaza lo. Angithi ibhenywa ngodamu, so ngalesis'khathi ngiyeka totally i-whoonga ngathi ake ngithi ukuyeka ugwayi ohlaza ngoba manje uzolukhe ungikhumbuza, yabo?"*	TSHEPO: "It becomes easy to go back to that thing, I came back and stopped even smoking cannabis because when you smoke it reminds you of that thing when you smoke this cannabis. You smoked it by rolling it as a joint, so when I totally stopped smoking whoonga I decided that I would have to stop smoking cannabis because it will remind me, you see?"

In the extract (38), Tshepo says that, when he returned from rehabilitation, he opted to quit smoking cannabis, smoking cigarettes only. Since whoonga is rolled and smoked the same way as cannabis, Tshepo was fearful that he would be reminded of whoonga. Tshepo cannot bring himself to mention the word whoonga, opting to call it "that thing". This reads as though he was actively creating a distance between himself and whoonga, even now. Other than Tshepo and Sizwe, for most participants, quitting whoonga does not include quitting smoking cannabis. All participants

still smoke cigarettes. Sipho returned to socialise with his former cannabis-smoking friends, who were not whoonga smokers, after desistance. Lunga smoked cannabis at home. and his family knew that he smoked cannabis.

Unlike Tshepo who halted smoking cannabis altogether, Mondli reported to occasionally smoke cannabis. Six months after desistance, the pull to use again came from his habitual thinking engrained as a whoonga smoker, that of the next fix. Mondli said that he had to stop himself many times from succumbing to the routine he had assumed as a whoonga smoker.

Extract 39:

MONDLI: *"Ngizivimba mina futhi ekhanda ukuthi hhayi ngeke, ngeke ngibuyele emumva futhi. Hhawu, ngeke phela ngoba sengikhathele, ngoba into eyayishiwo nale ekhaya ukuthi, 'wena, 1 step phambili 3 steps emumva, ayikho lento yakho uyadlala'; eyi ngibuke naleyonto, uthole ukuthi ngizojika sengithi ngiya eLindelani ngiyothenga".*	MONDLI: "I stop myself again in my head that no, never, never would I go back again. Hhawu, never now because I am tired, because what they used to say here at home is that, 'you, 1 step forward 3 steps back, we lost hope with you, you are playing'; ey, I would see that thing, and you would find that I would come back on my way to Lindelani to buy".

Mondli would, automaton-like, find himself repeating what he used to do six months earlier. He reported to have occasions of thinking about means of finding money, even though he had no immediate need for it, now that he was no longer a whoonga smoker. When he had money, he had "caught himself" travelling in the direction where he used to smoke whoonga. As he confessed later, he thought that the chances of such temptations cropping were great. In saying that he is able to stop himself, Mondli is perhaps articulating that internal ability to regulate his behaviour. He weighs the costs and benefits of the relapse, and concludes that starting afresh or going back would not be worth it. Perhaps this further explains why Mondli believed that the pain of desisting from whoonga was a deterrent. Therefore, for Mondli, going back would mean having to face that pain again. Mondli found that to be a perpetual cycle that always undermined his efforts to recover. Caregivers had also noticed this pattern of stopping, and relapsing. Mondli believed that by going back to smoking whoonga, he would be fulfilling who he had already been known as. Relapses have defined part of who he was as a whoonga habitué, and in breaking that cycle, this self-regulation proves imperative in guiding Mondli to sustain sobriety.

For Mondli, such a need to resist this tormenting pull to use again may come with presuppositions made in literature with regard to recovery in early stages. Mondli was at a vulnerable stage of recovery, where the pulls to use again were even more frequent and demanding.

For Lunga, who had desisted from whoonga for more than three years, the pull to use again had not subsided. Lunga mentioned that the urge to use again would still come to him.

Extract 40:

LUNGA: *"Kuyekufika ukuthi yabo, uthole ukuthi ngingaya ukuyobhema, kodwa kube ukuthi, 'Hawu ngeke sekube yisikhathi esingaka, ngabe ngiyagula', yabo?"*	LUNGA: "A feeling would come, you see, you find that I would feel like I would go and smoke, but it just becomes, 'Hah, never, it has been such a long time, I would be sick, you see?"

In the extract (40), Lunga found that the pull to use again would come over him. As a mechanism to maintain sobriety, in smoking again, Lunga would have undermined his efforts to remain sober for this long. He believed that he would be sick if he tried smoking again. The period of recovery may assist the person in recovery to remain sober. Gains that time adds in one's recovery assist individuals to remain sober. Again, the incremental gains of recovery at a stable level of sobriety may, in themselves, have mechanisms that allow an individual to progressively maintain sobriety. The danger for relapse is still there, perhaps not as strong or as frequent, but it reminded Lunga that he was not yet in the clear. The grip of the addiction and the pull to use again remains for some time with a recovering whoonga addict. For Mondli, this involved the effort to self-regulate his behaviour. For Lunga, the long time after desistance assisted in maintaining recovery. The effort needed could be reduced over time, making it easier to resist, nevertheless it is still there.

Relapse is a reality that participants had to face. For Sipho, apart from a three-month-long desistance, there were other unsuccessful attempts to quit whoonga. Among friends, after bad experiences in their hustling, they were caught stealing. Chased and beaten by the community members, they vowed to stop. In the extract, Sipho reports this stealing to have happened during the day. Sipho is expressing the daring and the indiscriminate nature of their theft. Thinking that the person who had seen them did not notice that they were stealing, he did not make it clear as to where he was going, when he left them.

Extract: 41:

SIPHO: *"Nje kamakhelwane emini sibanjwa omunye umuntu wakwamakhelwane ahambe ayosho, ahambe athi uyezansi thina sizitshele ukuthi akasibonanga sibaleke".*	SIPHO: "Just here at this next-door neighbour, during the day, we were caught stealing by someone from the neighbour's house and he went to report, and he left saying that he was going down there and we were telling ourselves that he did not see us and we ran away".

It seems as though the friends sensed that they were going to be reported, hence they ran away. And when they had been reported, the community punished them. Sipho found this a reason for them to stop smoking whoonga. Sipho described this group attempt ending with friends smoking with other people, until they realised that nobody had stopped, and continued smoking together.

7.3 Nurturing Potentials (Approximating Citizenship)

The theme nurturing potentials clusters efforts participants made in developing and maximising their trajectory towards full recovery and functionality. It includes reflections that described what drove the need to desist from whoonga use. Some were incremental nudges that addicts made to realise sobriety through desistance. For participants, as outlined in the previous theme, recovery begins with sobriety. It further involved the needs and the drive to function again. These are the negative reasons participants presented for evading negative addiction lives, becoming functional. Positive reasons are those that pull towards making something of themselves for the sake of their loved ones. Participants wanted to be normal in ways that do not draw negative attention and disapproval by the family and the community members. These behaviours contain the conscious effort geared towards normality, shedding off the *iphara* identity, to become functioning again. In recovery, these reflections could be considered efforts to becoming human again. Becoming human is completed by having relationships with the family, peers, and the community. Such involved actions and behaviours by participants that when they were reciprocated proved to participants to be beneficial, meaningful and rewarding.

For Sipho, who had been away for more than a month this time, compared with week-long bouts he had spent away before, returning home was a nudge that took him towards recovery. He was at a low, at this time selling scrap metal. Now a junkie, this usually indicates that other means of hustling had been taken away from the addict. Mandla described the task as having minimum risk compared with stealing, which could result in retaliation by those he stole from, and possible arrest. Although Mandla would steal scrap metal from people's homes, collecting it among the

community did not involve getting into trouble. Perhaps it is the addict's appearance that becomes a give-away, making an *iphara* identifiable from afar. It is easy to imagine it becoming difficult to get close enough to people to be able to steal from them. The next option would be begging.

Extract 42:

SIPHO: *"Angisenamuntu. Kufanana nokuthi angisenasihlobo ngoba wonke umuntu wasekhaya akasafuni ukusondela eduze kwami manje. Wonke umuntu akasangifuni manje. Sengiyisilwane nje".*	SIPHO: "I have nobody. It is the same as if I have no relatives because my family did not want to come close to me. Everybody does not want me now. I am an animal".

In the extract, Sipho explained that, in this state, he felt abandoned. He felt as though he had nobody and that nobody wanted him. This is when the realization hit him that committing crimes against the family and the community leads to ostracization and isolation. Sipho identifies this as a painful experience that was brought to his consciousness, sobering him, in knowing that being an *iphara* included being away from home, and what this really meant.

This realization made Sipho consider quitting; succumbing to the pull to use again, he did not stop. However, this gave him the resolution to return home. When he returned home, the family did not engage with him.

Extract 43:

SIPHO: *"Uma ngibuka ontanga bami, njoba sengibuyile-ke sengihlala la, ngiyababuka bagezile la ngaphandle mhlampe bayahamba baya koGateway bayikhiphe bayodla. Ngiyabuka ukuthi hhayi bo mina ... ngabe nami ngiyahamba nami. Imina kuphela ozicindezelayo ngale-whoonga le engiyibhemayo".*	SIPHO: "When I look at people my own age, as I had returned and stayed here, I would watch that they are clean out there maybe they are going to Gateway on an outing to eat out. I am watching and I am thinking; haibo, me … I could also be going. I am the one who is quashing myself with this whoonga I am smoking".

He lived on his own in his backroom. Not only did his family exclude him from outings, he felt that his former non-whoonga smoking friends could not accommodate him. In the extract, we are treated to a lamentation of someone envious and concerned with not being able to live a "normal" life. Sipho looked at others, envious of their ability to enjoy things enjoyed by young men of his age. He could not join them. This was because he was an *iphara* who was unable to be as normal as his cohorts. He noticed that his friends were clean, suggesting that he looked at his own dirty appearance disapprovingly. He compared himself with what he could be, and realised that his

present state fell far short of that. As he mentioned in the extract, his friend embodied what he could be: he would watch from afar his peers who were not whoonga smokers. They were clean and doing what normal young men his age would do. This involves going out and dining at malls. Clearly, he enjoyed these activities, but he seems amazed and saddened that "him" as he was then would not be able to join in. This "him", a nobody, watched others leave home and he would be envious. He wanted to be included. He, the animal he said he had become, not washing, was not human enough for others to include him. Sipho had the potential to be like others, and this bothered him. Perhaps he thought of himself as a loser.

In recovery, Sipho said that he just wanted to be normal; where people would not look at him, reminding him that he had stolen from them. His sense of being a normal person included being viewed as not different in a negative way. This involves the reversal of what he was, shedding off the *iphara* identity. Sipho said that he wanted to end all the stories that came with being troublesome in the community.

Extract 44:

SIPHO: *"Kungabi khona into ehlukile ngami njengokuthi 'hhayi lo watshontsha iTV yasbanibani', 'wenzani'.... Ngifuna ukuqeda zonke lezozitori lezo ngibe ne-record emphakathini njengomfana o-right walapha kasbanibani uyazitohela, uyazizamela, nabangani bakhe".*	SIPHO: "I don't want anything different about me for example 'no this one stole so and so's TV', 'he did this' …. I want to end all those stories and have a record in the community of a boy who is alright from so and so's house, he works, he is working out things for himself, and his friends".

This involves both the deficient and evading properties, negative factors that came with being a whoonga addict, as well as positive factors harmony with the community would bring. Sipho wanted the community to regard him as someone who spends time with his friends. This involves being able to find employment and being able to make something of himself.

In moving away from being an *iphara*, Sipho found that his behaviour and that of fellow whoonga addicts was antisocial. Sizwe was expressing being sick and tired of a life of being in trouble with the family and violating the community, in the process of life centring around acquiring the next fix.

Extract 45:

SIZWE: *"Wenze amacala, kuzoba iyona futhi leyompilo, ukuthi njalo fanele uvuke uqaqe. Ekuseni kufanele uthole into yokubhema, ntambama ... yabona ukuthi i-life emile leyo engayi ndawo ngoba ugcine ungasahlonishwa muntu. Uxabana nabazali bakho, abanye bagcina sebetshontsha endlini yakubo".*	SIZWE: "You create criminal cases, and this will be your life again, that you always wake up and unfasten. In the morning you have to get something to smoke, evening … you see that life is going nowhere because no one respects you. You fight your parents, and some even end up stealing in their own houses".

In the extract (45), the woes of whoonga addiction are such that it is burdensome, and recovery means relief. Sizwe expressed some negative reasons for moving away from being an *iphara*. He found it extreme that some would steal from home. He himself was rude and disrespectful to his parents and family members, demanding money for the next fix. He described whoonga as something that stifles progress, *"iyabambezela"*. The addiction to whoonga stifled his own progress in life. At 30, he had never been employed. He began dedicated use of whoonga soon after school. At this stage, this preoccupation robbed him of the chance to acquire a skill.

Mandla found a need to model good behaviour, now that he had been arrested; and he needed to prove that he had changed. It was a concern to him that he had been arrested, and he lamented that this had acquired him a criminal record. To be a better person who had been through difficult lessons in life, modelling good behaviour, to him, was beneficial to those who looked up to him. Mandla found that both arrests and being a whoonga addict made him lose in life. Mandla desires to provide help to his mother and his sister and to make his family life better. Like Sizwe, he finds that whoonga addictions and subsequent arrests have robbed him of the chance to change the family situation that he described as difficult.

Extract 46:

MANDLA: *"... now I know ukuthi nginabantu abeza emva kwami who look up to me ukuthi okay, this is my brother from jail. Uphumile ejele wenza nje, so uyishintshile impilo yakhe, so noMa that I still need to provide help ngimusize ngayo yonke indlela engingakhona ngayo. Ngino bhuti noSisi ekusafanele ngazane nabo and build umuzi wasekhaya. So kungishaye kakhulu ezintweni eziningi, but mentally I can see ukuthi…"*	MANDLA: "… now I know that I have people who are coming behind me who look up to me that okay, this is my brother from jail. He came out from jail and did this, so he changed his life, so and my mother that I still need to provide help the way I can help her in ways I can afford to. I have a brother and a sister that I still need to get to know and build my family's house. Therefore, it hit me hard on many fronts, but mentally I can see that …"

Sober, Mandla intimated that he was mentally prepared to take it now. Nurturing potential to maintain sobriety and a direct attribute to ending connections to his former life were made explicit for Sizwe by a refusal to socialise with people who had been smoking whoonga with him. For Sizwe, this was the most important thing, but the next step involved acquiring a relationship.

Extract 47:

SIZWE: *"Ukungabuyeli kulaba ekade ngihlala nabo ababhema i-whoonga. Okwesibili futhi ukuthi fanele ngithole i-cherry…"*	SIZWE: "Not going back to the people I used to hang around and smoke whoonga with. Secondly, again is that I need to get a girlfriend …"

Sizwe had made it clear that in his previous relapse he had lost a relationship with someone who was not prepared to be partnered with an *iphara*. He said that the woman was suspicious of his company of whoonga friends. Friends came to visit him in his home, as an appropriate venue to smoke whoonga indoors. In recovery, his next step would be to find himself a girlfriend. That person would be a buffer to smoking again. The girlfriend would present approval and a confirmation that he was no longer to be thought of as an *iphara*. Recovery involves intimate relationships that addiction to whoonga negates.

Although now Sipho had a three-year-old daughter, when he was a whoonga addict, he envied the state of being functional. This included the ability to be a father, and to start families. Sipho believed that this was something that would follow in the normal progression of his life. At that time, he was unable to be in a relationship.

Extract 48:

SIPHO: *"Ngaqala ngacabanga ngabona ukuthi ngeke, ontanga yami bawoBaba banezingane ngihlangana nabo ngiyiphara mina. Umuntu nomuntu unengane yakhe, into yabo iqondile. Ngiyabona ukuthi, haibo isikhathi siyangishiya … yabo?"*	SIPHO: "I began thinking and saw that no, my peers are fathers, and they have children. I meet them and I am an *iphara*. Everybody had children and their story is straight. I can see that, no, time is passing me by … you see?"

Echoing similar sentiments as Sizwe, Sipho found that whoonga addiction took him out of normal functioning as represented by the progress of his friends. Unable to have a relationship, he could not have children. He acquired a girlfriend after he had desisted. Recovery, and a return to normal functioning, include having an intimate relationship, and the ability to socialise with peers.

The issue of alcohol has been raised as a privilege in recovery support, particular in permitting its use in recovery houses. In this study, participants propose that alcohol could serve proof that a person had abstained from whoonga use. It also assured some participants in the course of addiction as a next step in the recovery process. This means that drinking alcohol affirmed to participants that they were sober. From this sample, whoonga addicts mostly prefer whoonga over alcohol. Community members and former peers enjoyed the company of those in recovery around alcohol, serving as proof that they had desisted from whoonga, and they were welcoming the former addict's recovery. To be normal, from this point of view, included desistance from whoonga but not alcohol, and as noted above, not even from smoking cannabis. For Sizwe, when he was reflecting on drinking alcohol as a whoonga addict, drunkenness is overcome by the need for a whoonga high. Mondli was relating incidents of drinking alcohol because he did not have resources for the next fix. While he would drink and it could be witnessed that he was drunk, he would go to bed. Drunkenness would wane, giving way to withdrawal symptoms.

Extract 49:

MONDLI: *"Ngoba even i-arosta, yabo i-arosta indlela eyinkinga ngayo ngisho ungaphuza utshwala uthi, 'othi ngivele ngidakwe namhlanje, ngoba ayikho into yokubhema' … uphuze uphuze uphuze ugologo ube yinhlabathi abantu uma bekubuka uyinhlabathi ushona embhedeni. Budamuke nya…"*	MONDLI: "Because even arosta, the way it is problematic, even if you drink alcohol and say, 'let me just get drunk today because I do not have something to smoke' …you would drink and drink and drink spirits and be very drunk. People would see that you are very drunk, and you would go to bed. Drunkenness will abruptly end …"

The contradiction that he would drink without having money to score the next fix must be understood in the context of local traditional functions that would be performed mainly over weekends. In the neighbourhood, these are methods of acquiring free alcohol. As a whoonga addict, Mondli mentioned that he would hang around homes in the neighbourhood to clean, assisting with preparations when there are functions. Whoonga addicts are freely available in the township for menial jobs.

Extracts 50:

MONDLI: *"Eyi ngaqala-ke eyi sengiyinto yaselokishini eyiphara nje, ngibizwe ngemicimbi … khona, nje…"*	MONDLI: "Ey, I started now, ey, I am something that is always in the township, just *iphara*, I am called when there are functions … that, just …"
RESEARCHER: "*Wenzani emicimbini?"*	RESEARCHER: "What are you doing in functions?"
MONDLI: *"Emcimbini phela ngizobheka amabhodlela, ngizoqoqa amabhodlela …"*	MONDLI: "In functions, I'm there looking for bottles, I am collecting bottles …"

Mondli learned that, as he was an *iphara*, this meant that he was always available in the township. Because he would know about all the functions, he would go to these functions to collect bottles. This could be recycling and cleaning up after guests. In this context that permits whoonga addicts to collect bottles, it would also be possible to acquire free drinks.

Drinking alcohol, for Lunga, was something he did late in his progression towards recovery.

Extract 52:

LUNGA: *"Ngoba notshwala nabo yinto engiyiqale nje sengiyeke isikhathi eside ngoba ngingafuni ukuthi, 'ngeke ngiyeke enyinto eyinkinga ngenxa yokuthi ngizothi ngiphuza utshwala…"*	LUNGA: "Because even alcohol, it is also something I just started after a long time because I did want that, 'I cannot stop something that is so problematic because I would that I drink alcohol …"

In this extract (52), Lunga seems to suggest that he was too vulnerable to take alcohol at the early stages of recovery. He thought that he had quitted something which was overwhelmingly problematic. One can add that he would not want to jeopardise his progress in recovery from whoonga. Perhaps from this point of view, unlike Tshepo, who desisted from cannabis smoking for fear of it reminding him of whoonga, Lunga believed that intoxication yielded a sense of not trusting oneself. Perhaps a pull to use would win under such conditions. Nevertheless, a sense is there that alcohol could be inappropriate at the early stages of recovery. For Sizwe, who was introduced to alcohol use after desistance by employed peers, drinking alcohol meant being welcomed by his community of peers. Alcohol consumption, for him, spending lengthy time with his non-whoonga smoking peers, perhaps not disappearing, and distancing himself from whoonga

smokers, proved to them that he was now sober. But as Mondli indicated, Sizwe confirmed that alcohol use during addiction to whoonga is not possible. Participants suggested that addiction to whoonga superseded the need to use other drugs, alcohol included.

In nurturing positive potentials, finding new ways of being, other than the difficult to deal with urge to use, the stigma and an inability to shake off the status of whoonga have lingering and enduring effects. These effects are difficult to surmount. They speak to the idea that whoonga addictions are disruptions in the person's life that affect the inner and the deeper psyche.

Extract 53:

MANDLA: *"Ey uku-deal-a naleyo situation leyo kubanzima kwesinye isikhathi usithola sihlezi sibhemile insangu to relax umqondo ngendlela esisuke sizitshela ngazo because kunalesis'khathi la esizohlala khona sibe bawu-15 and then abafwethu baphume bonke ukusale ngizobayi-1. And start realizing ukube e-life-ini yami angisithathanga lesa-step esathathwa ilabayana ngabe ngikephi ne-life yami? Ukube angiqhuzukanga la engaqhuzuka khona ngabe ngikephi ne-life so kuyabuya lokho. So noma ungenzani wenzeni, ngisho ungazikhohlisa uthini, there is a time where uzokhumbula khona ukuthi - I was a whoonga smoker".*	MANDLA: "Ey, to deal with that situation can become difficult at times when you find us sitting and smoked cannabis to relax the mind in ways we tell ourselves because there is a time when we would sit about 15 of us as brothers and they would leave and I would leave alone. And start realizing that if I did not take the step that they took, where would I be in my life? If I did not have a bump where I had a bump where would I be in life. That would come to your mind. Therefore, you can do this or do that, even say whatever you want to lie to yourself about, there is a time when you are going to remember that I was a whoonga smoker".

Mandla reflects that, even though one may discuss recovery, perhaps because one has desisted, he is still visited by a sense of remorse and perhaps even guilt whenever he is alone: this disturbs him deeply. In discussing the stigma, the long-lasting effects of believing that people are judging him, were found haunting. There is a sense that experiences of whoonga addiction were traumatic to some participants. In the extract (53), Mandla related that it is difficult to forget that one was once a whoonga addict. These seemed to be thoughts of regrets for trying whoonga in the first place. Mandla imagined a better life without the intrusion of whoonga. He finds his condition a grave mistake. It keeps haunting him that he was a whoonga smoker.

For Lunga, this management of these difficult emotions from his past, which are disturbing events and behaviour in his life as a whoonga addict, are deep and entrenched. In similar ways as Mandla, he finds them difficult to surmount, something he considered had been a big mistake. Lunga drew similarities with feelings a murderer would have.

Extract 54:

LUNGA: *"Ngoba ngisuke ngifuna ukuzijwayeza ukuba, ukuba-strong, ngoba akupheli, kusanalento leyana, angazi ngingayichaza ngithini, angazi, ngathi kukhona into oke wayenza eyiphutha elikhulu. Mhlampe njenge murder yinto engingayichaza kanjalo. Yabo unokuzisola sengathi une-murder, yabo?"*	LUNGA: "Because I would be trying to get used to be, to be strong, because it does not end, there is that thing, that thing, I do not know what I would say to explain it, I don't know, it is like there is something that you had done that you regret as if you committed murder, you see?"

In the extract (54), Lunga related that he was trying to be strong. His overwhelming feeling was that he had made a serious mistake, something that felt as weighty as murder. Lunga describes a sense of deep regret, and bitter remorse. These feelings made Lunga vulnerable to relapses. Whoonga addiction disturbed participants' lives in profound ways. Addicts carry deep and life-long scars from whoonga addiction, as a cause of enduring trauma. Hijacked lives reflect negatively over lost time and productiveness.

Mandla, who believed that whoonga turned him into a monster maintains that whoonga is destructive. For him, other than enduring scars, it turned him into a monster, the after-effects he needs to deal with now that he is sober.

Extract 55:

MANDLA: *"I don't see myself ngiyithinta futhi, ngiyifisa nje - ubone ukuthi ayilunganga. Akekho umuntu emufanele; nokho singeke simuvimbe, but akekho umuntu o-deserve-a ukudla leyanto. Leyanto; it turns you into a monster …"*	MANDLA: "I don't see myself dabbling again, or even just wish – to see how bad it is. Whoonga suits no one, even though we may not stop the person, but no one deserves to ingest that thing. That thing; it turns you into a monster …"

In reflecting on whoonga, Mandla is also connoting that whoonga addiction took away addicts' humaneness, rendering them animals. The nurturing of potentials is a theme that discusses the ability to overcome whoonga addiction where a sustained level of sobriety has been maintained and where participants were developing ways to function within the community. This included the lingering effects of whoonga use that present as mental agony, and psychological pain and distress.

7.4 Conclusion

Recovery from whoonga began with desistance, terminating whoonga ingestion, the cycle of relapse-reuse, and an *iphara* identity. Since participants had had relapses before, an internal resolve requires that participants summon a stronger or a different will. Desistance was difficult: it is painful, marked by withdrawal symptoms. To maintain sobriety involves managing the urge to use whoonga again that is prominent at the early stages of recovery. A non-*iphara* identity involves divorcing oneself from whoonga use, whoonga friends, and acts that are associated with being *iphara*, seeking a new non-whoonga smoking identity in non-whoonga smoking peers. Ending addiction careers is a return to normal life; however, participants were vulnerable to reuse because they struggled with dealing with this "normal" township life marked by boredom, and lack of employment, skills and leisure activities. While the decision and the act of desistance were largely difficult, so was the urge to reuse again, that did not immediately subside. Findings on whoonga addiction are consonant with the idea of whoonga addiction as a condition marked by relapses. Participants had several episodes in their addiction career of use-stop-reuse. Participants' recovery states were welcomed and celebrated by the community. Conditions participants reported to escape by smoking whoonga, for example, included difficult family situation, boredom, unemployment. Some of these conditions remained after desistance; some participants had to deal with the stigma that whoonga addiction accrues. After interrupting lives averaging nine years, the need to belong to the community was accompanied by a need to function. Finding employment and reorienting one's life were other struggles some participants had to deal with.

CHAPTER EIGHT
FINDINGS: RECOVERY CAPITAL

8.1 Introduction

This chapter on findings discusses the recovery capital, with a focus on internal and external resources that assisted the initiation and support for desistance and recovery. Participants found an inner resolve, an idea that a decision to desist whoonga should come from the person inside, to be important in initiating recovery. Findings show that recovery, including untreated recovery, was supported by families and caregivers. For some participants, recovery was facilitated by unrelenting support of a concerned caregiver. Support for recovery began at the initiation of recovery, encouraged and facilitated desistance. Findings in this study confirm that support for recovery is essential, though for one participant who was supported as a person, desistance and recovery were without even non-professional help and support.

8.2 Support for Initiating Desistance

Other than being stolen from by participants, and thus acquiring material loss, caregivers incur further financial costs in using a variety of ways to "treat" whoonga addiction that includes acquiring medication, supporting safe consumption of the drug, enrolling participants in institutions, as well as supporting recovery by buying them clothes and support to further education. Together with findings that show that caregivers incur financial costs, this study further concurs with studies that associate a high level of emotional distress with raising a child addicted to whoonga. However, this study shed light on support that began a journey towards recovery, influencing the initiation for desistance.

Participants indicated that they would leave their homes including their neighbourhoods for days to months, arising from interpersonal difficulties with family members. In a state of mixed emotions, it became a relief that the participant would not be around to steal, but it also became a concern of their guardian for their safety. In a case of Mondli's behaviour, as a whoonga addict, there were episodes in which he would steal from home. Mondli would, at various times, leave home for weeks. When he returned, his grandmother would be angry with him. In most cases, what prompted the return was that, at home, it was easier to find something to sell, therefore this return was initiated by an unsuccessful or a difficult hustle. In some exceptional cases, however, Mondli's return was prompted by the community looking out for him. Whoonga addiction suggests that life becomes perilous as a whoonga addict; there would be a threat to the livelihood of participants and their caregivers. Addiction to whoonga further indicates that caregivers are stressed by their family

member hooked on drugs; they are concerned for their safety. In returning home, Mondli discussed incidents where he would be seeking safety. By stealing, participants preyed on their communities.

Extract 1:

MONDLI: *"Eyi, even ngisho uGogo lapho ubesebona ukuthi, 'hhayi uyashona lo ngempelake labantu bamubamba' ".*	MONDLI: "Ey, even Gogo at that time could see that, 'no this one is going to die for real if these people would catch him' ".

In the extract (1), Mondli mentioned that the situation would be grievous, his grandmother would be afraid that if he was caught, he would be killed. As a caregiver, she tried several ways to save Mondli from physical harm. At different times, she would ask him to go to relatives. In other incidents, Mondli himself would leave his neighbourhood, a phenomenon where participants fled the area, causing trouble for a different neighbourhood. For example, Tshepo encountered his mother-in-law when he fled to his girlfriend to avoid the community wrath in his original neighbourhood. In an incident when Sipho left to stay for a few weeks in the rural areas, he was avoiding being caught by people who were looking for him. Fleeing from the community presents as one of the reasons for the emergence of whoonga parks in city centres. These colonies seem to have further provided the anonymity of the crowd, including where the like-minded would meet and where hustling and scoring the drug would be easier.

Other than the safety of the participants that becomes a concern, caregivers would also be concerned about their own safety and the well-being of their families. As Mondli continued with transgressions in the community, the grandmother's concerns moved to the concern with the safety and livelihood of her family.

Extract 2:

MONDLI: *"Hhayi ngithule angazi ngizokwenzenjani, ngiye nakuGogo, athi uGogo, 'Heyi ngihlulekile mina uwena, uzongiqhatha nabantu, ngizoshiselwa umuzi wami ngenxa yakho' ".*	MONDLI: "No, I am quiet and I do not know what to do, I would go grandmother, and grandmother would say, 'Hey, I am done with you, you are getting me into trouble with the community, they will burn my house down because of you' ".

In the extract (2), Mondli mentioned that, after causing many troubles in the community, he would not know what to do. He would reluctantly go to his grandmother, who would respond with fear that Mondli's behaviour was placing her in a position that violated the community. Persistent acts of stealing from the community placed her household in a position that was oppositional to the

community. She was afraid that the community would retaliate by burning down her house for harbouring a perpetual transgressor. Experiences of a caregiver to a whoonga addict suggest that personal safety of the whoonga addict extends to the family, and for the grandmother, it makes sense that she would be stressed. The moving of whoonga addicts away from the family could have been further encouraged by fear for their families' safety.

Mondli would have acquired scars and other tell-tale signs that he was a whoonga addict, had his grandmother not intervened when he was in trouble (Extract 3). His grandmother supported him, and would help him move to a place where he would be safer. In some cases, to avoid the community wrath, the grandmother would involve traditional methods of healing.

Extract 3:

MONDLI: *"Angifuni ukuqamba amanga, ukube uGogo ubengekho ngabe kuyabonakala ukuthi ay lomuntu, mhlampe ngabe nginezisini. Khona abangani bami abanezisini namuhlanje ngenxa ye-whoonga; abanye basayibhema".*	MONDLI: "I do not want to lie, if my grandmother was not there it would be clear that ay, this person, maybe I will not have teeth. There are friends of mine who have teeth missing today because of whoonga, and some are still smoking".

In light of acquiring different medications for her grandson, and other interventions the grandmother made to assist her grandson recover, she tried whatever promised to work. A sense of frustration, as well as not giving up is evoked, even though at times Mondli would disappear for days and weeks on end. These interventions included financial costs.

Mondli presented a case of coerced desistance: the caregivers' support for a participant led to desistance. Mondli's mother would incur some financial costs to assist Mondli's grandmother to acquire Methadone, in one of the ways that they wanted to help the participant quit whoonga. Mondli would drink Methadone but found that the high it gave was not high enough, as far as Mondli was concerned. Mondli would also smoke whoonga, inviting whoonga-smoking friends to his house. At this stage, he would remain at home, giving the impression that he was not smoking whoonga. The grandmother would notice that Mondli was smoking and buy more Methadone. These efforts were to help her grandson. In reflecting how difficult it was for his grandmother, Mondli believes that what he did was exploitative – *ukubaxhaphaza*. His behaviour was marked by extreme abuse, something that he admitted that he could not take as a person. However, a few weeks prior to this, Mondli had been given money to acquire pills that he said worked as well as Methadone. His friend had acquired the pills from a doctor to assist him to quit whoonga. The friend had not bothered to take them. Mondli told the grandmother, to give him money to buy these

pills, which the youngsters diverted to whoonga. The instruction to take the pill was made by the grandmother, because she did not see progress in recovery.

The grandmother demanded that Mondli drink this pill after she had suspected that, although he was living at home, he had not stopped taking whoonga. Mondli was associating with a friend of whom the grandmother raised suspicions. High as he was, Mondli took the pill to please the grandmother. At first, he thought that the pill would work like Methadone, and he had taken Methadone while he was high, to no effect. However, taking the pill led him to initiate recovery. When he was going through the painful withdrawal experience, the grandmother offered him Methadone that he had requested, and which he took. When he wanted his grandmother to buy him whoonga, seeing that the aversive reaction was not subsiding, the grandmother refused, opting to lock him up in his backroom. Reflecting on his recovery, Mondli had not been able to make his life better and to buy his grandmother a quality home. The grandmother is content now that Mondli lives at home. The grandmother's sister directed me to the grandmother, who was praising the recovery of her grandson.

8.3 Nurturing a Recovery Atmosphere

Another assisted recovery involved an engaged mother-in-law who confronted her son and made a pact with Tshepo, leading to enrolment at a rehabilitation centre. Before his mother-in-law discovered that Tshepo was smoking whoonga, her daughter had been going to lengths to find Tshepo smokes, sometimes at the expense of the basic needs and the welfare of their children. After the mother-in-law discovered from the community that Tshepo was smoking, she approached him and made him understand that she was going to support him as if he were her own child. Tshepo was to decide to quit and when he was ready, he would tell her. While waiting for the participant to be ready, the mother-in-law provided him with some money for essential fixes.

Extract 4:

TSHEPO: "*Angisayi phela ukuyophanta njengoba elukhe enginikeza lemali le ukuthi ngingaphumeli ngaphandle. Ngigcine sengimuchazela ukuthi: 'WeMa, sengi-ready ukuthi ngiyiyeke' ".*	TSHEPO: "I was no longer going out to hustle because she gave some money so that I would not go outside. I ended up explaining to her that: 'Ma, I am ready to stop' ".

The provision of essential fixes allowed Tshepo to live at home and be protected from the community wrath that would come with stealing. Perhaps, for the mother-in-law, it was embarrassing enough in the community that her son-in-law was a whoonga smoker; however, as

he mentioned, he was vexed by this drug. If Tshepo went out to steal, his life would be in danger. In supporting him with essential smokes, the mother-in-law was protecting the participant. This support further exerted pressure on Tshepo, making him accept that he was a burden to people. As he was unemployed, these were the people who supported his children. Upon Tshepo acquiescing in attending the rehabilitation centre, the mother-in-law paid the enrolment fees herself. Tshepo was not to be trusted with money. His mother had sent him a large amount of money for him to buy Methadone and to treat his addiction.

Tshepo's mother-in-law wanted to wait for him to be ready to desist from the drug. This supports the conviction that people addicted to drugs need to be in a mental position to recover. Such must be voluntary, and cannot be forced.

Extract 5:

TSHEPO: *"Mase kuba uyena-ke uMa lo engangihlala kwakhe, wase eyangibuza, ngamutshela ukuthi sengi-ready sengi-right manje; sengingayeka. Wase eyangibuza ukuthi 'ngi-sure sure sure ?' Ngathi mina, 'ngine-sure'. Wavuka nami ngoMgqibelo saya naye eBridge City wafike wa-withdraw-a imali, sahamba saya ema-office ale-rehab".*	TSHEPO: "It was then this mother the one I stayed with at her house, and she asked me, and I told her that I was ready I was right now, I can stop. She then asked if 'I was sure sure sure?' I said I was sure.' We woke up on a Saturday and we went together to Bridge City where she withdrew money, and we went to the rehab offices".

But Tshepo also felt that inner resolve was necessary for initiating recovery. Tshepo believed his socio-economic situation to be dire, compelling him to make something of himself.

8.4 Other Community Initiatives

In a study concerned with support for recovery, it is important to mention the role of the radio station Tshepo mentioned. This should include the nature of the rehabilitation centre as a community initiative that operated outside formal addiction treatment agencies regulating addiction treatment. The opening of the centre was sparked by the need for more rehabilitation centres in light of the growing addiction to whoonga, such sprang from necessity. That it was functional at the time of the interview, as Tshepo attested, shows that it had had some success, and that it was improving. The role of a community radio station programme presented innovative ideas that support recovery from whoonga. These elements suggest diverse ways communities support recovery, and they fall within recovery approaches. This particular programme paraded recovery. In a traditional sense, testimonies of recovery present recovery as a reality. These challenges present addiction narrative. Models, and stories of recovery, are evidence of recovery

supported by non-professional agents. Recovery was not the monopoly of addiction treatment. Tshepo's testimony was linked to both support for recovery, as well as reintegration into the community. Out of own volition, Tshepo had confessed to the public and the community at large that he had quitted whoonga. This confession would reinforce the drive to manage long-term abstinence. The knowledge by the community that he had recovered from whoonga use allowed him to be trusted, easing the reintegration into the community.

8.5 To be Ready and the Intent to Stop

Participants ranked as important, first, an inner resolve, and to be ready to desist. Although being supported, Tshepo insisted that the decision to stop taking whoonga must come from within oneself, backed by strong reasons. Tshepo described his inability to provide for his family, being a burden to those who supported him, and to his children, as well as the evaluation of his material situation. That he had not been able to improve his situation for himself or his dependents provided a sound reason for choosing desistance.

Tshepo found that he would have been less motivated to stop smoking whoonga had his material situation been better.

Extract 6:

TSHEPO: *"Because uma usuqalile kunzima, mina okwami kuthi ukuhluka because ukuyeka kwami benginezizathu ezibambekayo. Khona umuntu othola ukuthi akanangane, kubo basebenza kahle. So ukuyeka ngisho bangamusa e-rehab kubo singekho isizathu, yabo leyonto, so mina ngiyibuke ekhaya ukuthi kuyahlushekwa ekhaya ukuthi akukho muntu o-right".*	TSHEPO: "Because if you have begun it is difficult. For me, it was different because for my stop, I had sound reasons. You will find someone who does not have children, and their family is employed and doing well. Therefore, for them to stop even if they send them to rehab to them there is no reason, you see that, so for me, I looked at it at home we are poor at home no one is right".

This illustrates that there could be a lack of motivation by people from a middle-class background. Tshepo said that he was not able to support his children as a whoonga smoker. In a pre-interview meeting conducted by a rehabilitation centre he attended, Tshepo further used these reasons to support his admission. Tshepo believed that the negative aspect of poverty and the positive aspect of providing for his family made up the two-pronged initiative for desistance.

The support given to Sizwe to initiate recovery was in the form of the money for the acquisition of Methadone. Recovery, for Sizwe, was prompted by a fall-out with a couple he was living with, presented a turning point for his return home after a year of absence. Returning home and staying at home seems a conspicuous sign that participants want to recover; it further assured

those close to them of their intention. For Sizwe's family, it serves as a proof that he could be serious and that he needed to be assisted. Sizwe approached his aunt, who was employed, for money to buy Methadone to recover. Sizwe's aunt waited for two months before she could trust him with the money. In a story they heard from close family friends and neighbours on experiences with whoonga, they suspected that whoonga addicts lie about wanting to change. Sizwe also learnt that, despite many bottles of Methadone bought for the younger neighbour's boy, he had continued to smoke whoonga.

Sizwe believed that he was able to stop using one bottle of Methadone he administered himself, because of his strong inner resolve to change. Sizwe decided to remain at home, cutting down on his whoonga ingestion. His attitude changed: he was no longer rude to the family. This gave his aunt hope that he meant to change. Sizwe's aunt is the person he speaks to and is closest to. She encourages him to remain sober and to be hopeful about life. The aunt further bought Sizwe clothes to wear as he was now also bathing. Upon recovery, in avoiding his former whoonga smoking friends, Sizwe keeps the company of employed peers.

Sizwe learned that not only did a group of his peers discover his recovery, but the community knew about his recovery and they welcomed it.

Extract 7:

SIZWE: *"Ngike ngibizwe abazali babo mina, labafwethu ekade ngibhema nabo. Bangibuze ukuthi mina ngayeka kanjani ngithi, 'angenzanga ngamlingo kwakuzisukela kumina, lo ningamujahi ngoba manje uma nimujaha ngenkani uzoqhubeka abheme …' ".*	SIZWE: "I have been called by their parents, and the brothers I have been smoking with, asking me how I stopped and I say, 'I did not do magic, it came from me, do not push him now because if you push him forcefully he will carry on smoking …' ".

Sizwe reported that he would be approached by parents of whoonga smokers who wanted to know how he had stopped taking whoonga. Sizwe would tell them that putting pressure on them was not going to assist. Like with Tshepo, Sizwe affirmed that parents needed to be patient with whoonga addicts until they had prepared themselves to desist. Sizwe explained that Methadone worked for him but might not work with other people. Sizwe believed that the medication must be coupled with an individual resolve to want to stop, before the medication will be effective.

Extract 8:

SIZWE: *"Lapho umuntu usezinikele ukuthi uzobhema for life, ngingasho ukuthi, 'hhayi wangibuyela nje umqondo ukuthi angisesiyona lento ekade ngiyiyona' ".*	SIZWE: "And now the person has given themselves up to smoking for life, I would say that, no, my mind returned to me just that I am no longer a state I was before' ".

Sizwe believed that whoonga addiction required to resolve and a commitment to stop for one to become sober. Sizwe describes this as the return to his proper thinking - *ukubuyelwa umqondo*, a realization that he could not waste his life on smoking whoonga. Recovery meant that he was saving himself. The hope of making something better of himself relates to the establishment of new friends. Sizwe hopes that, through employed friends, he would find employment.

8.6 Support for Recovery

Participants who initiated desistance, and believed that they had achieved sobriety unassisted, nevertheless required assistance to realise recovery. Although unassisted recovery presented a solo effort, other than for one participant, the sample required support to recovery. Sipho was faced with a real possibility of his own demise. Sipho believed that he was left with no choice but to stop whoonga smoking at all costs. Without recourse to medication, he was able to summon courage, smoked cannabis heavily, and also required milk from his mother to assist with diarrhoea that ensued. Upon recovery, Sipho's family applied the test that if he was still a whoonga smoker, he would sell his clothes. His sister and his mother had bought him expensive sneakers. It was likely that they were grateful that Sipho stayed home after ridding himself of whoonga addiction.

Extract 9:

SIPHO: *"Bangithengela wona amateku abizayo, ngaba ne-phone, ngagunda ekhanda ngamuhle nje … uyabo".*	SIPHO: "They bought me expensive sneakers, I had a phone, I cut my hair and I was just beautiful … you see".

Buying him clothes assisted him to return to normal appearance. To buy him clothes to wear, his family invited Sipho to malls that he longed to be invited to. As discussed above, Sipho felt isolated by his family when he was a whoonga smoker. In recovery, this support meant that the family was welcoming him, thinking of him less as an *iphara*.

Extract 10:

SIPHO: *"Bangibuyisela esikoleni ngahamba ngayofunda eThekwini sengenza i-Electrical engineering; ngahamba ngayofunda e-college. Ngazama nje kwabonakala hhayi kuyahlanganiseka. Abantu ababengi-supporta nje uMa nosisi wami".*	SIPHO: "They took me back to school and I went to study at eThekwini doing Electrical engineering; I went to study at the college. I progressed and it was clear that something was happening. People who supported me are my mother and my sister".

Employed as an intern now, Sipho has aspirations to acquire a driving licence, with the encouragement and the financial support of his sister and his mother. Sipho expresses gratitude to them for their support.

Perhaps, for Lunga, lack of support was caused by his refusal to admit to his family members that he was a whoonga addict. Lunga acquired his own Methadone, fought his demons with withdrawals, till he was able to stop taking whoonga.

Extract 11:

LUNGA: "Hhayi, ngaziyekela mina, yabo nabo babengazi ukuthi ngiyabhema. Akekho nje owaye azi ukuthi, 'okay Lunga yeka ukubhema' yinto engazenzela mina yonke leyo ngazicabangela…bona bangifikela nento, 'khona into ekanje' ngagoloza ngagoloza. Futhi ibilana ekhaya".	LUNGA: "No, I stopped on my own. You see, they did not even know that I was smoking. No one just knew that 'okay Lunga stop smoking' it was something I did myself, and it came because I initiated it myself … them, they came with the thing, 'there is something like this' and I denied it, denied it. And it was here at home".

For Lunga to find employment that allowed him to appear normal and to afford Methadone, he was recommended for a job. It could be because Lunga tried to appear clean, and did not steal from the family, being trusted by his immediate neighbourhood members, that he was recommended for employment. Perhaps keeping clean, a habit instilled in him by his mother as they were growing up, assisted him to find this employment. Mandla desisted from whoonga use after being arrested. Mandla initiated long-term recovery per consideration of the state of his life. Whoonga had landed him in a nefarious position. He was also in possession of a criminal record. Mandla had already made the decision to desist long before he was released from prison. After prison, Mandla was able to find employment. Mandla regretted his addiction life that made him unable to take care of his mother and his sister. He could not improve their well-being; and building them a better house to live in was important to him.

Perhaps friends who dared participants on to recovery could be conceived as having assisted recovery. For Sipho, after dry detoxification, he felt confident to return to friends he had been spending time with before addiction to whoonga. As discussed above, this is how participants removed themselves from the whoonga scene. These friends provided a new group to socialise with.

Extract 12:

SIPHO: *"Sekuphele u-10 days sengizwa nami ukuthi hhayi manje sengingakwazi ukuthi manje ngiyozihlalela nabanye olova sizibhemele ugwayi wesiZulu".*	SIPHO: "After 10 days I was feeling that no, now I can be able to now go and hang around with other friends (loafers) and smoke the Zulu tobacco".

Sipho said that these friends had dared him to desist. They were convinced that he was soon going to relapse. As he remained in their company, he was able to handle those initial weeks and months, proving these friends wrong. Sipho was able to manage the first difficult part of recovery, and he was still smoking cannabis. These friends provided him with a refuge, people to be with, and people who, by their challenging him, encouraged him, and helped him acquire an extra reason to remain sober. When Tshepo returned from rehabilitation, telling his friends that he was not smoking whoonga anymore, they still doubted him

Extract 13:

TSHEPO: *"Usuphuma e-rehab unamanga kuzophela isonto elilodwa ubuyele kuyona lento".*	TSHEPO: "You are from the rehab, you are lying, before the end of one week you would be back to this thing again".

Tshepo said that his friends believed that he would relapse within a week. For Sipho, his friends started by giving milestones that were in weeks rather than in months; and since he kept their company, they could monitor that he was able to reach those milestones.

Extract 14:

SIPHO: *"Ngayekela manje ngisatshiswa abantu bethi ngisazobuyela, ngisazobuyela. Ngeke bayangisabisa laba othi ngiba-prove-le ukuthi lento ngeke ngiphinde ngize ngiyibheme, kuze kube yinamhlanje angikazi ngize ngiphinde ngiyibheme".*	SIPHO: "I stopped being bothered by people saying I was still going to smoke, I will go back to it again. No, they are just scaring me, get me to prove that I will never smoke this thing again, till today I have never smoked again".

For Sipho, this dare gave him the courage to prove that he was stronger, and that he was not going to relapse. He said that people challenged him, saying that he was not going to stop. Sipho was proud of his over six years of desistance; he laughed off the idea of a relapse.

After banishment from family and communal life, participants needed to confront their fear, dread, and nemesis − whoonga addiction. Most participants admitted to loss of any form of resistance to whoonga addiction in their progress towards addiction. For five participants, this took an inner resolve to face the monster they had created, nurtured and become, evoking images of

slaying the dragon. For one participant, recovery was facilitated by the guardian, his grandmother. Such assistance towards recovery is not limited to demanding recovery from participants. Facilitation for two participants was assistance with the acquisition of medication. For another, a mother-in-law assisted with enrolment in a rehabilitation centre when the participant had made an inner resolve. Participants' stories had to prove congruent, for the family and the community, with accepted ideas and behaviours of what constituted recovery. Having vacated the sphere of normal functioning in the early teenage years, full integration involves making inroads back into the realm of coherent life. Returning to the "game" or normal functioning, represented the beginning of healing. However, more struggles served as potentially derailing gained efforts acquired, requiring conscious efforts not to slip back, while carving out new ways of being. This transcends being a non-addict merely by virtue of abstinence from whoonga. It points towards a need to reclaim oneself. Such includes managing the past, avoiding relapses, as well as functioning productively, by taking care of the family, and becoming part of the community.

8.7 Conclusion

Findings in this study show that support was essential in recovery from whoonga. Although there was a case where addiction was hidden, for most participants support proved crucial. For a participant who was coerced, another who required medication to initiate desistance, and for the participant who was enrolled in a drug-recovery institution support included facilitating desistance. One participant was forced to ingest medication. While there is evidence that one solo recovery did not require family assistance, for participants in this study, recovery was nurtured and enhanced by family members. Participants ranked first the need for an inner resolve, strong reasons for a person to want to recover. The idea is that, while recovery is supported, it must be strongly and personally initiated. Recovery is contingent upon an individual resolve to quit whoonga. Participants advanced some negative reasons identified as negative encounters associated with whoonga use. Positive reasons promoted were the need to improve one's situation and the lives of important others. Such affirmed the resolution to quit smoking whoonga.

CHAPTER NINE
DISCUSSION

9.1 Introduction

This study made sense of addiction to whoonga and recovering from being *iphara*, a description of a whoonga addict identity at the peak of dedicated whoonga use. From the narration of experiences with addiction and recovery from whoonga by former whoonga addicts, the study concerned itself first, with (Section 1) what it was like to be addicted to whoonga. Second, the study explored (Section 2) what it was like to recover from whoonga addiction. Third, the study deduced aspects from participants' narratives of experiences with whoonga addiction that encouraged addiction to whoonga, making recovery difficult (Section 3). Discussed under the concept of recovery capital, this included, fourth, dynamics that constrained recovery (Section 4), where both third and fourth sections will make sense of these phenomena against individual, family, community, or organisational resources.

This chapter on discussions will begin by presenting a brief summary of main findings. A guide (see Table 9.1 below) on how discussions were conducted is on the following page. The first section will focus on what it meant for participants to become an *iphara*. The first subsection will discuss this phenomenon from the initial milestone on initiation of whoonga use, progressing to a state of being *iphara*. The second subsection will describe what it was like to be in this state of dedicated whoonga use. The second section will describe what it was like for participants to be in a state of recovery from whoonga. This will include subsections focusing on processes that led to desistance; pathways used to achieve such, including methods employed to maintain desistance from whoonga; and their accompanying feelings, thoughts, identity change, and bodily experiences. The third section will discuss recovery capital, in which internal resources, individual elements that assisted recovery, will be discussed first. The next section will focus on elements that individuals found to discourage recovery, elements that constituted struggles with recovery from whoonga. In making sense of findings, this chapter will address the research question by discussing findings, contrasting them with previous research studies and theories in addiction treatment, including moral, recovery, as well as ecological approaches.

Table 9.1

Guide for discussions

Sections	Superordinate Themes	Discussions	
1. Experiences with addiction to whoonga	Becoming *Iphara*	Initiating whoonga use	Initiating whoonga use as *"ukuganga"*
			Initiating whoonga use as *"ukuhlohlana"*
			Difficult home situation and childhood trauma
			Isolation, distress and depression
		Unfolding development of *iphara*	Enjoying the high
			A point of no return − painful withdrawals
			Pupa and chrysalis
			Modulators and interruptions
	Being *Iphara*	Dedicated whoonga use	Entrenched whoonga use
			Tramp-like state
			Hustling through crime
			Interpersonal struggles
		Outlier life of whoonga addicts	Isolation
			Ostracization
2. Experiences with recovery from whoonga	Becoming human	Prompts to desistance	Turning points
			Care − concern for oneself and others
		Desistance	Dry detoxification
			Medication-assisted desistance
	Being human	A non-whoonga identity	Leaving the whoonga scene
			Choosing positive identifications
		Family and community participation	Family support
			Community support
Recovery Capital	3. Constraining Dynamics	Individual level (internal resources)	Cannabis use
			Withdrawals - fear of pain
			Compulsion to use whoonga
			Friends and peers
		Family and Community/organizational level (external resources)	Motivation
			Family dynamics
			Community
			Schools, NGOs and government departments
	4. Enabling Dynamics	Individual level (internal resources)	Individual resolve
			Maturity
			Growing up and out
		Family and community/organisational level (External resources)	Caregiver support
			Peers
			Community support

9.2 Summary of Main Findings

In the discussion of findings guided by superordinate themes in Chapter Six, we discovered that experimenting with whoonga led participants to the dedicated use of whoonga. This process was described as becoming an *iphara*. However, for one participant, this initial experimenting did not immediately lead to addiction. Experimenting was discontinued as this initial whoonga high produced a negative physiological reaction. While all other participants became dedicated whoonga addicts from the first encounter with whoonga, progression to dedicated whoonga use was a process. It varied in the length of time it took, with indications that such can be modulated by the length of time participants remained at school. Participants described this state of dedicated whoonga use as being an *iphara*. By comparison with "*uskhotheni*", a term describing youth of delinquent nature before and after the whoonga epidemic, to be an *iphara* comprises its amplified characteristics. The term seems to particularise those who progressed to whoonga addiction, with indicators consonant with findings from previous studies and media reports. Such include the lack of concern with personal hygiene, the unkempt and dirty appearance of whoonga addicts, including opportunistic criminality.

Peers and an adult dealer who was also a whoonga smoker played a crucial role in enticing and availing whoonga to recruits. For most participants, whoonga was a different and a better high compared with Mandrax; and cannabis participants had smoked before. Participants wanted to experiment with a high they had heard about, been offered, and sought themselves − whoonga was easily accessible. Participants found boredom to be the pull, including elements of seeking a novel and a different or an enduring high. There are other "benefits" advertised apropos of taking whoonga. Such could be regarded as ploys and myths around the advent of a new and a novel drug in townships. However, smoking whoonga was a progression from cannabis use. Most participants smoked cannabis: the majority had begun adulterating it with Mandrax. Despite pre-addiction to softer drugs, the initiation and the progression to addiction to whoonga presented patterns consistent with addiction theories in terms of physiological and psychological effects. However, this study presented evidence of an aversive reaction to initial use of whoonga. People found an initial encounter with the drug producing discomfort that ended the progression to dedicated use. Progression from initiation to addiction reflected an occasional smoke of whoonga, sparked by a high that participants conceded to have found pleasurable. Most participants stated that at this stage of addiction withdrawal symptoms had set in. Others found it to be defined by a turning point, in which unruly behaviour and criminal acts were committed in pursuit of whoonga.

Addiction to whoonga was associated with a compulsion to take the drug. At this stage, the need for the next fix is described as evading symptoms such as stomach cramps, feelings of

disjointedness, generalised pain, feeling tired, constant yawning, and restlessness. Such symptoms render a person in a compromising position in which the compulsion to get the next fix meant that they would steal indiscriminately. As the addiction progressed, there was a need for "essential" smokes. Called *ukuqaqa* in the morning, there was also a need for an afternoon smoke to allow the addict to function, and to sleep, respectively. At the peak of addiction, participants found the need for whoonga to have been increasing, the number of fixes needed also increasing. Participants would smoke whoonga even when they had just smoked it, evidence of increased dosages associated with tolerance that would have set in. Participants would binge on whoonga at any available moment whoonga was plentiful. In the state of dedicated use, smoking whoonga now a sole engagement in their lives, they would have sold all their belongings, and been left in tattered clothes. While addictions began with stealing at home, then from the community, most participants would, in the state of *iphara,* collect and sell scrap metal. This is described as the worst condition they would find themselves in as whoonga addicts. At this stage, the family would have isolated them, and the community would be vigilant whenever they were around. Participants suffered wrath from the community in retaliation for transgressions they committed; endangering their lives, and those of their family members.

Findings on recovery from whoonga addiction in Chapter Seven, directed by the theme curative confrontations (becoming human), showed that whoonga addiction leads to painful bouts of withdrawal symptoms. Participants got to the stage where they wanted to stop smoking whoonga. Participants had tried to stop several times, prompted largely by extremely negative events associated with whoonga addiction. Participants who were arrested would stop whoonga use while in prison, suffering dry detoxification upon entry because they could not find the drug. Participants would return to whoonga use upon discharge. Peers further played a role in relapses, presenting an enticing environment that encouraged smoking whoonga. The prevalence of withdrawals in addicts' lives presents a life marked by immense suffering. This evidence suggests that pain was not enough of a deterrent to smoking whoonga. However, for one participant who desisted from whoonga use through an encounter with an aversive reaction to medication, pains associated with such a harrowing experience were thought of as deterring him from smoking again. This participant seemed not to have needed an inner resolve that other participants thought was necessary in initiating a successful desistance: his recovery was coerced and facilitated by his grandmother. Most participants who find pain an insufficient motivation for desisting from whoonga claim that people required an "inner resolve" that drove the determination to stop smoking whoonga. In light of previous unsuccessful attempts to desist, this determination was

different, with elements of deeper reflections about their situation. Such determination further propelled courage to desist smoking whoonga, to act on and to maintain that aim.

Findings on recovery from whoonga addiction in Chapter Seven, directed by the theme nurturing potential (approximating citizenship), showed that, in opting for desistance that participants presented as a bridge to recovery, they were driven by negative encounters and negative evaluations of their situations as whoonga addicts. Equally, they were prompted by a need to rescue and improve their lives, including those of loved ones. Driven by a sense of self-preservation, one participant used dry detoxification, the most daring natural form of recovery, a method of desistance without recourse to medication or professional assistance. Another participant used a mutual-aid organisation, namely, by enrolling in an institution. This participant further suffered dry detoxification. Perhaps described best as a case of an aversive reaction to medication(s), in one desistance case, the participant was coerced. Two participants used medication to augment pain and to initiate recovery. Finding money to buy Methadone, for an unemployed participant, was a challenge, and his family assisted. An employed participant bought Methadone himself, and both participants administered Methadone at home independently. Family members and the new group of peers assisted participants to maintain their recovery, rewarding their desistance with activities that gave participants a chance to manage their lives differently. Recovery meant distancing oneself from the whoonga scene; the influence of friends who may induce relapses. Recovery also meant finding a different set of friends to communicate and spend time with. Family members assisted recovery and, in the case of two participants, enforced and nurtured conditions of desistance. Other than an acceptance by the family and the community, in recovery, some participants had achieved a relatively normal functioning, particularly those (two) at the stable level of recovery. Early recovery was marked by urges to smoke again, struggles to reorient oneself back to normal functioning, that included finding employment.

9.3 SECTION 1: Experiences with Addiction to Whoonga

The first section of the first research question in this study explores meanings participants attributed to addiction with whoonga, viz., what it was like to be addicted to whoonga. The stories of addiction to whoonga are stories of journeys to the underworld, the fringes of society, living in darkness, desolation, cold, and suffering a painful existence. The person would have been seduced, and later commanded by a drug whose cravings were extreme: whoonga was an all-consuming and insatiable beast. Dabbling with whoonga unfolded as people smoking whoonga becoming beasts, whoonga was ready totally to consume the person, disrupting all the areas of human functioning and interests. Whoonga use was marked by a loss of care: care for oneself, and for

others. The undirected or misdirected hero fumbled into the edge of the world, some walking away from pain, existential difficulties, inability to fit in, and assisted by a gang-like orientation. This story begins with going to the belly of the beast, a march to a meaningless, narrowly focused life of despair, anxiety, isolation, and lack of care, merely living in the moment.

9.3.1 Initiating whoonga use

Findings in this study show that initiating whoonga was regarded as *ukuganga*, with the distinction that it involved an element of *ukuhlohlana.* These are youthful, misdirected and risk-taking behaviours among township boys hanging around smoking cannabis. For one participant, such was considered an escape from a difficult life situation at home. For another participant, smoking whoonga provided something to do, when dropping out of school left him with nothing to do. Advertised, whoonga was presented to addicts as an enduring high, and for others an aphrodisiac.

9.3.1.1 Initiating whoonga use as *ukuganga*

Addiction to whoonga began with what participants considered an "innocent" experimenting with whoonga, labelled *ukuganga*. This was described as child-like naiveté, in relation to the application of the term on behaviour by adolescent boys, who are young and would not have known any better. This in a sense is where boys in the township would engage in mischief, being troublesome and committing petty wrongs. It must be conceded that addictions to whoonga began with the availability of a novel drug in townships. Experimenting with whoonga links to testing a new drug and tasting its high. Even though this description was a reflection made when participants had stopped taking whoonga, having witnessed the detrimental effect whoonga had on their lives, participants could easily pass judgement on the young and the naive self. Initiating whoonga had elements of risk-taking, hedonistic behaviour that drew participants to a criminally oriented subculture. This description of initiating whoonga portrays a sense of risk-taking, that reads as a remorse, a cry that they did not know any better, supported by the stage at which most participants took whoonga. Whoonga addiction and its perils were not as known; and its negative effects not as obvious. Participants smoked whoonga as part of the early cohort when whoonga was newer and not as pervasive. There are signs within these narratives that whoonga was growing at a fast pace, and aggressively taking hold.

In the context of initiating whoonga use, taking this drug would suggest elements of being an adolescent reflecting risk-taking behaviour, that could involve truancy. While *ukuganga* described in other contexts involved serious transgressions, in initiating whoonga it must be

limited to age-related meaning. It would, however, be incomplete without the element of lacking direction and unsavoury, criminal behaviour that were described to be involved. The term *ukuganga* applied in other contexts in these discussions, is aligned with the behaviour of an adult, suggesting an act that is repudiated and unacceptable. It is something an adult, who knows better would not do, implying that they were a group of youngsters who did not know any better, and possible were simply lacking direction. This implies insufficient education, either as formal education, or guidance on drugs. However, it must be conceded that such further involved a culture that did not give guidance on age-related behaviour.

9.3.1.2 Initiating whoonga use as *ukuhlohlana*

Considered *ukuhlohlana*, initiating whoonga in the context of other boys one hangs around with in the township confirms a sense of dare-devil and risk-taking, but further includes careless and misdirected behaviour. Unlike *ukuganga*, *ukuhlohlana* has elements of knowing or forewarning that with the behaviour lurks danger. On the other hand, it makes such a masculine property, pointing to seeking adventure. Importantly, the term encapsulates the role of peers that other studies have indicated as an important factor in the initiation of drug use among adolescents. This finding seems to confirm a relationship drawn between studies that relate adolescence as a precarious stage of transition from being a child to being an adult. Adolescence is marked by identity-seeking that includes risk-taking behaviour, such as experimenting with drugs. This further seems consonant with feeling grown up, associated with a proclivity to taking drugs. However, this position is confounded by the fact that participants had already experimented with softer drugs, as discussed below. This means that it cannot be sufficient to consider an initiation into whoonga use as an initial experimenting with drugs. Rather, whoonga use was a progression from smoking cannabis, and a majority of participants had smoked Mandrax before. However, elements such as boredom, academic difficulty, truancy and lack of motivation to be at school, particularly the influence of peers, were involved in driving initial use.

9.3.2 Difficult home situation and childhood trauma

Findings in this study showed that taking a drug was a way a participant dealt with a difficult situation at home, where there were interpersonal squabbles, lack of a relationship with his elder brothers, and importantly, feelings of abandonment by his father. The participant described his taking to whoonga as “escaping” this situation. He also judged his family situation as that of struggling. In suggesting that his home situation was “difficult”, he further implied being indigent. The participant admitted to displaying enduring patterns of difficult behaviour from

childhood. Findings in this study would relate to other studies associating drug use with childhood trauma, a difficult family and home situation, as well as abandonment, and the lack of a father figure. Studies that include personality and individual differences that link to drug use may further explain part of these findings. For Watson and Parke (2009), drug addiction is associated with profound tragedy that occurred to some addicts' lives.

What became clear, as an important aside suitable for presentation in this context, is that participants had absent father figures, largely through death. Only two participants had available men "present" in their lives. For one participant, the father was present by being absent, and for the other, while I saw him and I was introduced to him as a step-father, upon data collection, he was never mentioned in discussions. Rather, as it was discussed in findings, for this participant, his mother and his sister were heavily involved in his recovery. They helped him achieve stable recovery that approximated a move towards citizenship. Participants were largely from female-headed households, in the community of INK townships, where only 57% of households had both parents available. In two instances, although male figures were living in the home, they did not seem to be available. This was the case with a participant who struggled and seemed to be longing for a father-son relationship. For this participant, a sense of belonging was found in joining gangs, when he was imprisoned. Studies that link drug addiction with a lack of positive role models would assist in making sense of the findings in this study (DiReda, 2014). It can further be contended that this points towards lack of direction and guidance in the transition through perilous teenage or adolescent years.

9.3.3 Isolation, distress and depression

Traumatic events prior to smoking whoonga could serve as precipitants to smoking whoonga. Directly, the emotional state associated with dropping out of school as a result of behavioural problems, coupled with difficulties at school and falling grades could have signalled a resignation to irregular life for an adolescent. In a study by Brook et al. (2006), greater intrapersonal distress (e.g., depressive mood) was linked to substance abuse. Indirectly, smoking whoonga was a direction toward truancy. One reason for becoming troublesome at school included cannabis use, truant and unruly behaviour that could result in a trajectory of deviant behaviour. Brook et al. (2006) further included truancy as one of the factors associated with a high level of drug use among adolescence, including unconventionality (e.g., tolerance of deviance).

However, elements such as boredom, academic difficulty, and lack of motivation to be at school, was a description of falling between the proverbial cracks. Smoking whoonga could perhaps be less a way of dealing with boredom, and more of dealing with isolation. On one hand

when the cohort is going to school, leaving school suggested that the participant was excluded, and smoking whoonga would involve escaping isolation. On the other hand, an act of leaving school further suggests that mainstream life rejected the person. It could be from a sense of shame that one would not report to parents and caregivers. It could also be the fear of a reprimand, as it was truancy. Whoonga facilitates deviancy when the direction guided by limited possibilities in a township was driving a cannabis-smoking boy towards the company of shady and rogue characters when authorities had rejected him. Smoking whoonga inadvertently included rejecting authority. Taking a drug to deal with this painful situation is an escape. Judged by consequences, such can be considered a maladaptive attempt to escape this situation. Drug addiction from the dislocation theory is a maladaptive response to isolation and not belonging.

9.3.4 Unfolding development of iphara

From findings in this study, addiction to whoonga began with a voluntary experimenting with the drug, confirming findings of studies on the early stages of initiating drug use (Leshner, 1999). The process leading to this state is linear. It started with a hedonistic drive, but included the loss of control, in which smoking whoonga was an act of evading withdrawals. Participants had made prolonged and conscious efforts to continue enjoying the pleasurable whoonga high they were initiated into, or had independently sought. Although not instant, sliding into addiction was not a single event. Two participants had warning signs that their addiction was becoming intense; while others learnt after irreversible and painful withdrawal symptoms had set in. Some participants realised that addiction to whoonga had set in and was irreversible; when the compulsion to use the drug demanded that they seek money to obtain the next fix. When they were once addicted, ceasing to ingest whoonga became difficult. Becoming an addict unleashed rogue behaviour which they did not expect from themselves or know that they were capable of. Cravings and withdrawals were now pushing them deeper into addiction. Addicted, they had to acquire constant fixes of whoonga; such increased as the addiction progressed. In seeking ways to make money to acquire the next fix, addicts alienated themselves from their families and the community. In return, these people brutalised and isolated them, now visibly whoonga addicts. Findings in this study show that the progressive development from initiating whoonga to dedicated use was difficult to interrupt as the pace at which addiction is realised can be modulated; and there are ideas that this progression could also be interrupted.

9.3.4.1 Enjoying the high

Findings in this study show that intrinsic to the development of becoming a whoonga addict is that the whoonga high was experienced as a better, more exhilarating and a different experience. As Kemp (2019) noted in the neurological effects of drugs, the experience of the high is fully reinforcing. Compared with drugs participants took before whoonga − alcohol and Mandrax − findings in this study showed that, after an introduction to whoonga, participants refrained from taking Mandrax and alcohol altogether. Cannabis use remained largely as an ingesting method through which whoonga was consumed. In acquiring whoonga, this is a package that includes the financial costs the whoonga burden had on addicts' lives. While whoonga was advertised by peers to have an enduring high, evidence from findings indicates that, together with aphrodisiac effects, this could be fictitious. Such advertisements remain ploys that can lead to the experience of the whoonga high. The experience of the drug would diminish initial reports of such effects. In the development of whoonga addiction, the whoonga high was neither enduring − rather, the intake of the drug increased − nor did it encourage a sexual experience. On the contrary, the sex drive was diminished. Participants described the whoonga high as *iyashaya*, that it was exhilarating and *imnandi*, a high that was pleasurable − it made one feel calm and contented. This experience of a whoonga high match proposals that whoonga is a euphoric depressant (VICE, 2014). A description of this high coincides with the effects of an initial encounter with highly addictive drugs, including heroin, that are presented as intense in ways that promote its use. Kaminski (2014) finds this as defining the insidious nature of whoonga as a drug.

Progression to whoonga use was enforced by the whoonga high. Studies on addiction to whoonga confirm that, when compared with softer drugs, the whoonga high was described by Mokwena and Huma (2014) as intense and severe. In many ways, this accounts for the attraction to whoonga, as much as a whoonga high further accounts for the entrapment the high presents (Mbanjwa, 2011). Drug addicts would feel trapped by their addiction to a drug (Kemp, 2019).

The whoonga high encourages continuous use of the drug, enforcing dependence on the drug. Studies on tolerance, a result of the continuous use of the drug, show that this could result from an inability to reach the initial high, thus "chasing the dragon" (Strang et al., 1997). While participants limited a description of chasing the dragon to the ingesting method, the idea that it also means chasing the initial high that leads to addiction is presented (Morgan et al., 2019). Continuous use of whoonga, now informed by trying to reach the initial high, is associated with increased use that promotes dependence on the drug. The continuous use of whoonga from inception to a dedicated state links to the pleasant nature of the drug, a finding consistent to patterns associated with drug use, and its effects on pleasure centres of the brain. For Kemp (2019), these

effects are vastly reinforcing. With regard to whoonga, they facilitated the progress to the dedicated use of whoonga. Findings confirm studies that attribute the neurological compulsion and motivation for continued ingestion of the drug as associated with increased intake of the drug, leading to addiction (Gardner, 2000; Le Moal & Koob, 2007).

9.3.4.2 A point of no return − painful withdrawals

Continuous ingestion of whoonga, driven by the enjoyment of the high, reaches a turning point, whose salient registration is initiated by bodily complaints. This stage involves the realization that one is losing control over the drug (Kemp, 2019). As a turning point, it has signalled a transition from enjoying the high to being compelled to take whoonga to ward off withdrawals or pain. This stage should often coincides with the victim dropping out of school (Shembe, 2013), where the school time inhibits hustling that will take pain away. However, the stage is dominated by patterns culminating in development of whoonga addiction, leading to quitting school. Such effects were noted by Shembe (2013), in a study in which participants who were school-going whoonga addicts would leave school, prompted by a need for the continuous ingestion of whoonga. The progression to dedicated use of whoonga involves a stage where withdrawals, such as stomach cramps, described as *arosta*, set in (Mbanjwa, 2014). Participants felt "ill" when they did not take the drug, and the compulsion to take the drug was now motivated and enforced by pain avoidance. This study confirmed prominent symptoms associated with whoonga addiction, largely around excruciating stomach cramps, and generalised pain (Mokwena & Huma, 2014). Such pain compels drug use; and, as noted by Leshner (1999), drug addiction begins with a voluntary ingestion of the drug. Later, however, participants felt compelled to take the drug.

9.3.4.3 The unfolding of *iphara* identity

The final stages of the movement towards dedicated whoonga use, the precursor to full-blown whoonga use presents as the unfolding of the whoonga identity. Findings in this study show that addiction to whoonga became arresting to participants, when the compulsion to seek the drug resulted in criminal and rogue behaviour. This was prompted by a demand to acquire money for the next fix. In response to physical withdrawals, the compulsion to take the drug required that participants hustle. Hustling is the term Hunter (2018) uses to describe the means involved in acquiring whoonga. Hustling for whoonga was described as *ukuphanta*. It has as its *modus operandi* the acquiring of a commodity to sell. Addicts must acquire money, then buy whoonga so that one can smoke. Methods of hustling involve risk-taking behaviour associated with another

addictive behaviour, gambling. Particular to whoonga addiction is that it further involves acts that put one's reputation and life in danger, risking injury when caught stealing. At this stage, most participants appear normal, relatively clean, and perhaps there is still a concern with how the community perceives them.

The acting out of the need to acquire whoonga suggests an acceptance that the person has lost control over the drug. This control was shown as irretrievable. Participants seem to accept that they had lost a fight, assuming an *iphara* identity. The reflection made by participants on this progression towards addiction was now an engagement with complete acceptance of the life that revolves around hustling for the next high. It highlights, however, the compulsion to take a drug with a high so intense that participants were ready to do whatever it took for the next fix. In many ways, it also involves the acceptance of a transition to a different space, described by studies in the progression of a drug from initiation. Findings in this study confirmed that whoonga addiction is fuelled by an increase in the intake of the drug. Behaviour exhibited is consistent with a movement from occasional to increased use of the drug (Le Moal & Koob, 2007; Murray et al., 2012). Patterns include an increased preoccupation with the drug and its acquisition, where the sole aim is to continue smoking it.

9.3.4.4 Modulators and interruptions

The speed at which individuals took to progress from experimenting with whoonga to a realization that whoonga addiction had set in can be modulated by remaining at school, with an indication that smoking whoonga can, at initial stages, be interrupted. For a participant who remained at school although the progression continued, it took longer for withdrawals to set in. This was in comparison with participants who took whoonga after they had left school, where the setting in of addiction seemed instantaneous. There seem to be similarities between contending reports, in which whoonga was reported to be so addictive, one encounter would lead to drug dependence (Naidoo, 2010). On the other hand, this study suggested ideas that this progression could be modulated and may be interrupted. Even though observations that whoonga addiction was "instant", from findings, such a use would not mean "overnight", nevertheless experimenting with whoonga always led participants to whoonga addiction. Participants who remained at school seemed to have reduced the speed of this process. Going to school may well have interrupted the increase of the intake of the drug, presenting a distraction and giving whoonga dabblers something to do.

Findings in this study present evidence of an aborted advance to the addiction stage, where an initial encounter with whoonga would lead to the termination of its intake. Ideas that an initial

encounter would be repulsive, question whether it was possible that experimenting with whoonga does not always lead to addiction. In the study of the progression to whoonga, it is possible that a number of people may not reach addiction to the drug (VICE, 2014). On the other hand, it presents surprising results that the participant was invited to retry whoonga when he was employed. Acting on that invitation, he progressed to being addicted two years after an aborted try. For this participant, whoonga was destructive in ways that led to losing employment.

9.3.5 Dedicated whoonga use

This section describes being an *iphara*, a state that participants see as a developed state of whoonga addiction. In the progression towards the peak of addiction to whoonga, a turning point, the sole preoccupation with whoonga, participants were stuck in a routine that is consistent with life as a whoonga addict. Participants reach a complete cycle that involves the embodiment of this identity and completing the escape from the world. Whoonga addiction involves a selfish preoccupation with the drug, where interpersonal relationships deteriorate, and care for self and others diminishes. As a realization of the entrenchment of addiction to whoonga, these are ways in which seeking after whoonga became the centre of addiction life.

9.3.5.1 Entrenched whoonga use

Findings in this study show that when the transition from occasional to dedicated use occurred, smoking whoonga became the only meaningful activity in participants' lives. At first, the continued use of whoonga was enforced by pain from withdrawals. At this stage, participants smoked whoonga regularly, increasing the intake, succumbing to bodily demands marked by the processes of *ukuqaqa* and bingeing. Demand for the drug became insatiable, and participants would spend much of their time smoking whoonga. They would binge on whoonga whenever it was available. Participants expressed a compulsion to take the drug, in which the thought of hustling for the next whoonga high was present even when the current high was being experienced. Descriptions such as that whoonga is a jealous drug, captures the pull to take more of the drug at the expense of competing life demands. To be an *iphara* involves an occupation that participants equated to full-time employment: it marks a concern with the now.

This stage of addiction to whoonga marks perhaps the longest state in whoonga addiction lives. Remaining at school and keeping employment would have been difficult. Whoonga addiction, in many ways, required and demanded that participants increase its intake. Perhaps unique to the whoonga addiction, is the phenomenon of *ukuqaqa*. Such marks a stage in the evolutionary development of smoking whoonga in which it becomes necessary, in order for a

person to function. It signals the increased intake of the drug, showing that addiction to whoonga was taking root. These essential smokes were needed in the morning for a person even to begin to think of means of hustling for the next high. Addicts were compelled to acquire a smoke before they could sleep. Perhaps therefore, foresight would suggest that a whoonga addict would go to sleep at night while still in possession of sufficient whoonga to smoke in the morning. However, foresight is retarded: participants report bingeing on whoonga whenever it was available, living in the now. This also means that essential smokes must happen on an everyday basis, minimally twice a day. There was an indication that such smoking could be sufficient; and that presenting as normal is possible if money was available and perhaps moderation was to be employed.

Findings in this study further showed that there is a need for a whoonga high that is so compelling that participants will think about ways of hustling for the next high while still high from a previous smoke. Perhaps coupled with whoonga binges that marked both dependence and tolerance to the drug, this stage further indicated the increasing intake of the drug. Whoonga seems to promote its intake increasingly as the addiction to whoonga progresses. The fear of withdrawal propels this need for the drug. It becomes less likely that smokers would take whoonga for enjoyment. From the analogy of chasing the dragon, participants will never again achieve that initial high. When the preoccupation with the next high intrudes on a current high, it is difficult to imagine that participants are smoking whoonga because they are enjoying it. The drug seems to give more of partial relief from withdrawals: it becomes a medication or a temporary cure, rather than an object of enjoyment. The sense of chasing enjoyment of the drug, which had waned since inception, seems to be enacted by these binges. From this understanding, smoking whoonga as chasing the dragon is not limited to the drug administration method; this heroin-variant drug is ingested. It links to a motivation and a compulsion to ingest more of the drug.

The idea that whoonga is a jealous drug proposes that it is compulsive and all-consuming in nature. It also suggests that it draws attention to itself in ways that compete with other life demands. Smoking whoonga excluded taking other drugs, including alcohol and Mandrax. Participants indicated that the priority they place on smoking whoonga makes other needs, like feeding and personal hygiene fall away. Without food, the bowel movement ceases to function normally, and the body without nutrients becomes emaciated. Sexual interest and the pursuit of females that could have begun the dabbling with whoonga would also have waned. Potential female partners distanced themselves from whoonga addicts, mocking them when they saw them. One participant was abandoned by his love interest after she suspected that he had resumed smoking whoonga. In describing it as *isilingo*, whoonga addiction appears as a vexation, something that presents as difficult to get rid of. Participants found that smoking whoonga, at this

stage, brought complete submission to a state of being a whoonga addict − nothing but whoonga mattered. This stage coincided with the pre-contemplation stage, in which individuals have little or no interest in considering change (Di Clemente et al., 2004). Life had begun to exclude everything else, the concern now being the drug. This coincides with observations by Kemp (2019), that life is dominated by cravings and compulsions, including feelings of being trapped, and having no control over the drug. This loss of control over the body extends to other aspects of life, such as increased criminal activities and the destruction of interpersonal relationships. The obvious contradiction is that, while they would have felt unable to control the intake of the drug, the drug had narrowed and focused their lives on getting the next high. This, to some extent, gave control over life events at this time of addiction.

9.3.5.2 Tramp-like appearance

To be an *iphara* involves a distinct appearance; a repulsion towards whoonga addicts is further driven by opportunistic criminality. Addiction to whoonga implies abandonment of other activities, prioritising whoonga over feeding, where the hustle for the next high leaves little time for bathing or for washing. Participants described their state as having let themselves go, in which, according to Kemp (2019), aspects of usual living are avoided or neglected. In becoming *amaphara*, participants were characteristically dirty, lacking hygiene and in tattered clothes. This going deeper into whoonga addiction results in a tramp-like state. The description of whoonga addicts by the media indicates that whoonga addicts are recognisable by physical appearance (Barclay, 2015; Motsoeneng, 2015). Participants describe this lack of hygiene a result of a concern with acquiring the drug arising from a busy life of hustling. Participants showed in findings that remaining relatively clean, and presenting as normal, would be possible if the supply for a fix or some money is constant: that would remove the need to hustle. Hustling proves very difficult, and includes looking for scrap metal. Scrap is usually burnt to remove the metal; this includes handling dirt.

The loss of personal hygiene is further promoted by lack of facilities. Having sold all their personal belongings, and when the money acquired is directed to whoonga, there would not be any money to buy toiletries. When personal belongings have been sold, there would not be clothes to change into after taking a bath. Participants left home for long periods of time. Some were not allowed to enter the main house for fear that they would steal, or have interpersonal squabbles caused by addiction to whoonga. Participants further indicated that the darker skin (complexion) most whoonga addicts are associated with was linked to the exposure to the elements − they were looking for scrap metal in the sun. This situation deteriorates as the drug addiction progresses,

linking to the constant need for the drugs that mark whoonga addiction. This study presented reasons for people addicted to whoonga remaining dirty, and how the zombie-like appearance described in the media manifests (Chapman, 2013a; Motsoeneng, 2015). Whoonga addiction was particularly marked as a phenomenon because it increased what people considered homelessness. Whoonga addicts appear as homeless people in towns, congregating as colonies of dirty youths in cities that signalled the emergence as well as the growth of whoonga addictions in South Africa (Daly, 2014; Motsoeneng, 2015). Such accounts for the reason communities, including police officers, found whoonga addicts in their cities a concern, and the removal of colonies important (Barclay, 2015; Tobo, 2014).

9.3.5.3 Hustling through crime

Findings in this study indicated that part of hustling for a high demands engagement in criminal activities. This confirms an association made between whoonga addicts and crime; and perhaps one of the major reasons whoonga addicts are ostracised. In Durban CBD, this complaint levelled by citizens included the fear of squalor, personal safety, as well as the spread of the whoonga ingestion (Daly, 2014). Findings show that most participants would sell their personal belongings. They would steal largely at home, in the neighbourhood and the community, stealing for money to buy whoonga; this became a norm. Some participants remember creating havoc, causing what they considered “flops” and transgressions in the community, losing control over their drug intake. Participants committed largely petty, but also serious crimes, that included mugging, breaking and entry, as well as interpersonal violence (assault). In some cases, participants would be arrested, acquiring criminal records in the process.

The effects of crime whoonga addicts commit was largely a focus made on the backdrop of communities in affluent peri-urban areas (Daly, 2014; Tobo, 2014). A sense of vigilance that accompanied the increasing number of whoonga addicts in townships further signalled increase in criminal behaviour. It stressed impatience of communities with the rampant increase in negative behaviour associated with whoonga addiction (Barclay, 2015; Motsoeneng, 2015). In townships, communities turned against their own whoonga-addicted children, and under the direction of the drug whoonga, tensions between parents and their children emerged (Masikane, 2018). Such are reminiscent of tensions the struggle cohort had with their parents or elders over political positioning in the mid-1980s (Mdluli, 1987). What is clear is that whoonga addiction creates a rift and tensions between whoonga addicts and communities (Charles, 2014). After crime committed in townships, people would flee from vigilante attacks, and this accounts for the emergence of whoonga parks. In the mobile life of whoonga addicts, addicts leave each place in escaping

community wrath. However, it is also possible that whoonga addicts would have found the company of other whoonga addicts presenting a greater chance of smoking if the hustling was tougher, as described by the case of bluetoothing (Chambers, 2018; Mabena, 2017; Tsipe, 2017). This means that the tendency of whoonga addicts to congregate in a community presented some form of support centred on the drug, maximising hustling as a group. Whoonga addiction makes it safer to deal with its perils when people congregate in numbers. Judging from bluetoothing, this community presents as pathological and toxic. This is further supported by evidence from findings that such a community hinders recovery, providing an environment enticing to drug use, that would aid relapses. It presents traits of a gang subculture.

9.3.6 Outlier life of whoonga addicts

Findings in this study show that participants were ostracised by the community. This was largely associated with criminality, but there were elements of interpersonal difficulties with siblings, the family members, including the community. Such a response is not strange in a traditional African community, where individuals who are seen to work against the community are sidelined (Metz, 2011). This describes what Metz (2011) referred as a failure to be a human, being exhibited by failure to honour other human beings, and being antagonistic to its members and the community as a whole. In the recent history of the emergence of townships, outliers who presented as *tsotsis*, refusing indictment to Apartheid forced labour, chose crime to survive, and though feared, they preyed on the community, and were not accommodated by communities (van Onselen, 1977). In the political era, the descriptions of *com-tsotsi* further suggested the repudiation of outlier life in a political arena. *Tsotsism* and its gang-like culture lingers at the back of whoonga addiction, particularly in a link with prison whoonga addicts are likely to be exposed to, and maybe even model their culture around. Such are ways that do not include participation in the communal good. Metz (2011) noted that such persons would be given labels such as “animals”. Participants in this study confirmed such a reference to their own behaviour as whoonga addicts.

9.3.6.1 Ostracization

Participants encountered episodes in their whoonga-smoking careers in which the community threatened to beat them. In other cases, the whoonga addicts would be caught stealing, chased by the community, caught and beaten up in vigilante attacks. In other cases, the community members would call the community police, and participants would be arrested. What is clear is that the family and the community members were vigilant whenever whoonga addicts were around. Appearing a whoonga addict decreases the chances of hustling, now being kept at a

distance and watched. Hustling suggested that participants had to do it at night, collecting scrap metal and selling it. During the day, they would remain hidden away from the prying eyes of the community, where they would smoke whoonga. Members of the community, including children, would laugh at the *iphara*, meaning that participants related as feeling disrespected. Participants reported to be scapegoats for crimes they were suspected to have committed. Being an *iphara* in the township means that one becomes a suspect for all crimes committed in the neighbourhood.

Studies on addiction to drugs find repugnance towards addicts featuring profoundly in addicts' lives (Hsieh et al., 2017). Marginalization and stigma associated with addiction adds to the woes of living life as an addict. Studies on whoonga addiction show that whoonga addicts are not wanted either by their families or their communities (Dintwe, 2017; Grelotti, n.d.). Functioning at night where no one wants you, involves functioning on the fringes of society, signalling a life that has been relegated to darkness. Families will go for weeks without knowing or bothering about the whereabouts of their family member. This implies a sense of giving up on them, a situation that would subscribe to the view by Orford, et al. (2010) that families react in "withdrawn" and disengaged ways. To some extent, this further accounts for the emergence of whoonga colonies in city centres (Chapman, 2013a). Participants left their neighbourhoods to gain the anonymity of the crowd in whoonga parks. Whoonga addiction signalled a detachment from the family and community life.

9.3.6.2 Isolation

Findings in this study showed that, as a result of ostracization, participants felt lonely and isolated. This became apparent when they were in their worst state of whoonga addiction, a dismal state when they would collect scrap metal as the only available means of hustling. Relationships with family members had been cut off and the community found their only use as menial workers, for instance, cleaning up after township functions. There is an indication that this isolation was at times unbearable and could have prompted a need to end drug addiction life. For some participants, it served as a nudge, where returning home moved a person closer to initiating the end to whoonga use. This stage coincides with reflecting that is associated with the contemplation stage: participants took stock of the loss of relationships in their lives (Prochaska & Di Clemente, 1982). Feelings of isolation, being alone without anyone could have been a turning point, introducing the need to abandon addiction to whoonga. Such is a painful feeling associated with being rejected, being treated as a pariah, not belonging. Connections with fellow whoonga addicts seem to be fluid, with no loyalty to a particular group of friends. Participants moved from one group to the other, driven by hustling. This was a conditional relating, based on achieving a common aim −

getting and sharing a fix. Sharing among whoonga addicts in their own community could involve some form of care and could perhaps be authentic. Kemp (2019) finds isolation to feature in addiction lives, where drug addiction causes rifts in interpersonal relationships. Isolation that could have led to the initiation of drug use featured in excess during addiction.

9.4 SECTION 2: Experiences with Recovery from Whoonga

This section addresses the second portion of the first question by exploring what it was like to recover from whoonga addiction. In digging oneself out of addiction, the story morphs into a story of becoming, the making of a mature human being. The study of recovery from whoonga describes the process of returning from the state of addiction, a voluntary choice that can be coerced to abstain from ingesting whoonga, marking the beginning of recovery. This story of becoming human involved an acknowledgement of the past, the now, in relation to the concerns with the future. Desistance begins with plans made before a person can attempt the act of quitting. This includes preparations that vary from a day, confounding this with instantaneous remission, to several months. Attending institutions, as well as seeking medication to ease withdrawals, are anticipated with desistance. This process culminates in ending the ingestion of whoonga. To maintain this decision, participants had to find strategies for dealing with relapses. Divorcing oneself from whoonga use includes distancing oneself from whoonga-smoking friends. For some, this would at least be at first during the fragile, early recovery stage. It also involves seeking new friends and a return to behaviour similar to routines before whoonga addiction.

9.4.1 Prompts for desistance

Recovery from drugs is a turning point that has remained the most notable in the progression of an addiction to a drug because it means ending the addiction career. This phase becomes significant because it involves a complete overturn of one's life trajectory that can be regarded as the direction back to real and community life. However, like most other transitions, which mostly were automatic, requiring compliance with the demands of the drug, recovery suggests a resolution to resist the demands of the drugs. Turning points present a chance for a participant to pause and reflect, and to rethink their present position in life. Such may present as life-threatening situations, a deeper reflection or coercion; there are elements of maturing out of the drug, becoming "human". Recovery from addictive drugs is prompted by the negative evaluation of the present, and the consideration of the future.

9.4.1.1 Turning points

Laudet et al. (2006) believe that the multiple negative consequences of substance use may include poor physical and mental health, financial difficulties, homelessness, criminal justice involvement, and estrangement from family and friends. Bad experiences lead to the evaluation of temporality and culmination of the truth appear as results. Desisting from whoonga use is followed by enduring pain from withdrawals, particularly for participants who used a natural way that was intense, the aversive reaction being dramatic.

In this study, turning points have been used to describe any milestone that recorded a change in the addiction journey, including the realization of losing control over a drug and recovery. In literature, the major turning point signalling a return to normal life is highly prized as an event that is a turn around the corner in an addiction life. In drug addiction, career people would meet situations that are negative, that would drive desistance. This study found turning points sobering events or predispositions that, for Kassai (2019), mark the beginning of recovery and the change of identity. Findings in this study confirm the descriptions of turning points by Laudet et al. (2006) in which participants reached rock bottom. Multiple negative consequences of whoonga addiction included homelessness, criminal justice involvement, and estrangement from family and friends. Turning points were associated with bad experiences that jolted individuals, according to Kemp (2019), to reorientation to temporality, the evaluation of the past and the future, which usually culminates in the truth. This truth is the reorientation to the reality of their situation. Such a change can be dramatic (Kemp, 2019), as noted in this study by cases of the use of dry and aversive detoxification.

9.4.1.2 Care – Concern for oneself and others

Findings in this study show evidence of instantaneous remission from whoonga propelled by a sense of self-preservation. For Granfield and Cloud (2001), the motivation behind this form of recovery is driven by avoidance-oriented goals. For this participant, turning away from the drug required minimum preparation; it was a concern with one's well-being that seemed more than just care for oneself. It was a desperate need to survive potential overdose and a life-threatening situation. This desistance was a response to a confirmation by the community members, giving feedback to the participant that his life was in danger. Appearing emaciated and an apparition presented impending danger of dying. Instantaneous remission suggests that individuals would, without recourse to medication, abruptly interrupt their addiction lives. For this participant, this was described as dry detoxification. This participant reached a crossroads in his addiction career. The choice was to continue with drug addiction and perish; or to quit whoonga to bring an end to

the drug addiction. For a participant who was rejected by fellow whoonga addicts, chasing him out of their house, perhaps rejection and feeling excluded presented a low. Such spurred this participant on to return home, considering desistance, and working on a means to ease pain, and act on it. Notions of recovery from addiction include the employment of the technologies to care for oneself (Foucault, 1988) by enduring concomitant pain, acting on a decision to end drug use (Prochaska & Di Clemente, 1982).

Findings in this study show that participants chose to stop smoking whoonga directed by a concern or a care for loved ones. For Granfield and Cloud (2001), this motivation for recovery would be encouraged by approach-oriented goals. One participant made this decision when his arrests and sentence moved his mother to tears. For another participant, it was a need to improve the life of loved ones, to realise the responsibilities of being a father. He saw himself as a burden to people who were availing the drug to him, and taking care of his children and himself. He could see that he was not being responsible. Quitting whoonga meant that he was driven by a need to act according to the responsibilities. Quitting whoonga therefore became a way of assuming responsibility over one's roles in life to be able to take care of those dependent on one. From a life that was selfishly indulging in drugs, recovery is considered becoming *umuntu*, because at the core of being *umuntu* is to care for oneself and others (Swanson, 2007).

9.4.2 Desistance

Findings in this study show that participants considered desistance from ingesting whoonga as marking the beginning of recovery. Perhaps the most difficult hurdle in opting for ending addiction and maintaining recovery is the psychophysiological effects of prolonged drug use. Ideas that recovery is a heroic act highlights ways people choose to desist from using whoonga. Attempts to end drug use had been unsuccessful in the past as they resulted in relapses. Perhaps, therefore, a successful attempt has required a different and a stronger will. Desistance presents an action stage, in which reflections that compelled the need to desist are put into action (Prochaska & Di Clemente, 1982).

9.4.2.1 Dry detoxification

Dry detoxification, as a desistance method, describes the mechanism of quitting a drug that falls within the category of natural recovery. Natural recovery involves ending drug use without recourse to medication or professional help (Cloud & Granfield, 1994). Dry detoxification is associated with painful withdrawal symptoms for which neither medication, professional nor mutual aid support is rendered. For a participant, such connotes a dramatic and abrupt cessation

of whoonga, where nothing to ease pain was used. With regard to a whoonga situation in South Africa, Monyakane (2018) introduced this term, dry detoxification, to describe this method of quitting whoonga use, under conditions of arrest, where desistance is coerced. Elaborations on this term describe harrowing pain caused by the body purging itself of physiological effects of the drug (Khumalo et al., 2019). Detoxification is associated with early stages of ridding the body of the drug, usually in an institution and where professionals would assist. Dry detoxification includes desistance without professional or medical help, but it links to an instant change. It presents as the most difficult way of ceasing whoonga use, as an ordeal marked by pain. Voluntary detoxification marks this independent effort to stop using whoonga, however, participants who were arrested, including the participant who was assisted by a mutual-aid organisation, all suffered desistance without medication.

Recoveries from addiction are heroic journeys marked by heroic acts (White, 2002b). Desistance from whoonga use through dry detoxification would be considered heroic as it marks the drive to endure unbearable pain that comes with withdrawals. In this study, such was voluntary and solo, driven by an intense state of being at the crossroads, facing death. The destructive nature of addiction to drugs presents a situation that is regarded by some researchers as driven by the instinct to preserve one's life (Kemp, 2019). Conditions that led to dry detoxification were a reaction to death, presenting desistance and recovery as seeking life itself. For this participant, quitting whoonga was compelled by a need to survive. The drug began with a pleasurable high, but drove this participant to the brink of death, and as Kaminski (2014) pronounced, whoonga addiction is pernicious. Perhaps, a predisposition driven by a death instinct.

9.4.2.2 Medication-assisted desistance

Findings in this study show that medication assistance featured in assisting participants initiate desistance. In two cases, there were preparatory phases between the decision to desist whoonga and acting on it. For one participant, this was delayed by the need to acquire medication − he was unemployed, and he needed someone to fund medication. This participant returned home, communicated his intent to stop, and began staying at home to indicate to the caregivers, who did not trust him, that he was serious about ending whoonga ingestion. Two participants underwent a preparatory phase, in which they began to cut down on their whoonga ingestion. Medication was also self-administered at home, under the direction of professionals from which they had acquired the medication − the medical doctor and the pharmacist. Findings in this study advocate the need for availing medication to whoonga addicts who are willing to stop taking whoonga (Scheibe et al., 2018). Given the number of whoonga addicts, it makes sense that available health centres

would dispense medication and assist in availing medication and attending to other health conditions (Myers et al., 2012).

Seeking medication to assist participants to desist from whoonga use and recover, involved reflections, the basis of which was the knowledge that desisting from whoonga presents with withdrawals which are painful; that maintained addiction, causing relapses. Medication and seeking it were therefore ways participants dealt with their immediate world to achieve desistance. This included the realization that individuals cannot abstain without medication. Finding medication meant communicating with caregivers and doing whatever it took to remain within the caregivers' favour. This included ideas on the evaluation of self-efficacy (Bandura, 1999). It also involved the application of skills to manage the world around them in order to achieve the aim. Participants had to evaluate their capabilities against the available possibilities in the world, that involves functioning and acting in the world in ways that yielded desired change.

In a whoonga situation, an advocacy for availing medication has directed great effort in dealing with whoonga addiction in South Africa, drawing parallels with how the country dealt with HIV/Aids by availing ARVs (Marks et al., 2017). Findings in this study show that, for a participant who was willing to desist but could not afford medication, OST programmes would assist. At the time of the interviews, one of the trials of these programmes had begun in Durban, the main CBD for this population the sample was taken from (Scheibe et al., 2020). In a township situation, even if there was knowledge of such a programme, transport costs would present a challenge. With availing medication to communities, it would make sense that OST, perhaps at first as a mobile clinic, would be made known and accessible to willing whoonga addicts. Community-based programmes have used professionals such as clinical associates (Scheibe et al., 2020), and registered nurses (Myers et al., 2012) in assisting with dispensing medication. In other countries, amendments to dispensing laws were advocated. Drug addictions require treatment by high-end professionals (Coppen, 2014b; Weich, 2010; Weich et al., 2008). Although desirable and necessary (Fernandes & Mokwena, 2016), they will be insufficient in dealing with whoonga addiction.

The case of aversive reaction to medication presents a situation in which medication that induces negative physiological reactions to initiate desistance would be considered part of OST. At this stage, Methadone in the form of syrup, has been the only OST available in South Africa (Weich et al., 2008). This suggests that other forms would have to be considered, including Naloxone. From community-based trials in Tshwane, trial projects have included Naloxone as part of OST (Scheibe et al., 2020). Medication-assisted desistance is one way people initiate recovery; and for recovery approaches, they are important. In a whoonga situation, as noted in other

situations where recovery frameworks are advocated (McKeganey, 2011), medication-assisted recovery forms the intersection and a need for a collaboration of both approaches. The call for a truce among these approaches is made in consideration of an addict who would benefit from medication assistance (Alexander, 2009). As White (2009) noted, drug addicts should do whatever it takes to desist from drug use, but those in recovery would need to be assisted to maintain abstinence. This position resounds as the fundamental concern with recovery, life after desistance, and support for continued abstinence (McKeganey, 2011). Harm-reduction measures are accused of not presenting a method through which people would move to desistance (SAMHSA, 2013, as cited in DiReda, 2014). In a situation described as "parking" on medication, a number of people remain on OST without any progress towards desistance (McKeganey, 2011). This falls within the ambit of harm-reduction measures, alleviating suffering in a non-judgemental way (Marks et al., 2017). The aim of recovery is a long-term support for abstinence from prescribed and non-prescribed drugs (Page et al., 2016).

The use of medication in initiating recovery marks a position that recovery frameworks are an extension of addiction treatment. Medication facilitates recovery by minimising pain from withdrawals, rendering desistance bearable. Physiological effects of drug addiction can be alleviated by medication, implying that they are the reality of addiction to drugs. Other than presenting an intersection of medical/harm-reduction and recovery approaches, these are backgrounds that support the notion as Laudet and Best (2015) noted, recovery builds from addiction treatment.

9.4.3 A non-whoonga smoker identity

Findings in this study show that, after successful desistance, maintaining such a decision involved assuming a non-whoonga smoker identity. Divorcing oneself from smoking includes removing oneself from the whoonga scene and re-establishing relationships. Notions of recovery from addiction include leaving the drug subculture that encouraged drug-taking behaviour (Foucault, 1988). This is a retraction of the steps and the direction people took towards the addiction phase; and it is marked by seeking communion with the family members, non-whoonga smoking peers, as well as the community.

9.4.3.1 Leaving the whoonga scene

Findings in this study show that participants described themselves and likened their behaviour as whoonga addicts to that of animals and monsters. At the early stages of recovery, participants indicated a movement away from whoonga smoking behaviour and friends. One

participant stopped smoking cannabis, claiming that the cannabis joint was a reminder to smoking whoonga. Participants shunned their former whoonga-smoking friends; these friends presented an environment that is likely to lead to relapses. At the early stages of recovery, avoiding such friends was a way of avoiding relapses. Participants who were arrested and desisted from whoonga use returned to whoonga by returning to friends they had socialised with months before the arrests. Returning and staying home further ensured that there was minimal contact with situations that would influence relapses, mainly whoonga-smoking friends. Symbolically, this movement away from friends proposed that participants did not identify with smoking whoonga or the company of people who smoked whoonga. Part of this movement away from the whoonga scene suggests a different identification that denounces one's former animal behaviour. Although participants were empathetic to the addicts' plight, one assisting them with money for fixes whenever the participant could, others laughed at and mocked whoonga smokers in similar ways the community had laughed at and mocked them when they were smokers. Findings in this study are commensurate with studies that show that recovery involves moving away, physically or symbolically from the opiate scene, avoiding opiate users (Waldorf, 1983).

9.4.3.2 Choosing positive identifications

Findings in this study show that part of recovery involves seeking positive identifications. The friends that participants returned to socialise with were friends they had before they smoked whoonga and who did not graduate to smoking a powdered cannabis joint. In daring a participant and doubting his recovery, these friends presented an engaging and somewhat positive atmosphere of recovery that, for the participant, presented milestones towards full recovery. These friends presented support for early recovery and an alternative place to go to for a company of peers. Friends welcomed participants, and they would use them to make an example to whoonga smokers that smoking whoonga can be overcome. This is an atmosphere that was encouraging to the decision to quit smoking whoonga. These friends made participants feel welcomed, accepted, and even made them feel normal, further serving as a distraction from smoking whoonga. For one participant, a hope to gain employment through these contacts further brought hope for a complete reintegration into normal life. These findings are consonant with studies and observations that recovery involves creating new interests, new social networks, and a new social identity (Molobi, 2018; Waldorf, 1983).

9.4.4 Family and community participation

Findings in this study presented situations in which desistance was initiated, facilitated, and coerced by family members. These caregivers were concerned with the welfare of the family member, and they were engaged in their response to participants' addiction. Members of the community, including peers, supported participants after desistance, and, by welcoming them, they encouraged, applauded, and accepted their recovery status. For participants, being with the family and the community, suggested a turning point that signalled recovery.

9.4.4.1 Family support

Most participants found an inner resolve that motivated the beginning of their recovery, and one participant in this study did not require support or assistance − he was employed and could afford to buy medication for himself. For most, recovery was supported by family members, with an insistence by a grandmother and support by a mother-in-law presenting encouragement, and facilitating the initiation of desistance. Findings in study confirm that recovery can be coerced (The Betty Ford Institute Consensus Panel, 2007). A participant's grandmother was concerned with a poor recovery outcome, including the lies by the participant about taking his medication, despite funding of medication. The grandmother insisted that the participant take the medication that led to desistance. Despite mental anguish presented by addiction to whoonga by her grandson, the grandmother was persistent, though at times she would give up on him. Findings in this study confirm studies on parents and caregivers suffering psychological pain and distress as a result of involvement of their children with drugs (Groenewald & Bhana, 2015; Masombuka, 2013; Mathibela & Skhosana, 2019). Such support was unrelenting, but it presented a case of an involved caregiver. According to Orford et al. (1998b, as cited in Hawkins et al., 1992) caregivers would be "engaged", however, they were "withdrawn" at some times.

Support by a concerned mother-in-law who confronted the participant on rumours that the participant was smoking whoonga, sparked a conversation about recovery. The mother-in-law indicated knowledge about recovery, that addicts needed to be ready mentally before they could desist from taking a drug. The mother-in-law was understanding of the participant's situation. In an effort to shield him from the community, she funded his essential smokes. She further funded the enrolment in the rehabilitation centre and took the participant for recovery when the participant was ready. Findings in this study seem to further confirm mental anguish that comes with fostering or raising an addicted person that includes fear for their safety from community retaliation. There is evidence that whoonga addiction presented costs to these caregivers; in this study, support included costs for recovery, in the form of the enrolment fee and the acquisition of Methadone.

Costs associated with providing essential smokes, to shield the guardian and present a recovery atmosphere was reported in this study and present as different and peculiar. Such support could have been associated with being an enabler to the drug addiction behaviour. For example, such can be attributed to the participant's girlfriend, who provided him smokes at the expense of other needs in ways that supported addiction. The mother-in-law had sent out an “ultimatum” that engaged Tshepo in ways that lead to recovery. Studies on whoonga addiction in South Africa associated distress of parents in knowing that their child was involved with drugs (Mabusela, 1996). Researchers recommended support for parents (Groenewald & Bhana, 2015; Mabusela, 1996).

The mother-in-law required the participant to be ready to commit before she would assist him in his committal. A similar idea is related by a participant who had to wait for a while to obtain money from a family member to buy medication, the relative doubting his authentic intention to desist. This participant proved by remaining at home that he fully intended to recover. Other than providing money for medication, the family member was supportive of the participant, buying him new clothes and encouraging him to make the best of his life. Participants were grateful for the support they had received from caregivers and family members; and this includes visits during imprisonment, supporting and funding their education, accepting them as members of the family by allowing them to participate in family life. From definitions of recovery, recovery involves making amends with family members, signalling care and becoming *umuntu* again. Recovery, from an *ubuntu* perspective, was the act of becoming human (Swanson, 2007), which for Vandermause (2011) involves a search for being whole; caring for, and being with others.

9.4.4.2 Community support

Findings in this study show support from the community members at the early stages of recovery after desistance of whoonga use. Such involved accommodation or acceptance, praise and encouragement. These are measures that supported recovery, helping participants evade relapses. Peers presented an alternative group for participants to socialise with when they had abandoned the company of whoonga-smoking friends. Participants felt accepted by these sober friends, and by being part of them, they were able to cement their recovery.

9.5 SECTIONS 3 & 4: Recovery Capital

This section is captioned recovery capital: it covers the discussions of both internal and external resources that supported desistance and recovery from whoonga. The discussion of internal resources that supported recovery will derive from findings, attributes participants

accorded to external support received, and engaged in, when instituting recovery. The next section will discuss dynamics from the narrative of addiction and recovery by the sample, factors attributable to encouraging addiction, and thus discouraging recovery.

9.5.1 Factors that support recovery from whoonga addictions

While recovery was initiated by an inner resolve, a strong determination, and a will to desist using whoonga, for one participant, it was initiated by support by a caregiver. This means that support, and in particular, not giving up on a family member who is a whoonga addict is difficult; however, such persistence assisted recovery. For a participant who used voluntary dry detoxification, in his eyes, his whoonga addiction career would have ended in his death. He had reached an intersection where continuing to smoke signalled that he was going to die. This participant reported to have been left with no alternative but to quit. To summon courage and bear the pain of withdrawing from whoonga was compelling in a life-threatening situation. Perhaps this individual resolve kept one participant going. When he had decided to stop, he had to wait for money to buy Methadone. This participant associated courage to desist as a reason for stopping. This participant found that physical pain was not enough of a reason to stop. Strong reasons seem to tie in with a drive that would sustain one to endure pain that desistance invites. Secondary reasons affirmed this inner strength by giving addicts a purpose. A participant who was employed noted that he spent his income on whoonga, failing to provide for himself, let alone for his family. One participant who saw whoonga addiction as a stumbling block to his role as a father, further saw himself as burdensome to those who were supporting him and his children. Together with a participant who made this resolution to stop as a refusal to cause pain to his mother, this presented reasons of concern for loved ones.

9.5.1.1 Individual factors that encourage recovery

The discussion of individual resources employed overlaps with factors that prompted recovery. To elaborate on internal resources, these would be reactions to reaching a crossroads that prompted and supported a decision to stop.

9.5.1.1.1 Crossroads, reaching rock bottom

Literature reveals that a need to change and to end an addiction life is usually prompted by a bad situation, described as hitting rock bottom. Individual resources employed to remove oneself from a difficult situation relate to negative factors associated with addiction to whoonga that an individual is trying to escape. The drug and its consumption proved to be burdensome to

individuals. In leaving the whoonga scene, people are finding relief for themselves. In the case of natural recovery, such was prompted by a need to survive. In a number of cases that describe a transition towards recovery, participants communicated a need to improve their lives. As discussed above, such was prompted by the harm their addiction lives had caused participants. The need to end whoonga use further included the concern with the welfare of loved ones, who were disadvantaged by participants' preoccupation with whoonga. In reaching a crossroads, the need to desist from whoonga use was a drive by both positive and negative factors. It was an escape from negative conditions and a wish to harness life free from whoonga use, an enticement by possibilities of life flourishing without whoonga. This included making amends and addressing the wrongs whoonga addiction lives had caused.

9.5.1.1.2 Maturing out and growing out of the drug

Recovery from addiction culminated in, and was supported by a change of identity, enforced by elements that relate to both maturing out as well as growing out of the drug. From a traditional perspective, the act of leaving the drug is defined by making amends with family members and the community. It is an act of growing up and maturing as a human being. Such was defined by a yearning to act responsibly as a person for the benefit of others, ending a selfishly engrossed life defined by a preoccupation with a drug at the expense of everything else. In seeking a balanced life that catered for his and other people's needs, the participant was acting as mature adult, consistent with their age. Whoonga was introduced into participants' lives in early to late teenage years; the crossroads gave them the opportunity to review the continuity of this behaviour until adulthood. For participants who thought that whoonga addiction had robbed them of fulfilling needs associated with their responsibility as parents or children and human beings, recovery had an element of maturing up. The view that smoking whoonga was therefore inconsistent with their identity, suggested that leaving it was a form of maturing out of the drug. This involves a realistic orientation to life. Early studies on recovery associated maturing out of the drug as one of the ways people addicted to drugs end addiction lives, mainly in natural ways (Searby et al., 2015). This desistance is largely driven by a drug identity presenting as inconsistent with identity − who the person perceives himself to be.

9.5.1.1.3 The resumption of a new non-whoonga smoker identity

After desistance, the resumption of a new identity characterised by acts opposing behaviour to that of the whoonga identity, dubbed here as a non-whoonga identity, suggests being "normal" again. The new non-whoonga identity facilitated the choice of the company participants kept that

steered them away from temptation to reuse, and forged and confirmed this change of identity. The new identity must devise new ways of being. In early recovery, support to reorientate oneself is a request for assistance to manage the whoonga identity and to take an informed direction. This includes making a break away from familiar whoonga-smoking ways. These ideas resonate with studies that find recovery the management of the former addict identity. Such includes the management of the "spoiled self", reclaiming oneself (McIntosh & McKeganey, 2000).

Seeking employment was a way of finding some occupation and something valuable to do. Recovery indicated a need for life that is useful, a life that flourishes away from drug-taking behaviour. This life is less identified with a drug use: it suggested a meaningful participation to improve one's life. Participants mourned lost time; life influenced by a need to please friends − whoonga-smoking friends. Participants lamented a wasted life, the trajectory life would have followed without the drug, that would have been different. Participants were dealing with remnants of themselves and imagining what they could make of their lives. The mourning over that untapped self was evident. Behaviour after desistance was consistent with the resumption of a new identity, although it defined as "normal" the void created by lost years. Such was evident and may be very difficult to deal with. In recovery, participants' behaviour assisted managing the relapse; and there were efforts to forge new ways of being defined by a new identity. This assisted in managing relapses and in prolonging abstinence.

9.5.2 Support for recovery

Findings in this study show that recovery is supported. The study presented evidence that family members were essential; they proved indispensable to the recovery process. It is perhaps surprising that support included assistance that began with the initiation of recovery, and that desistance could also be coerced. There was a case in which addiction was kept a secret from family members; and as a result, recovery could not be assisted.

9.5.2.1 Support for desistance

In desistance and recovery from whoonga, support proved essential for a case of coerced desistance. This support by a caregiver who was involved in the participant's life had an input that affected positive change. In this instance, support was given by an adult − responsibility served as an unrelenting guide. In the case where a mother-in-law confronted the participants, this support began as an environment that nurtured a nudge towards desisting whoonga use. This caregiver further guided the participant towards a particular method of desisting from whoonga and further facilitated the enrolment. A participant who required medication to desist from whoonga use was

supported by a family member who bought Methadone for the participant. In these cases, support for recovery began with initiating desistance. For most participants, support was received to enable recovery after desistance. After desistance, family members assisted participants by buying them new clothes. They were further involved in family outings. Participants were now involved in the family life. Recovery involved care from the family.

9.5.2.2 Flourishing, approximating citizenship

Recovery from whoonga addiction showed to be success stories for participants at the stable level of recovery. Findings in this study showed that participants did not only overcome drug addiction. Life after recovery was seen as flourishing. In the case where a participant was employed as an apprentice for a professional occupation, support was given to him by family members. This participant returned to school, concluding his high-school level education, and gaining a post-matric qualification. These findings confirm that recovery results in citizenship. As a qualified member of society, his skills will continue to give support to the community.

9.6 SECTION 3: Individual Factors that Encourage Addiction and Thwart Recovery

This section addresses the last section of the research questions, the deduction of factors that encourage whoonga addiction and this would include those that discourage recovery.

9.6.1 Factors encouraging whoonga addiction

The study took from experiences with whoonga addiction elements that encourage whoonga addiction. Stages in the journey to and from whoonga addiction include factors and events before addiction to whoonga, and elements that make it difficult to quit whoonga use.

9.6.1.1 Availability of whoonga

Kempen (2019) noted that the availability of heroin as a drug initiated the increase of whoonga addiction in South Africa. The introduction of a drug with severe and intense effects availed the opportunity to abuse the drug that was highly addictive. From findings in this study, the availability of whoonga presented an ability to abuse the drug and to promote its use. For example, trading in whoonga, a case of a returning convict who sold whoonga, was a chance to make a living out of this drug. Participants found a whoonga high at first to be intense, pleasurable, and exhilarating. Whoonga became a drug of choice that they preferred over Mandrax. But as Kempen (2019) further noted, the availability of the drug further led to increased availability. With increased consumption of whoonga, the market increased. But it must be argued that there are

pulling factors that made an increase in addictions to whoonga rise to an epidemic, including factors that made it take hold.

9.6.1.2 Cannabis use

Addiction to whoonga occurred in a context in which participants smoked cannabis as boys in the township. The age of inception of whoonga use by participants, an event that took place after participants were already smoking cannabis, is from early to mid-teens. In the whoonga addiction situation, the rampant use of cannabis particularly by youth is a cause for concern. In describing cannabis as a Zulu tobacco, participants implied that cannabis use was normal, and claimed its use to be within their traditional rights. In recent history, Asuni and Pela (1986) showed the use of cannabis in traditional settings among African people in sub-Saharan Africa. However, Peltzer and Ramlagan (2007) indicated that its use was under the control of elders. This would include the control over its use by youth. As the second most abused drug in Africa, cannabis use is rampant among youth in an urban setting (Abudu, 2008). This presents a worrying factor in the context of whoonga addictions, where cannabis use was a precursor to whoonga use.

Within the gateway theory, sanctioning cannabis use among youth as means of dealing with addictions to whoonga could be perceived as an infringement on rights of those who would use it without exhibiting problematic behaviour or social dysfunction. As a base drug, perhaps cannabis is a requisite for the subsequent development in experimenting with powders. Five participants had adulterated their cannabis with Mandrax. From findings, cannabis use is acceptable, and perhaps because compared with whoonga it is a softer drug. But it could be that, because of its rampant use, parents, caregivers and the community seemed to tolerate cannabis use. A participant who would not be caught dead smoking whoonga, smoked cannabis at home. Participants smoked cannabis after desisting from whoonga use, and during recovery. In the context of whoonga, this study implicates rampant use of cannabis in the whoonga addiction in South Africa. Researchers find the process of rapid urbanization, pointing to the uprooting of people, to have allowed the drug to be consumed largely by youth (Peltzer & Ramlagan, 2007). In many ways, consumption of this drug in a non-traditional environment was further affected by loss of control over its consumption by elders, pointing towards the break-down of traditional ways directing the consumption of the drug.

9.6.1.3 Friends and peers

The uppermost factor in the initiation of whoonga was the role and the influence of peers. Participants were in the company of various groups of friends when they smoked whoonga for the

first time. One strand of such a company involves the group of boys smoking cannabis together, who went on to experiment with whoonga. Mandla described this as *ukuhlohlana*, presenting a sense of risk-taking behaviour among boys. The other strand involved joining a group of friends who were already smoking whoonga. These friends would then offer the drug to the participants or advertise the whoonga high to them. In advertising the high, perhaps the conceptions that these are ploys to lure people to whoonga use relates to two factors. Firstly, because these stories of how "useful" or "exciting" the whoonga was, were temporary, if they were not false, but proved to be mythical in the long run. Secondly, such an invitation is that experimenting with whoonga leads to addiction, and given the subsequent destruction whoonga caused for participants, it presents as having nefarious intents. But the whoonga high, as participants conceded was pleasanter, meaning that, in some way, it was confirmed to be a "better" high, as advertised. Even though there are enough reasons to believe that this involved risk-taking behaviour, and with ample proof from other participants that the progression to addiction warned of some dangers lurking in the addiction path, the pull of the drug caused participants to ignore the signs. This could further be confounded by the fact that participants took whoonga at its earliest phases of inception in South Africa. This serves to argue that the idea was that, since few whoonga addicts were visible then, participants could have not known about the full effects of whoonga addictions. Nevertheless, there are reasons to conclude that the recruitment of other people promised increased probabilities of gaining fixes; and recruiting those employed would be an assurance of a predictable source of fixes.

Upon reflecting as an adult, one participant disapproved of the availing of whoonga to young people by an elder. This draws from an expectation that elders would provide moral guidance to younger men. The participant repudiates his act and it is within a traditional framework from which the participants draw this moralising. Perhaps to understand why he was a role model in the first place, one must accept the culture of the veneration of prison life. While it can be argued that such a veneration is a preparation for potential arrest that being brought up in such an environment would bring, it is however misdirected. The ex-convict became a role model for boys who were already smoking cannabis, presenting a direction such an admiration was already paving for the boys toward potential career criminality. This seems to be consonant with a study in which a participant in recovery reported not to have had a positive role model before addiction to drugs. As a whoonga addict himself, this drug dealer was not admired for a lavish lifestyle, but because, as a "made" man (belonged to the prison gang), a form of toughness, his persona was something these boys would have aspired to. While it could be conceived as a survival skill, it is also in the absence of positive role models that a truant subculture would be embraced. Perhaps, therefore,

whoonga would feature in boys who admire a criminal subculture before a trajectory that may with or without whoonga addiction lead to them becoming troublesome themselves.

9.6.1.4 Boredom

Findings in this study associated experimenting with whoonga as a means of escaping boredom. Although maladaptive, Mthembu (2017) found substance abuse to be a coping strategy used by youth in a township to deal with boredom. In socially disadvantaged areas in South Africa, Ngantweni (2018) linked the influence of peers, leisure, and boredom as predictors of a drive behind substance abuse by youth. In describing boredom, findings involved the interplay between environmental and individual factors. Participants took to whoonga because the environment offered nothing exciting to do, particularly for a participant who had left school. A chance to be offered whoonga was precipitated by a need to have the company of other people and to smoke cannabis with them. On the other hand, boredom meant that participants were escaping monotonous conditions by seeking stimulation. Participants who smoked whoonga as a group of cannabis-smoking friends, experimented with whoonga as means of seeking novel experience, finding something exciting to do.

Literature on boredom proposed that both environmental factors interacting with individual factors are involved. This interaction happens when the environment presents an individual with a monotonous existence − there is nothing exciting for the person to do. Unemployed and not going to school, having dropped out, this is a sense of prolonged, mind-numbing boredom. Not only is there nothing to do with oneself, there is no end in sight for this state of "doing nothing". The sheer nature of this existence attracts negative labels, considering a state of being *uskhotheni*. Remaining idle in the township and joining a band of youths who were already sitting around unemployed, and not going to school, is not an informed choice: it merely presents as an escape.

Research studies on the boredom associated with the township environment goes to the lack of adequate facilities for positive leisure utilization. Given crowdedness, an average of 7.5 people per square kilometres, one gets a sense that, even if the facilities were available, they probably would not be sufficient, or not diverse enough. However, the ability to deal with boredom refers to an internal state of a person experiencing despair and because they view the environment as offering nothing stimulating to do. When boredom is equally distributed within the similar environment of youth experience in townships, and other people do not take to drugs, this confirms that boredom in the township environment is an individual reaction. While it is possible that the environment has provided nothing to do, it was a choice to use whoonga as something to do that distinguished smoking cannabis: whoonga is a maladaptive response. It is also possible that risk-

taking behaviour, fuelled by proneness to boredom, which are individual factors, would contribute. Clearly, difficulties at school are noted, but are confounded by the use of drugs; and other truant behaviour could be associated with the use of cannabis and whoonga.

Research studies on "ennui" tend to describe boredom as an affect (or emotion) rather than an effect. Unlike emotions that boredom may motivate, ennui does not prescribe what a person should do about the state. Emotions have built-in responses on how one would react to that feeling; boredom does not. Boredom is associated with a sense of meaninglessness, a sense that the world is happening around and excluding the person, since the person feels unengaged. From this angle, environmental factors influencing boredom could be that people lack activities or have limited options to engage in. But it also means lacking the skills to deal with this environment. As a driver, and perhaps a necessity, boredom describes dissatisfaction with one's existence, prompting others to be innovative. For some, when it becomes "the empty workshop" for the devil's hands, this is usually associated with destructive behaviour. Seeking friends to do something with can, in many ways, be considered dealing with boredom in a limited environment. With minimal leisure activities, opting for stimulation such as in a whoonga situation, was associated with risk-taking behaviour. After recovery, boredom did not subside; and remaining sober meant finding different ways to deal with or to endure boredom.

A study on whoonga addiction in townships identified "unstructured lives" (Mokwena & Morojele, 2014) as a concept that coincides with idleness. Such a context promotes drug addiction (Ardington et al., 2016, as cited in Mthembu, 2017). Findings in this study show that participants, as boys in the township, joined various groupings in the local neighbourhood, and different sections, in fluid ways. In this context, hanging around has the function of counteracting boredom. Consistent with studies on leisure time utilization, lack of leisure activities left little else a person can do in a township environment. However, in a study that compared Black African and White counterparts with regard to the availability of leisure resources, it was found that they played a limited role. White counterparts had more leisure resources and they appeared to be more prone to drug use than their Black counterparts (Sharp et al., 2011). In a township setting, coping with boredom was a struggle that involved finding positive things to do that would occupy the person and advance their lives (Mthembu, 2017).

9.6.1.5 Schools and parenting

Studies on whoonga addiction associated addiction to whoonga by youth with dropping out of school (Shembe, 2013). The understanding was that the need for a high, the compulsive nature of the drug, led to a constant need for fixes; therefore, taking whoonga was incompatible

with going to school. Findings in this study confirm that dropping out of school resulted from a competition the drug had with going to school. Whoonga addiction requires constant fixes, and therefore hustling. While this suggests that participants left school because they needed more whoonga, there were also struggles at school, truancy, and disruptive behaviour linked to cannabis and whoonga use. This presents cases that indicated that whoonga addiction prompted leaving school. Findings in this study show that dropping out of school and subsequent unruly behaviour was prompted by addiction to whoonga; however, there is evidence that dropping out of school led to experimenting with whoonga. It was lack of structure, where supervision and something to do was missing, having negated school. Addiction to whoonga gave participants something to do.

Findings further showed that difficulty with academic work also featured. While a link between academic performance and the use of the drug that led to dropping out of school could not be established, participants who remained at school longer conceded that whoonga addiction affected their grades. There is also an indication that remaining at school prolonged the progression to whoonga use, with participants who remained at school taking longer to reach a stage of dedicated whoonga use. In the context of beginning to use drugs at school, the relationship with authority deteriorated. Teachers were involved in warning students of their deteriorating grades, their unbecoming conduct, and some displayed awareness that participants were taking drugs. Though participants lied about leaving school, suspensions were not followed up. Literature attests to the large number of classes in township schools, and perhaps attending to individual students would be difficult. The recommendation to attend to personal and social problems that students from difficult backgrounds present with, was made by these studies. In this study, it seems that this should be extended to students who present with emotional and academic struggles. However, in a situation where teachers are overwhelmed, a concern with progressing students is a push towards making something out of a difficult situation for those students who are willing. With students presenting with drug problems in the context of non-existent mental health facilities at school, it is easy to imagine teachers being overwhelmed.

Some participants did not tell their parents about suspensions or leaving school. Some pretended to be going to school; another participant told one parent that he had been expelled. In a study conducted on university students from a similar environment, teachers were requested to extend their concerns, and investigate personal circumstances of struggling township students. However, in another study on the attitude university students had towards their school education in townships, the “move with the movers” practised by teachers is a concept that proposed that teachers gave little attention to struggling students. Participants in this study did not drop out of

school out of mere rebellion against authority − difficulty with academic performance was also indicated.

Literature on parenting has indicated that parents who maintain a full-time job would find it difficult to adequately attend to their children's needs. In a township situation, having a job includes travelling to work in adjacent suburbs, extending absence of such parents. To be able to monitor their children, whose school hours fall within the working hours where parents are at work for those hours, township parents would find it difficult to monitor their children closely. Parents leave for work early in the morning before their children leave for school, returning after the children had already returned from school. Distal presence in their children's life seems to describe this situation. Parents would also not monitor children who went to school in other townships or neighbouring Indian and Coloured townships. Since these townships are outside the township, learners would need transport money. A participant used those monies to support a whoonga habit. His mother was not aware that he had directed his transport fare to buying whoonga. The choice to go to a non-township school is based on different education standards the Apartheid government presented for different race groups. Participants went to the schools perceived to offer better education.

Even though the population of INK has 57% of households with both parents available, in this study, male figures were conspicuously absent. Although the study was largely concerned with addiction and recovery from whoonga, it was easy to notice that participants came mostly from female-headed households. One participant had an absent father but who was alive. The participant felt abandoned by his father, resented him, and chose not to communicate with him. A participant who went for higher education communicated assistance from his sister and his mother. Other participants' fathers had passed away when participants were young. One was at lower primary school when his father died. This becomes important in a context where participants reported to find former convict models.

9.6.2 Factors that discourage recovery from whoonga addiction

This section lists and discusses factors that were associated with discouraging recovery from whoonga.

9.6.2.1 Withdrawals - Stomach cramps and pain

Echoing a study that investigated the experience with addiction to heroin, participants in this study found that it was difficult to describe withdrawals from whoonga, described as *arosta*. For some participants this was in the form of stomach cramps. For most, it included the harrowing

feelings accompanying stomach cramps. Participants reported to have a feeling of disjointedness. Such a feeling was further extended to describe a situation in which whoonga addiction suggested that participants' lives and the world were falling apart. The physical pain was unbearable. It was aligned with the idea that whoonga addiction was a compulsion. To use it continuously was motivated by a need to evade pain. Participants equated this compulsion to use whoonga to a command that instructed them to carry on finding the next whoonga fix. This further involves committing transgressions knowingly. Such a drive rendered them slaves to a drug that "instructed" them to act in a way they regretted afterwards. Whoonga, personified, had a life of its own, that rendered participants losing control over the drug.

There is enough evidence in the media of community wrath meted out against whoonga users. Encounters with communities often resulted in participants being beaten, with the danger of physical scarring. One participant was happy that he had desisted from whoonga, and emerged relatively unscathed. He found that some of his whoonga-smoking friends would lose their teeth in these beatings. Noticeably, is that whoonga addicts become an easy target for communities, perhaps because whoonga addicts are associated with stealing. When there are a number of such addicts in a township, it is always not easy to discern the culprit. Whoonga addicts are not trusted; participants confirmed that they would lie to get themselves out of trouble. However, most participants were caught stealing from communities. They would leave those neighbourhoods seeking another neighbourhood where they could hustle. To shield a grandson from the mob justice, a grandmother assisted the participant to move to another neighbourhood. The threat of having their house torched or their grandson killed, was a reality. Communities participants move to allow them to hustle, implying that the environment must be amenable to the acquisition of whoonga fixes, otherwise, it would be abandoned. Participants would not return home for some time, living with whoonga-smoking friends. This was further motivated by a need to gain a constant high, and new ways of hustling for whoonga in a group.

9.6.2.2 Relapses and fear of pain

Addiction to whoonga involves spates of cessation and resuming drug use. Participants would stop taking the drug for a variety of reasons. However, withdrawal symptoms, would incline them to revert to whoonga use. Either through pressure from families, a difficult encounter, or dissatisfaction with one's state as a whoonga addict, participants attempted to desist from whoonga use. Owing to arrests, these episodes of stopping whoonga use were coerced. In prison, where whoonga is not available, participants would stop taking whoonga and would suffer intense withdrawals, dry detoxification. Those participants who stopped on their own or as a group would

return to whoonga use whenever whoonga was available; those in prison returned to whoonga after discharge. These participants attributed their return to whoonga use to returning to the same group of friends they had before arrests. This, for these participants, meant that they returned to the environment that was conducive to whoonga use. For these participants, the pain that came with dry detoxification encouraged them to resume smoking whoonga again. Even before the last successful attempt at desisting whoonga, participants demonstrated the ability to stop taking whoonga.

9.6.2.3 Lying and untruthful life

Findings in this study showed that, to avoid accusations, and as part of hustling, lying or deception was a strategy used by whoonga addicts. Participants began by lying to parents, some by omission, not confessing that they were no longer going to school. Some presented false reasons for not going to school. When participants had stolen, they would refute accusations. When a participant was given money to buy Methadone, the participant would lie about taking it, lie about even buying medication, making claims that they had quitted, further lying that they were stealing to smoke. Such behaviour makes it difficult to assist an addict. Life propped up by lying includes failure to be authentic to other people. It symbolises a lack of care for their well-being. But lying also includes not being authentic to oneself. Lying becomes a problem for participants when well-meaning caregivers cannot discern authenticity from deception. This makes it difficult for caregivers to support addicts; and it makes it difficult to trust participants, at least at first. Outsiders wonder whether participants are genuine about their willingness to recover. Recovery itself was doubted for participants who returned from institutions (prison or rehabilitation centre) claiming that they had quitted smoking whoonga.

9.7 SECTION 4: Family Factors that Encourage Desistance and Support Recovery

As a risk factor, adverse family conditions were implicated by a participant in the initiation of addiction to whoonga. Discussions have established from findings in this study that family support was not always necessary, but proved essential for most participants, in a journey towards recovery from whoonga, both before, but predominantly after desistance. The family engagement in addicts' lives directly contributed to ending addiction to whoonga, facilitated desistance and a motivation to desist, and provided aid to desistance. Indirectly, family support motivated and encouraged recovery, paid enrolment fees, and funded the return to normal functioning, including support for a life after whoonga addiction, seen as thriving. Despite horrendous abuse caregivers

suffered, captured by a participant as *ukubaxhaphaza*, suggesting gross abuse, they gave support, but they demanded proof of sincerity.

9.7.1 Family engagement

From a view by Orford et al. (1998b, as cited in Hawkins et al., 1992), the caregiver, parental and family involvement in lives of participants as addicts was largely withdrawn or disengaged. Support became effective when they were involved, and as established above, it was contingent upon appropriate behaviour consonant with proper willingness and intent to change. In a case of coerced desistance, the opposite was true, where the lack of intent and improvement towards desistance prompted a caregiver to take action. From the discussion on family engagement under the family support section above, caregivers experienced extreme distress with the participants' behaviour as whoonga addicts, that at worst presented a threat to their lives. From studies on how parents and caregivers experienced life with a child addicted to drugs (Masombuka, 2013), findings in this study confirm that it is difficult and emotionally distressing; prompting a recommendation for the extension of support to these parents (Groenewald & Bhana, 2015). There are insufficient resources to deal with drug users. In light of the increasing need for more high-end professionals to be made available, support must be provided for family members. It has not been clear how families would receive such support. From the view by Orford (2008), addiction medicine, with a focus on the individual addicted to a drug, would provide limited answers. The capacity of addiction treatment will be stretched. Limited resources are available, especially in light of the drug-use escalation presenting extra demands on the health care system (Meel & Essop, 2018; Mokwena, 2015).

It is from this point of view that traditional ways of supporting families are recommended. Traditional settings provided ways of supporting families. In a situation where children are raised by a village, employed parents will know about the child playing truant from school. Ideally, when every elderly person represents a parent, managing truancy would be easier. People who are elders would not model gangster culture to young boys, enticing them to drug addiction, and they would behave in exemplary ways. In the absence of a father, the individual functioning within the nuclear family setting in township is individualistic. In minding one's own business, community support has been overruled, and shunned. On their own, families become overwhelmed by dealing with a child "possessed" by whoonga. In this study that is presenting alternative approaches to addiction treatment under the guidance of recovery approaches, several ways of dealing with addiction to whoonga among youth are advanced. Firstly, while mainstream support is needed in initiating drug addiction, the focus should move from reacting to addiction, to preventing drug use. Findings in

this study showed that smoking whoonga was encouraged by conditions where youth did what young boys without any form of authority or guidance would do. In many ways, the study of the lifeworld of whoonga addiction exposes another real struggle in township communities, upholding the diagnosis by Robert Mendelson identified by McKnight (1995) as "lack of community".

9.7.1.1 Engagement as understanding, coercion and financial

The involvement of a caregiver who chose to confront a participant, creating a platform on which to negotiate recovery was driven by a concern for the safety of the participant. The caregiver's views were progressive and on a par with an established understanding of addiction within the drug-addiction paradigm. Pertinent to this understanding is that recovery from whoonga addiction was difficult, and that it cannot be imposed. This knowledge seemed to have encouraged the caregiver's engagement; it facilitated a common and an empathic understanding of the plight of the participant as an addict. Such was followed up further by the engagement of available resources. In this engagement a participant with a caregiver was truthful. Such presented a solution, as much as it was a turning point that jolted a response. To the participant it presented a subtle ultimatum, where part of his decision in getting "ready" was driven by the financial burden the participant correctly assessed that he had become to the family. This support created an understanding that the participant received money for essential smoking that saved him the trouble of hustling. This support adds to financial needs that the caregiver had to provide. The recovery of their family member, as identified by other researchers, included payment for rehabilitation fees.

In a case of coerced desistance, it was a lack of progress towards recovery despite a number of Methadone bottles bought, and other efforts rendered to encourage desistance. In a situation in which a caregiver was prepared to employ whatever strategy within their means that would or promised to work, desperate attempts describe frustration constituting this unrelenting support. As established, participants lie to caregivers, making it difficult to trust addicts with their own welfare. Support for whoonga addicts, although necessary for recovery, proved to be difficult. Engagement by caregivers was useful in recovery, despite that it presented a sense that they would be overwhelmed. Parents may not be able to afford to support recovery, rehabilitation centres being expensive.

9.7.1.2 Supporting families by engaging communities

As discussed above, family members did not only support recovery; they assisted with the initiation of desistance. One participant's grandmother insisted that he take medication. She did not give up on her grandson. Another confrontation by a concerned mother-in-law allowed the

setting of conditions for initiating recovery. While the participant had not decided to stop taking whoonga, the mother-in-law provided him with necessary smokes, described above as essential smokes - *ukuqaqa*. This saved the participant from the dangers of hustling. The mother-in-law was also understanding (and seemed informed) of the nature of addiction, concluding that the participant needed to be ready first before he could desist. While waiting and providing the essential smokes, further pressure was placed on the participant, who had become a burden to those who took care of him. He had neglected his responsibility as a father to provide for his children. While this was support, it also served as a nudge towards recovery.

Family members played a huge role in the recovery of members. Even for participants who did not require medication, their recovery was supported by the family members. For example, a participant who opted for dry detoxification, was glad to announce his desistance to his mother. He had asked her for milk that he thought was going to help with diarrhoea. After desistance, the family gave the participant what he considered a test to prove that he had quitted. Family members bought him clothes, expensive sneakers, and took him to the mall. This is something he had longed for at a distance as a whoonga smoker, unable to approach his family and to participate in their outings. When he had proved that he stopped, by not selling his clothes and by remaining at home, his mother, and particularly his sister who was employed, insisted that he return to school. The participant now a professional intern, they paid for his education.

In this study evidence that family support plays an essential role in recovery that extends to the initiation of recovery was tendered. Findings further confirm studies that show that families suffer a great deal of distress from having a child addicted to drugs. While these studies recommend a need to involve families in treatment, arguing that treatment should give support to families, and in particular mothers, resources will be insufficient. Drawn from these conclusions is that families struggle and would not independently be able to support their own child addicted to drugs. Immediate communities did not render support: they remained a threat to the lives of participants and their families. At this stage, other than welcoming recovering participants, the general community rendered minimal support in encouraging recovery [desistance]. Most participants were not engaged in any form of mutual assistance; nor had they knowledge of available community support by local organisations or government initiatives.

9.7.2 Communal and organisational factors in whoonga addiction and recovery

This subsection of the section 4 discusses micro- and macro-level factors associated with addiction and recovery from whoonga. This discussion will deduce from findings elements that

relate to the macro factors in addiction and recovery from whoonga. They will exclude individual factors; and family factors were discussed in the last subsection above.

9.7.2.1 Political change and transition

Kempen (2019) finds the history of whoonga addiction to have been prompted by the availability of the drug on South African shores. Findings in this study show that whoonga was plentiful, easily accessible and available. The availability of whoonga was contingent on the political transition in South Africa, becoming available with the advent of democracy and the introduction of the country to the global community. Drugs flooded the country. This was linked to the increase of underworld activities − a trend in countries undergoing socio-political transitions (Ivanova, 2010; Racz, 2006). When police were implicated and their officials convicted for activities linked to the underworld, researchers linked the increase of drug usage in South Africa to corruption and moral degeneration (Vahed, 2015). Inevitably, this has been linked to xenophobic attacks in fear that African nationals have brought drugs into the country (Charles, 2014; Vahed, 2015). Whoonga was a drug with links to the heroin trade and ideas that adulterants were an active drug in whoonga were no longer confounded. Research studies have identified the composition of the drug, associated with the influx of heroin from the Middle East. Tanzanians are implicated in the eastern trade route of heroin (Boomgaard, 2010). As noted, youths addicted to whoonga have neither something to do with this influx of drugs coming to the country nor are they profiting from such. Nevertheless, the availability of a drug that was different and indeed having a different and a better high, whoonga became insidious, people committing their lives to the use of the drug.

9.7.2.2 Political leadership

In light of its response to HIV/Aids, the current government was considered prompt and decisive in reacting to whoonga addiction in South Africa. Prompt legislation was passed, while dispelling myths around ARVs considered the major ingredient in whoonga (Cullinan, 2011). However, as Mokwena (2015) noted, in whoonga addiction, a national strategy to curb whoonga addiction has not been promulgated. This becomes important in coordinating multi-sectoral interventions that are recommended by researchers in curbing whoonga addiction. The pernicious nature of whoonga addictions, judging by their effects, is such that tailor-made strategies are suggested, with claims that it cannot be business as usual. This becomes important in streamlining resources and giving direction to communities regarding what needs to be done. At this stage, communities have not been given a clear guideline on how to deal with the scourge of whoonga

addiction, considered a pandemic. Perhaps a cynical view from Hunter (2019) would be that politicians associate whoonga addiction with urban criminality, suggesting that, since it evokes economy − whoonga economy makes money, therefore whoonga addicts contribute financially in their non-criminal engagements. Innovative ways suggested with regard to availing OST or even the tapered administration of the drug itself should be evaluated for the South African situation.

9.7.2.3 Townships settings

Drug addiction landed and thrived in township communities, the drug being made available. Also, the drug arrived in conditions that were fertile to its use. As discussed above, cannabis use, boredom, elements of poverty, as well as lack of community − all such social aspects contribute in perpetuating whoonga addiction among youth. As established, life in townships is a struggle; poverty, and lack of access to recreational facilities tied in with poor leisure utilization limits available interests.

9.7.2.4 Community resources

Studies into media reports on whoonga addiction in South Africa have presented a situation in which addiction, as a problem, has not been discussed comprehensively by the communities concerned. Sensationalising whoonga addiction stories has been repudiated − while this catered to their readers' interests, it failed to produce reaction from the public to the gravity of the problem we are facing (Mabokela, 2018). Mabokela (2018) found it disturbing morally that, though the reporting of pro-African newspapers did not largely infringe on the ethics governing publication, however, they ignored the crucial responsibility of conscientising the readers by bringing the whoonga issue to their consciousness. In a culture of consumerism researchers need to be careful about getting caught up in seeking top-down solutions and the implication of disempowering communities by providing a service for them. There is a reliance on the government and its agencies regarding the direction in dealing with whoonga addictions. In pursuit of a concentrated concerted effort, the government, as the chief administrator, should give direction on the curbing of the pandemic. At this stage, as Mokwena (2015) noted, there is no formal strategy promulgated.

From findings in this study, the development of addictions, participants did not go to school. Unemployed parents could not monitor their children's movements. Under township conditions, parents must go to work, and, from employment statistics, they would be lucky to have employment. They remain at work for a long time every day. Sometimes the travel is lengthy. Parents are usually home long after schools have closed. This proves an over-reliance on teachers for guidance. Studies confirm that teachers can assist further to engage students who present with

academic and social problems (Mampane & Bouwer, 2011). This also finds parents unable to attend meetings to support teachers. From the lack of follow-up from the caregivers, the teacher-child-parent triangle was not functioning.

9.7.2.4.1 Regenerating and enabling communities

Communities have reacted largely with anger towards whoonga addicts, in worst cases, killing them (Masikane, 2018). Some communities are reported to assist youth with funding their enrolment fees. Elders, who are otherwise expected to be positive role models, sometimes encouraged whoonga addiction. The gang subculture, the admiring of prison gangs, evident in the language used, and the veneration of gangster-subculture was subtle, and yet evident, prevailing unabated. From studies collaborating the mental anguish and the role of parents in rearing a child addicted to drugs and in particular whoonga, evidence in this study supports ideas that parents themselves need assistance. They feel overwhelmed, presenting evidence that families cannot do it alone without assistance. This had led to a number of researchers in the area requesting some form of support for parents and caregivers. African people have their ways of supporting families, sharing child-rearing, and presenting adult authority.

9.7.2.4.2 Engagement as social action

The study was influenced by a need to find ways of engaging communities in curbing whoonga addiction. From one angle, the focus on the creation of an empathic understanding of the plight of whoonga addicts is a humanistic appeal to support people addicted to whoonga. Communities can be unkind to drug addicts and their families. This understanding of whoonga addiction as a phenomenon is yet another human experience. Something that happens to real human beings, a case White (2010) considers putting a “face” on addiction. In familiarising addiction, a process of *de-zombie-fying* whoonga addicts, making their experience a human experience, is a hope that it may affect stigma, marginalization and isolation associated with whoonga addiction. Isolation may exacerbate the feeling of alienation and would make recovery difficult.

The study presented ways of creating a sense of community that would provide both recovery-oriented approaches as well as prevention. From the African traditional sources, guidelines that would give a framework in negotiating the transition to adulthood would help support youth in townships.

9.7.2.4.3 Enabling the community, unleashing belonging

As Kretzman and McKnight (2005) noted, communities are a place of belonging, an end-post for recovery from drug addiction. White (2009) maintains that a good drug-addiction strategy should support and build communities. For Alexander (2015), communities are sites of healing and recovery approaches, platforms for healing. In drug addiction, the monopoly of addiction treatment has discouraged alternative approaches (Chavelier, 2019). Recovery approaches enable communities and other means to support the maintenance of long-term recovery. The creation of peer support appears within the recovery paradigm. The creation of communities allows people to render support to one another.

9.7.2.4.4 Facilitate motivation and prevention

Recovery support in the form of peer support facilitates the motivation to quit using drugs. Peers model recovery. Traditional ways that enforce belonging and support transitions to adulthood are ways of instilling a sense of belonging. Such further provides an educative environment that would include drug addictions, together with other ways of becoming a mature human being. Recovery, as an alternative to drug addiction, is a concern with availing support for long-term recovery. Such includes support by both professional and non-professional agencies. Recovery approaches support aspects of addiction treatment that enable desistance, thus encouraging recovery, e.g., medication, professional and mutual aid institutional assistance; however, such refutes the monopoly of drug-addiction treatment. This is a position that supports diverse interventions that align with recovery.

9.8 Conclusion

The chapter presented a discussion on findings that addressed the questions posed by the research study. The chapter began by exploring experiences with both addiction and then recovery, describing and making sense of them as they appeared in participants' lives against the background of individual, familial, communal, and organisational dynamics. From these experiences of recovery from whoonga, the chapter excavated elements that supported recovery, as well as elements that hindered recovery.

CHAPTER TEN
CONCLUSIONS

10.1 Introduction

This study set out to understand addiction and recovery from whoonga. In a short span of time, since the emergence of whoonga in the 2000s, the focus by most authoritative research studies involved has been on determining the taxonomy of the drug, in order to assist addiction treatment. With the rise of a new drug that produces dedicated users, recommendations for intervention measures were typically within the addiction-treatment paradigm, drawing from this worldwide approach that focuses on mainstream medical support care. This was further supported by parallels drawn from experiences the country had with the previous scourge, HIV/Aids. In view of a number of whoonga addicts, and where available institutions would be insufficient and inaccessible for the communities inflicted by whoonga addictions; the suggestion further involved ways of availing addiction treatment to communities. The review of theoretical literature in this study evaluated the suitability of drug addiction models, particularly in low-to-medium income countries and adopts aspects of ecological and recovery approaches that advance the realization of therapeutic communities. The study drew from ecological approaches, arguing that the focus on addiction treatment is insufficient in a whoonga situation including the treatment of addictions worldwide. In searching for a one-size-fits-all response, the failure to acknowledge the contribution of the history and the context of communities afflicted by drugs in the rampant increase of the ingestion of mind-altering substances around the world is at the core of the failure of addiction treatment worldwide. Therefore, in diagnosing addiction treatment, its failure is caused by treating symptoms without examining root causes.

In searching for the inclusion of root causes of addiction, the dislocation theory was an ecological approach employed as an umbrella conception for theorising on socio-cultural and economic forces that drive addictions worldwide. Dislocation theory finds toppling the current economic system that alienate people in ways that they seek relief from drugs and other addictions, an imperative. Before (and perhaps the only way to) that, it finds cure in connections, and a realization that we are social beings, and in an embrace for an onslaught, we only have one another. At local, individual, and community levels, the creation of communities that establish bonds and connectors manifest in peer support and other recovery approaches. Communities are placed in a situation where they support families, and where raising children is the responsibility of all community members. Exemplary role-modelling is suggested. In presenting the model that local African communities would identify with, the inclusion of an African experience was needed. The

basis for an overwhelming sense of alienation in conditions African people, as a group, identify with wherever they are, was linked to a situation that makes them susceptible to drug use. The new model targets prevention by bolstering resilience and instilling insulating factors against drug use. This is done through the recommendations that focus on the negotiation of the most vulnerable stage of adolescent development; transitioning to adulthood. These, the marking of passage to adulthood, were drawn from the usefulness and the potency of these methods drawn from the traditional ecology, the environment that nurtured the common development of African people, founded on care.

Results showed that addiction to whoonga transformed participants in profound and deleterious ways. Addiction was characterised by a state of being *iphara*, a term that describes the embodiment of dedicated whoonga use. While whoonga addiction was initiated in pursuit of pleasure, escaping difficult life situations, and boredom, and where the influence of friends and peers dominated, it soon became a burden, with the body becoming the site for pain. The state of being a whoonga addict is described as a preoccupation with the drug and the now, in which there is a deficiency of care for oneself, others, and other life concerns. Largely because of crime committed in the pursuit of the next fix, whoonga addicts are marginalised and ostracised by the community and family members. Other than isolation, to be an *iphara* is a perilous and precarious lifestyle, in which vigilante attacks from the community retaliating would put addicts' lives and the lives of those close to them in danger. Arrests presented criminal records with huge implications for future employability.

Recovery from whoonga was founded on survival instincts and a sense of self-preservation when difficult conditions as an addict were presented to participants' lives. The crossroads within whoonga addiction lives jolted participants to the correct orientation to the truth, demanding reorientation to the present, that involved the evaluation of the past and concerns with the future. Although desistance can be coerced, an inner resolve to end addiction lives was deemed necessary; and such bolstered courage to attempt desistance. Desistance involved the use of Methadone: this was difficult particularly for participants who desisted from whoonga use without recourse to medication and professional help. Recovery marks a sense of growing and maturing; taking responsibility for oneself and others, which are efforts of becoming *umuntu*/human; making amends with peers, family members, and the community. Such ideas were consistent with the conceptions of recovery around the world.

10.2 The Appropriateness of IPA

The study used IPA as a methodology within phenomenology to capture voices of important stakeholders, people who were involved. These voices inform on how to help youth recover from whoonga addiction. IPA allowed for detailed accounts of experience with whoonga addiction from a realist orientation. This addressed real-life issues, presenting relevant interventions that are applicable in curbing whoonga addictions. IPA mandates the inclusion of contextual factors that are ingrained in the understanding of the phenomena. In a study of addictions, the inclusion of socio-cultural, economic and historical factors that drive addictions as they were deduced from the experiences of the lives of participants in townships is the inclusion of factors that link addiction to its root causes. The study tried to strike a balance, by including both the angles of IPA. The hermeneutics of empathy, and the creation of an empathic understanding of addiction lives that promotes care. The study accommodated critical hermeneutic, dubbed the hermeneutics of suspicion. These included the political and social factors. Such were deduced from physical, social and political concerns. Concerns included cultural and traditional issues relevant to the application of mainstream approaches in the context of the dominated and the marginalised sections of South Africa. As an ecological approach to drug addiction, the contextual factors that form the background of addiction to whoonga and recovery from whoonga addiction as the phenomena under study are important in making sense of whoonga addiction in South Africa.

With regard to the use of the IPA methodology, IPA concretises terms in real-life experience, asserting experiences in terms that otherwise remain mental constructs. For example, Monyakane (2018) introduced the term “dry detoxification” in relation to coerced desistance from whoonga. This study demonstrated and elaborated on what desistance without medical recourse or professional help would look like; including a case when it was voluntarily executed, and another where it was enforced by a non-statutory force or mechanism.

10.3 Contributions of the Study

The study presented evidence focussed on recovery by participants who were in their homes, and in a township setting. Studies on recovery from addiction to drugs in South Africa and around the world have sourced participation in rehabilitation institutions, upon or after participants were discharged. This is a focus on those who recovered from addiction using mutual-help organisations. This study expanded conceptions of ways people recover from drugs that included voluntary and solo attempt at dry detoxification that flourished. The study presented varieties of desisting from whoonga that included largely non-professional approaches although institutional,

part-professional, and medication assistance were also employed. The study uncovered recovery experiments that went unrecorded as recovery from whoonga, since no formal institutions were engaged in desisting whoonga use. Contrary to popular presuppositions and drug stereotypy, recovery from whoonga and the notion that addictions are retractable were presented in stories on addiction to whoonga that ended positively. The study is one of the few that has presented such empirical evidence of recovery in South Africa: the first for whoonga addiction, and the first set in a township community.

The study references the global approach to drug addiction, a theory that had remained a pariah and that is revisited in light of its compelling tenets in finding alternative ways of dealing with addictions. As an experiment, the rat park experiment that the dislocation is based on proved within the positivist approach that there are multi-factor causes of drug addiction. The environment is seen as a variable in original experiments that formulated the establishment of addiction treatment. In this study, this ecological approach was shown to be fundamentally congruent with the African approach that was formulated, particularly the community-oriented presuppositions. As a human race, we are moving closer to showing that we have created a world that is not amenable to being human. Since we created a person out of a multinational company, clearly, we are submitting to be directed by a non-human entity; and at worst by a psychopathic non-human. From this view, addictions are the manifestations of our reality. However, this study found the basis of *ubuntu* philosophy cited by the dislocation theory to be fixed on a particular era in the South African politics, namely, the advent of democracy. This version of *ubuntu* presents a limited and compartmentalised view that can be located to its use as a tool. Efforts to explicate other versions of *ubuntu* philosophy, and to make an adaptation that filters other African traditional aspects to realise a drug addiction model, were necessary.

The study included both addiction and recovery from whoonga. Most studies in this area focus on one and hardly on both sides to the problem. Perhaps this robbed the study of a concentrated effort. However, I believe the study was able to familiarise whoonga addiction lives, presenting whoonga addiction lives and their ending as happenings that occurred in the lives of real human beings. To present a human face of whoonga addiction would assist in reducing the stigma and marginalization of people addicted to whoonga. Inevitably, this will further put pressure on the unwilling.

10.4 Implications of the Study Findings

The study invites a variety of approaches in curbing whoonga addictions in South Africa by professional and non-professional agencies, refuting the monopoly of addiction treatment. This

is an advancement of inclusion of a different paradigm in approaching addictions, a concern with support for abstinence and long-term recovery, that filters in preventative measures. The community is central to advancing interventions that would be drawn from their strengths rather than a focus on pathology. The study advocates the creation of a framework that allows access to OST, thus the employment of aspects of harm-reduction measures. In South Africa, that includes availing supporting professional expertise. Recovery approaches are considered building up from addiction treatment. Such includes medical treatment and the acknowledgement of the need for OST in initiating recovery. With regard to intervention, there is a role that harm-reduction measures could play, particularly in availing OST. Within the understanding that multi-sectoral approaches necessary for a whoonga situation, the need to work together is an intersection of these approaches at the initiation of desistance. Within a collaboratory structure, psychosocial interventions would be included. The focus of other interventions and programmes would be to build up recoverees. However, South Africa, being new to mass addiction, available facilities have so far been aligned with addiction treatment. Rehabilitation centres are often located a distance away from communities. Efforts on harm-reduction measures would avail addiction treatment to communities. Communities should elicit supporting structures, collaboration, or even integration, that would be cost-effective in the delivery of health and mental-health care. This suggests a dialogue between harm-reduction and recovery-aligned approaches.

The need to build communities by drawing from their strengths is not limited to drug addiction and the creation of peer recovery groups. On one hand, the building of communities involves the creation of peer groups that support and encourage recovery. These groups assist youth to navigate the transition from adolescent to adulthood, drawing from a model of exemplary behaviour, the idea of positive role models. On the other hand, there is a need for a massive shift in uplifting communities at large. Elimination of poverty, inculcation of skills, offering of quality education, affording recreation facilities, and participating in leisure activities, must be improved. The call to build communities includes a call for ways to change the material conditions of township communities, in which they are empowered to find solutions to deal with their own problems. Such programmes should not be limited to a reaction to social ills as they manifest, rather the refocusing on energies on education, skills development, leisure management and raising children to develop into mature human beings.

10.5 Recommendations of the Study

This section formulates from the implications of this study recommendations (with regard to policy, clinical application, as well as for future research studies).

10.5.1 Recommendations with regard to policy

At the core of the study is to accommodate "other" interventions and to include alternative and innovative approaches in curbing whoonga addictions that support recovery and promote prevention. This includes professional and non-professional ways including innovative ways of supporting recovery from whoonga. People may not need government validation in promoting recovery, as is the case with the radio station and the concerned caregivers. However, institutions that support recovery would need to be regulated and assisted to render affordable mutual support in recovering from whoonga, an addiction-treatment plan. On the need for medication to augment pain from withdrawals as ways of desisting whoonga use, a recommendation for a complementary role of recovery approaches with harm reduction measures is advanced. How this would manifest requires further deliberations that include all the stakeholders. Recovery as an approach requires implementation − making recovery visible, that can be aligned with harm-reduction measures. The common goal being recovery, this suggests that addiction treatment that supports desistance is required.

At this stage, the government requires a strategy on dealing with whoonga addiction to be realised and to be promulgated to the people. Such a strategy should give guidelines to different agencies, a focus on streamlining, coordinating resources, and giving directives to various agencies. As identified by researchers, guidance would be needed in recommended multi-sectorial approaches that require collaboration by various agencies. From this study, government policy should involve recovery approaches to drug addiction. Recovery approaches must be represented in this formation of addiction treatment policies that are responding to whoonga addiction in South Africa.

In education and counselling Black African children, particularly those addicted to drugs, measures that filter in the teachings of past heroes as ways of building "self-esteem" are recommended. Promotion of *ubuntu* as a philosophy should be part of Life Orientation classes, and to include the history of African people. The teaching of *ubuntu* should include teaching such as a contending philosophy and way of viewing the world. Perhaps this would assist the end of religious and politically aligned interpretations that further political ends.

10.5.2 Recommendations with regard to clinical application

Recovery from whoonga is a reality that can be presented as a choice in a psychotherapeutic encounter with whoonga addicts.

Access to Methadone and the inclusion of aversive medication should be considered in the OST package, as evidenced by trials under harm-reduction measures. Other means of availing

OST through health centres, or identifying suitable professionals in their dispensing that include clinical associates and professional nurses, is recommended.

Counselling encounters with Black African children should consider bibliotherapy on African readings that present historical African achievements and heroes. This further suggests a probe on spiritual alignment as an intervention to problems African people present with including addictions to whoonga. The need is to reorientate African people seeking professional help. This is where issues of "self-esteem" can be addressed.

Devising new recovery strategies must access career and life-skills' development that includes career choices in guiding recoveries. This suggests a collaboration with peer-recovery support, a movement of peers that support long-term recovery.

This study indicated a need for psychosocial support after recovery to assist people in recovery to reorient their lives and deal with psychosocial distress acquired before, and during addiction; and that would have lingered after addiction to whoonga.

With regard to supporting programs meant for interventions in communities, these should focus on strengths, refraining from seeking pathology, with the major focus on strengths in building communities supporting healing relationships.

Drug-addiction professionals cannot be ethical without evoking socio-cultural, political and economic causes of addiction in their theorising and interventions. Interventions should refuse to promote consumerism, where "tailor-made" strategies are top-bottom treatments rendered to communities.

10.5.3 Recommendations with regard to future research

Recovery approaches depend on aggregating research studies that will give ideas on other forms of recovery pathways.

A study that focuses on recovery experiments in other provinces that would also include the study on female whoonga addicts is recommended.

10.6 Limitations of the Study

At this stage of whoonga addiction, the world is identifying ways of filtering recovery approaches to drug-addiction policy plans. Identifying recoveries is not enough. The model requires to move beyond convincing researchers and policymakers that recovery is possible. In the case of whoonga, while identifying recovery is a good start, implementation should be the priority.

The study was not a search for objective truth − it was concerned with making sense of whoonga addiction from reporting by people who were involved. While the intention would be the

transferability of findings, this limits generalizations. The study was motivated by presenting culture-relevant therapy, making links with the environment, as causal effects can be difficult. However, in line with Klingemann (2001), the focus was on increasing social-support services and non-drug alternatives within the community, as well as enhancing personal networks and relationships that may help improve life functioning, as well as culturally-relevant therapy, and Afrocentricity (Ali, 2016).

In trying to simulate life-likeness, or a sense of verisimilitude (Hänninen & Koski-Jännes, 1999), the study included both addiction and recovery. Perhaps it can be conceded that a focus on recovery would have sufficed for the main purposes of this study.

In conclusion, participants in this study present evidence of overcoming whoonga addiction. They offer an opportunity for the emergence of recovery support in the creation of peer recovery-support groups. Participants would model recovery, presenting hope to those addicted and the community that overcoming whoonga addiction is a reality. Such should alleviate stigma and create pressure on the unwilling. Peer-recovery groups provide communities of former whoonga addicts with a place to go to. Such communities are best positioned to support early recovery experiments in empathic and non-judgemental ways. To filter preventative measures, reorientation of youth to traditional African ways that support and bolster a sense of pride in who they are, is necessary. Instilling mechanisms of earning membership to the community, and guidance on navigating transition to adulthood, for example, rites of passage amongst youth, would be necessary. The message is that actions and behaviours reverberate, affecting their communities. For youth to understand the plight of own communities, teaching individual responsibility for the health and welfare of communities, is important for prevention.

10.7 Conclusion

Addiction and recovery from whoonga by this sample from INK townships involves stories of recovery and overcoming that bring hope. They usher alternative paradigms to curbing drug addictions. Such is the call for the inclusion of ecological approaches in the treatment of addictions advancing the understanding of whoonga addiction as a phenomenon. Ecological approaches advance the building of communities, which includes the meeting of peers as a movement, at a local level. On the other hand, building communities means changing socio-economic and cultural conditions that are behind addiction. Whoonga addiction could be a barometer, a microcosm of worldwide alienation. We are placed in a revolutionary change on how we live our lives. Such needs to happen: the individualist world is proving to be pathological, run by a psychopath, an

unknown face of the multi-industry “person” who alienates one from another. Such may have profound effects in Third World settings, particularly in marginalised communities.

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Appendix 1: Informed Consent - English

UKZN HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE (HSSREC)

Date: _____

Hallow

I am Thabani Khumalo, a PhD student supervised by Professor Nhlanhla Mkhize at the University of KwaZulu-Natal, doing a research study on addiction and recovering from whoonga addiction.

You are being invited to consider participating in a study that will talk about your experiences with being addicted and recovering from whoonga addiction, which could take up to two hours or more. There could be follow-up interviews, where I will ask for another interview to ask for clarity on issues that would have arisen from this interview. If at any time you feel uncomfortable to continue you are allowed to discontinue. Your personal identity will not be revealed, and what this means is that when reporting on your personal experiences on a final report a pseudonym will be used.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (Protocol Reference Number: HSS0116/019D).

In the event of any problems or concerns/questions you may contact the researcher at (**083 962 1818**) or the research supervisor at (**031 260 5001**) or the UKZN Humanities & Social Sciences Research Ethics Committee, contact details as follows:

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Personal information shall not be used in this study. Tapes and notes will be kept by the researcher at his safe at his residence for the period of five years after the research study has been completed.

CONSENT

I _____ have been informed about the study entitled "Addiction and recovery from *whoonga*: an interpretative phenomenological analysis of the lifeworld of INK addicts" by Thabani Khumalo.

I understand this study will assist give insight to how health care practitioners and planners can assist whoonga users recover, and that you could serve as a model to addicts and in that way, contribute in ways to curb its rampant use.

I have been given an opportunity to answer questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting anything and since there are no benefits that I am entitled to.

If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher at **0839621818** (Email: 9604368@stu.ukzn.ac.za). You can also contact my supervisor, Prof. Nhlanhla Mkhize, at **031 260 5001** (Email: Mkhize@ukzn.ac.za).

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION
Research Office, Westville Campus
Gavan Mbeki Building
Private Bag X 54001
Durban
4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604557 - Fax: 27 31 2604609

Email: HSSREC@ukzn.ac.za

I hereby voluntarily consent to take part in the study:

_____ _____

Signature of Participant Date

_____ _____

Signature of Parent/Guardian Date
(Where applicable)

_____ _____

Signature of Witness Date
(Where applicable)

Appendix 1a: Permission to Audio-Record Interview

I also CONSENT / DO NOT CONSENT to be audio-recorded during the interview (circle appropriate option)

_____ _____

Signature of Participant Date

_____ _____

Signature of Parent/Guardian Date
(Where applicable)

_____ _____

Signature of Witness Date
(Where applicable)

Appendix 2: **Isivumo (Informed Consent) - Isizulu Version**

UKZN HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE (HSSREC)

ISIVUMO

Ikhasi Elinolwazi Ngocwaningo Elazisa Abazobamba Iqhaza Kulolucwaningo

Usuku: _____

Sawubona

Ngingu Thabani Khumalo. Ngenza izifundo zobudokotela (PhD), *ngaphansi kocwaningo olwenganyelwe uSolwazi Nhlanhla Mkhize eNyuvesi yaKwaZulu-Natali, lapho ngenza khona ucwaningo ngokusetshengizwa kwesidakamizwa i-'wunga', yintsha.*

Ngiyakunxusa ukuba ubambe iqhaza kulolucwaningo. Ngizocela ukuthi ungazise ngokwaziyo mayelana nokubhema iwunga, kanye nokuthi ukuyeka ukuyibhema iwunga kwenzeka kanjani. Uzokhuluma ngalokho okwaziyo nokwenzeka kuwe uma ubhema iwunga noma ngalokho owakwenza kusukela lapho ukhetha khona ukuyeka ukubhema iwunga, kanye nezindlela ozisebenzisayo ukuzigcina ungasabhemi. Bengicela unginike nemvume yokuthi lezizingxoxo ngiziqophe (akuphoqelekile), kanti zizothatha isikhathi esithi asibe amahora amabili. Ngizocela futhi unginike ithuba lokuthi ngibuye, ngiphinde ngibuzisise kahle ngalokho okushilo ukuze ngicaciseleke kahle. Sekothi uma sengikuhluzile lokho owakusho, ngibuye ngiphinde ngicele ukuthi sihlangane ukuze ngibone ukuthi ngisahamba kukho yini lokho owawukushilo. Lokhu sikwenzela ukuqiniseka ukuthi umbiko wami uyahambisana yini nalokho owakusho. Owokugcina umhlangano uyobe usuzokwazisa ukuthi lolucwaningo luthole ukuthini.

Kusemqoka ukuthi ngikwazise ngemigomo ebekiwe uma kwenziwa ucwaningo okufaka ukuthi imibono yakho kuphela esiyidingayo, imininingwane ngawe njengomuntu ngeke ivezwe ekubhalweni ngalolucwaningo. Futhi, uma uzizwa ungaphathekile kahle ngalokho okuxoxwayo, ubona ukuthi ngeke ukwazi ukuqhubeka, usho, bese uyayeka ungaqhubeki. Ngeke ujeziswe noma uphathwe kabi ngokwenza kanjalo. Uyacelwa nje ukuthi ubambe iqhaza njengomuntu oceliwe ongaphoqiwe ngokwenza lokho.

Lolucwaningo lunikezwe imvume ukuba luqhubeke ikomidi ebhekelene nokwenziwa kocwaningo ngendlela engahlukumezi umphakathi kanye nalabo ababamba iqhaza, i-UKZN Humanities and Social Sciences Research Ethics Committee (Inombolo yalemvume: HSS0116/019D)

Uma kunezinkinga noma izikhalo/nemibuzo ungathintana nami (Thabani Khumalo) *kulenombolo* – **083 962 1818** *noma u-supervisor walolucwaningo noma ongamele lolucwaningo uSolwazi* Nhlanhla Mkhize – **031 260 5001** *noma kulelikheli:* Psychology Department, UKZN, Private Bag X 54001, Durban, 4000; *noma nalo lelikomidi* UKZN Humanities & Social Sciences Research Ethics Committee. *Ikomidi ungalithola kulemininingwane elandelayo*:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION
Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604557- Fax: 27 31 2604609
Email: HSSREC@ukzn.ac.za

*Njengoba ngike ngachaza, imininingwane yomuntu eqondene nesiqu sakhe (personal information) ngeke isetshenziswe uma sekubikwa ngalolucwaningo. Njengoba lezizingxoxo sizoziqopha (recorded) uma uvuma, mina njengomcwaningi ngizokugcina konke lokhu kwikhabethe lami elikhiyekayo ekhaya lapho ngihlala khona kuze kuba unyaka ka-*2024, *okuyiminyaka emihlanu ngemuva kokuthi lolucwaningo luphelile njengoba imithetho yocwaningo iyalela*.

UKUVUMA

Mina _____ *(amagama akho aphelele) ngazisiwe ngocwaningo olusihloko salo sithi:* ***"Ukubhenywa nokusimama ekubhemeni iwunga: Kuhlungwa ngokuhlolisisa izimpilo zalabo abasimama ekubhemeni iwunga kwintsha esimamayo yasemalokishini ase-INK,"*** *olwenziwa u*Thabani Khumalo.

Ngiyaqonda ukuthi ukubamba kwami iqhaza kuzolekelela ukuthi kubenokukuqondisisa kahle ukusetshenziswa kwewunga emphakathini waseINK ukuze imizamo yokukunciphisa uma kungase kwenzeke, kuqedwe futhi lokhukudlondlobala kokubhenywa kwayo.

Nginikeziwe futhi ithuba lokuthi ngibuze futhi ngaphenduleka ngokunginelisayo ukuthi lolucwaningo lungani nokuthi liyini iqhaza lami.

Ngiyafunga futhi ukuthi ukuzimbandakanya nokubamba iqhaza kulolucwaningo ngikwenza ngothando olusuka kimi, angiphoqiwe, nokuthi uma ngizwa ukuthi okukhulunywayo akusahambisani nami noma akungiphathi kahle, ngingayeka noma inini futhi kungekho muntu ozongiphoqa ukuthi ngiqhubeke uma ngingasathandi ukuqhubeka.

Uma kusekhona eminye imibuzo engifuna ukucaciseleka kuyo ngingathintana nomncwaningi kulenombo ethi 0839621818 (Email: 9604368@stu.ukzn.ac.za). *Ngingathintana futhi noSolwazi owengamele ucwaningo, uSolwazi* Nhlanhla Mkhize (031 260 5001 *noma*: Mkhize@ukzn.ac.za).

Uma nginemibuzo ngamalungelo ami njengomuntu obamba iqhaza kucwaningo, noma uma ngixakwa okuthile okuphathelene nocwaningo noma umcwaningi qobo lwakhe; ngingathintana nekomidi ebhekele amalungelo abantu ababamba iqhaza, kulemininingwane engenzansi:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION
Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000

KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604557 - Fax: 27 31 2604609
Email: HSSREC@ukzn.ac.za

Ngiyakuqonda konke okungasenhla futhi NGIYAVUMA (Consent) *ukubamba iqhaza, ngaphandle kwempoqo noma ingcindezi.* YEBO / CHA

_____ _____

Signature of Participant *Usuku*/Date

Isigenesha yalowo obamba iqhaza

_____ _____

Signature of Parent/Guardian *Usuku*/Date

Isigenesha yomzali / umbheki wengane

(Uma kunesidingo)

_____ _____

Signature of Witness *Usuku*/Date

Isigenesha kafakazi

Appendix 2a: Ukuvuma Ukuqopha (Consent to Audio-Record)

Ngiyavuma ukuthi inkulumo-ngxoxo iqoshwe: *YEBO / CHA*

_____ _____

Isigenesha yalowo obamba iqhaza *Usuku*/Date

_____ _____

Isigenesha yomzali / umbheki wengane *Usuku*/Date
(Uma kunesidingo)

_____ _____

Isigenesha kafakazi *Usuku*/Date

Appendix 3 – Interview Schedule

MAIN QUESTION

ENGLISH: I gather that you have been addicted to whoonga and you stopped smoking it. Could you please tell me in detail about your experiences as a whoonga addict, leading to your recovery?

ISIZULU: *Ngiyathola ukuthi ubukade ubhema iwunga wayeka. Ngicela ungazise kabanzi ngempilo yakho usabhema i-wunga, kuze kube uyayiyeka*.

2. PERCEPTIONS OF RECOVERY LEVEL

ENGLISH: Reflecting back, how did whoonga addiction affect your life? Please explain in detail.

ISIZULU: *Uma usubheka nje, uqhathanisa; ubona ukuthi ukubhema i- wunga kube nomthelela muni empilweni yakho? Ngicela uchaze kabanzi.*

3. TURNING POINT AND MOTIVATION TO STOP

ENGLISH: Why did you stop smoking whoonga?

ISIZULU: *Wayiyekelani iwunga?*

4. MAINTENANCE

ENGLISH: How do you make sure that you do not take whoonga anymore, in case there is an urge to take it?

ISIZULU: *Uma kwenzeka ukuthi uyaye uyihalele iwunga, uzivimba kanjani ukuthi ungayibhemi?*

5. RELAPSE(S)

ENGLISH: Did you try to stop before and fail? If Therefore, what happened?

ISIZULU: *Wake wazama ukuyeka wehluleka? Uma kunjalo kwenzakalani?*

6. RECOVERY CAPITAL

ENGLISH: How did your family react to your addition to whoonga? What is the role of your family, friends and peers, and the community in your recovery. Please explain in detail.

ISIZULU: *Umndeni wakho wenze njani ngokubhema kwakho i- wunga? Ubani okusize kakhulu emndenini wakho, kubangani nakumphakathi ukuthi ukwazi ukuyeka ukubhema iwunga?*

7. IDENTITY CHANGE

ENGLISH: How are you different now from when you were an addict? Please give examples, capturing your life "before" and "after" quitting whoonga,

ISIZULU: *Usuhluke kanjani manje kunangesikhathi usabhema? Ngicela ungiphe izibonelo, ezikhombisa ubunjalo bempilo yakho, 'ngaphambi' kokuyeka, uqhathanisa nempilo 'emva' kokuyeka ukubhema.*

8. ENDING

ENGLISH: Is there anything else you would like to tell me? Please feel free to do so. Kindly allow me to contact you again for another short interview if after listening to this one, I could still need clarity on some issues or confirm if what I had analysed about this interview is a fair reflection of what you said. I will definitely contact you when I am done with this research study, to give you feedback of what I found.

Would you like to speak to someone about your experiences with this interview?

ISIZULU: *Ngabe kusekhona yini okunye ongathanda ukungitshela khona. Uma kunjalo, ngicela ukhululeke ukuqhubeka.*

Bengisacela ukuthi ungivumele ukuthi uma sengiyilalelisisile lenkulumo esikade siyiqopha namhlanje, ngiphinde ngikuthinte uma nginemibuzo ngayo, lapho ngidinga khona ukucaciselwa kabanzi ngokade ukusho. Sekothi uma sengiyihluzile lenkulumo, ngiphinde futhi ngikuthinte ngibuyekeze ukuthi ngisahamba kukho yini lokho obukushilo. Sengokuthinta uma sengisiqedile lesisifundo engisenzayo ukukwazisa ukuthi ngithole ini.

Ungathanda ukukhuluma nomuntu ofana nozonhlalakahle mayelana nalenkulumo esiyiqophe namhlanje?

Appendix 4 – Ethical Clearance Certificate

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

17 June 2019

Mr Thabani Khumalo (9604368)
School of Applied Human Sciences – Psychology
Howard College Campus

Dear Mr Khumalo,

Protocol reference number : HSS/0116/019D
Project title: Addiction and recovery from *Whoonga* : A phenomenological analysis of the lifeworld of youth 'in recovery' from INK townships

Approval Notification – Full Committee Reviewed Protocol
With regards to your response received on 13 June 2019 to our letter of 05 April 2019, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL.**

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number. PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 1 year from the date of issue. Thereafter Recertification must be applied for on an annual basis.

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

Yours faithfully

.....
Dr Rosemary Sibanda (Chair)

/ms

cc Supervisor: Professor Nhlanhla Mkhize
cc Academic Leader Research: Professor Ruth Teer-Tomaselli
cc School Administrator: Ms Ayanda Ntuli

Humanities & Social Sciences Research Ethics Committee
Dr Rosemary Sibanda (Chair)
Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban 4000
Telephone: +27 (0) 31 260 3587/8350/4557 **Facsimile:** +27 (0) 31 260 4609 **Email:** ximbap@ukzn.ac.za / snymanm@ukzn.ac.za / mohunp@ukzn.ac.za
Website: www.ukzn.ac.za

Appendix 5 – Permission letter from the Department of Social Development

social development
Department:
Social Development
PROVINCE OF KWAZULU-NATAL

FAX : 033-264 2075	HUMAN RESOURCE DEVELOPMENT
Telephone/Ucingo/Telefoon : 033 264 2078	174 Mayors Walk Road
Enquiries/Imibuzo/Navrae : Mr VW Gumede	Private Bag X9144
Email address : velaphi.gumede@kznsocdev.gov.za	Pietermaritzburg
Reference/ Inkomba/ Navrae: S6/5/3	3200

Mr T Khumalo
2 Candis Gardens
149 Mt Vernon Road
HILLARY
4094

Contact No: 083 962 1818
Email: 9604368@stu.ukzn.ac.za

Dear Mr Khumalo

PERMISSION TO CONDUCT RESEARCH IN THE ADDICTION AND RECOVERY FROM WHOONGA: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS OF THE LIFEWORLD OF YOUTH IN RECOVERY FROM INK TOWNSHIPS

1. This matter has reference.
2. Kindly be informed that the permission has been granted by the Head of Department for you to conduct research in the department for you to fulfill the requirement of your PhD.
3. The permission authorizes you to: -
   (a) Conduct Interview with employees from Social Services who are working with people who are recovering from whoonga in the department at their consent deemed relevant to your research project and maintain high level of confidentiality; and
   (b) Share your findings with the Department.

Wishing you success during your research project.

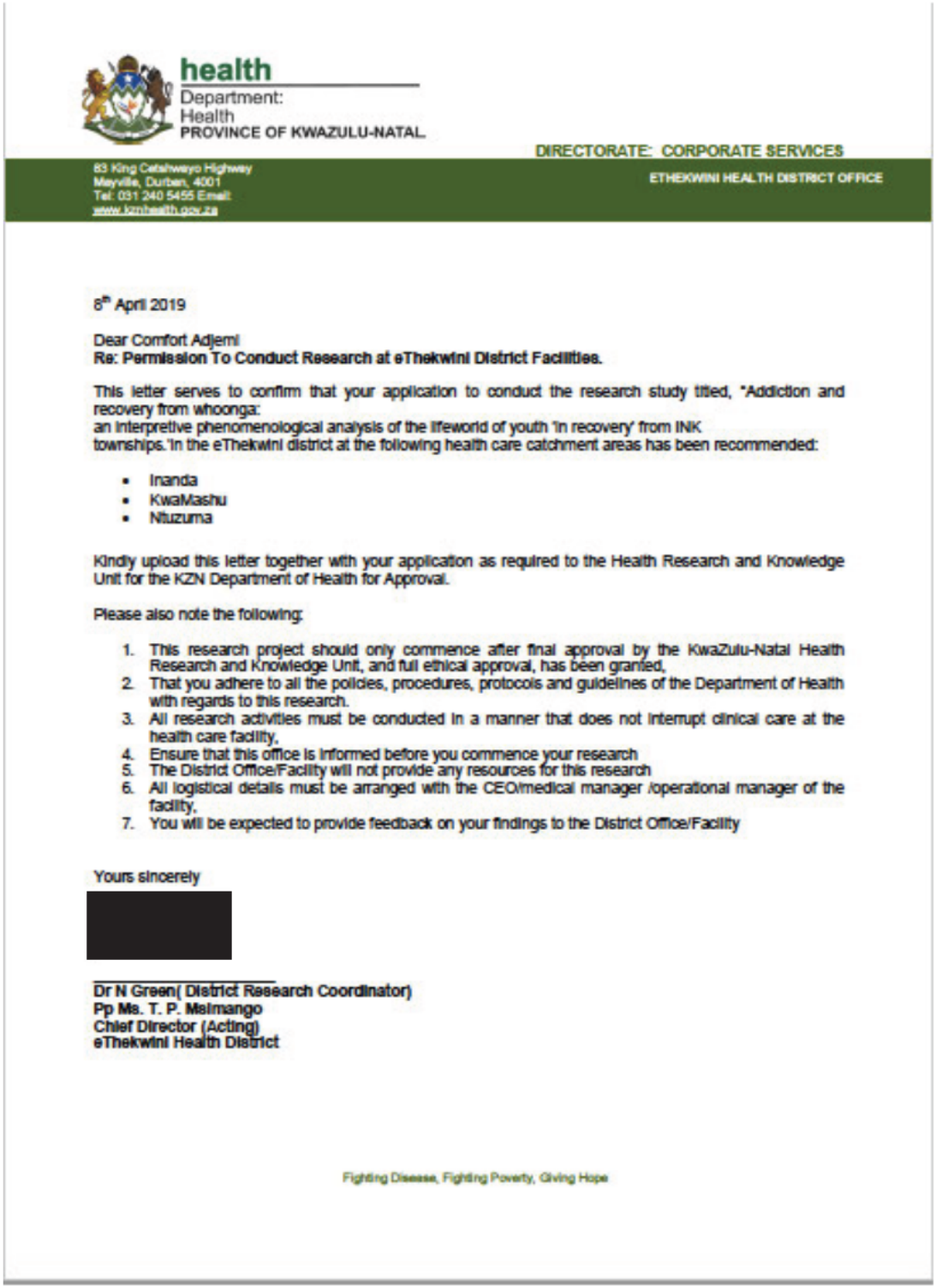
Yours Faithfully

[redacted]

MS NG KHANYILE
HEAD OF DEPARTMENT

DATE: 2019/06/07

Appendix 6 – Permission letter from the Department of Health



health
Department:
Health
PROVINCE OF KWAZULU-NATAL

DIRECTORATE: CORPORATE SERVICES

83 King Cetshwayo Highway
Mayville, Durban, 4001
Tel: 031 240 5455 Email:
www.kznhealth.gov.za

ETHEKWINI HEALTH DISTRICT OFFICE

8th April 2019

Dear Comfort Adjemi
Re: Permission To Conduct Research at eThekwini District Facilities.

This letter serves to confirm that your application to conduct the research study titled, "Addiction and recovery from whoonga:
an interpretive phenomenological analysis of the lifeworld of youth 'in recovery' from INK townships.'in the eThekwini district at the following health care catchment areas has been recommended:

- Inanda
- KwaMashu
- Ntuzuma

Kindly upload this letter together with your application as required to the Health Research and Knowledge Unit for the KZN Department of Health for Approval.

Please also note the following:

1. This research project should only commence after final approval by the KwaZulu-Natal Health Research and Knowledge Unit, and full ethical approval, has been granted,
2. That you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
3. All research activities must be conducted in a manner that does not interrupt clinical care at the health care facility,
4. Ensure that this office is informed before you commence your research
5. The District Office/Facility will not provide any resources for this research
6. All logistical details must be arranged with the CEO/medical manager /operational manager of the facility,
7. You will be expected to provide feedback on your findings to the District Office/Facility

Yours sincerely

[redacted]

Dr N Green(District Research Coordinator)
Pp Ms. T. P. Maimango
Chief Director (Acting)
eThekwini Health District

Fighting Disease, Fighting Poverty, Giving Hope