

**AN OCCUPATIONAL PERSPECTIVE ON THE JOURNEY OF RECOVERY FROM
SUBSTANCE ABUSE AMONG YOUNG ADULT ZIMBABWEAN MEN**



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ABSTRACT

Substance abuse is a rising global health and social problem that is associated with serious medical, psychiatric, family, occupational, legal, financial and spiritual problems. While recovery from substance abuse is possible, it is a subjective and contested process. To date, the recovery process has not been explored from an occupational perspective in Zimbabwe, where as many as 60% of all readmissions at Zimbabwe's psychiatric referral centre during the period from January 2010 to December 2011 were secondary to substance-induced disorders, and less than three percent of these patients moved into long-term recovery or sustained sobriety with rehabilitation follow-up.

This qualitative narrative inquiry explores the journey of recovery from substance abuse among young adult Zimbabwean men. The aim of the study was to investigate how occupations played a role in the recovery journeys of each of these men. Three young adult men identified as former substance abusers were purposively selected for the study. Data generation occurred through in-depth narrative interviews with each participant. Principles of trustworthiness and validation emphasising the persuasiveness, coherence and pragmatic use of the narratives were applied throughout the research process, and ethical issues in narrative research were upheld. Ethical clearance was applied for and granted by the University of Cape Town's Human Ethics Research Committee and permission to do the research was sought and given by the Medical Research Council of Zimbabwe.

The findings of the study — explanatory stories — were produced through narrative analysis. These stories revealed substance abuse to be an occupation associated with both positive and negative consequences. Recovery from such abuse emerged as an ongoing occupational transition negotiated through participation in other occupations, and influenced by both personal and environmental factors. The way in which occupations were abandoned, modified and newly adopted during the process of this occupational transition is discussed. The construction and reconstruction of a positive occupational identity was seen as central to the process of occupational transition.

The study concluded that engagement and participation in 'engaging occupations' was an intricate contributor to the recovery journey for young adult Zimbabwean men, and that narrative interviews should be used in generating data to explore the occupational nature of life and its events.

DEFINITION OF TERMS

Addictive behaviours: undesirable behaviours that become the major focus in a person's life and can result in serious adverse medical and social consequences with a primary, chronic, neurobiological disease explanation resulting from genetic, psychosocial and environmental factors (Lowinson, Ruiz, Millman & Langrod, 2005).

Former substance abuser: an individual in sustained and stable sobriety for at least one year, who is functioning well with respect to occupational engagements to enhance his health and well-being.

High-density suburbs: urban residential areas that are densely populated and have poor service provision.

Identity: The stable, consistent and reliable sense of who one is and one's standing in the world. Identity is considered to be more of a rational and dynamic process of meaning to oneself and one's meaning to others, rather than a constant construct (Josselson, 1987).

Mental Health: 'A state of wellbeing in which every individual realizes his or her own potential, can cope with the normal stressors of life, can work fruitfully, and is able to make a contribution to his or her community' (WHO, 2010).

Occupation: Everyday doings of people to occupy themselves, or sets of activities performed consistently and regularly, bringing forth structure on time and energy use. Occupations are given value and meaning by individuals and by their culture (CAOT, 2002; Chang, 2008).

Occupational identity: "A composite sense of who one is and wishes to become as an occupational being generated from one's history of occupational participation" (Kielhofner, 2002, p. 119).

Occupational perspective: "Describes a standpoint whereby the significance of phenomena is described in relation to relational human action as described in the discipline of occupational science. It appreciates that human action is shaped through habit, context and creativity" (Galvaan, 2010, p. 8). An occupational perspective considers issues by applying an occupation-focused philosophical lens and theory (Parnell & Wilding, 2010).

Occupational science: a scientific discipline of everyday living, applying the systematic study of humans as occupational beings. In this science, humans are explored from an

occupational perspective (Clark, Parham, Carlson, Frank, Jackson, Pierce, Wolfe & Zemke, 1991).

Occupational transition: “A major change in the occupational repertoire of a person in which one or several occupations change, disappear and/or are replaced by others” (Jonsson, 2010, p. 212).

Recovery: “Is a voluntarily maintained lifestyle characterised by sobriety, personal health and citizenship” (The Betty Ford Institute Consensus Panel, 2007, p. 222).

Recovery journey: This involves the passage from substance abuse to recovery where an individual returns to a healthy physical, emotional, social and mental state.

Sobriety: the total abstinence from alcohol and all illicit drugs (The Betty Ford Institute Consensus Panel, 2007)

Substance abuse: is a maladaptive pattern of substance use (alcohol, drugs and psychoactive substances) leading to clinically significant impairment or distress, which is shown by recurrent substance use leading to failure in fulfilling major obligatory roles; engaging in physically hazardous situations; recurrent legal problems or persistent social or interpersonal problems occurring over a 12-month period (DSM-IV, American Psychiatric Association, 1994).

Transition: The process or a period of changing from one state or condition to another (<http://www.oxforddictionaries.com/definition/english/transition>) or “interruption in the pattern of everyday life” (Blair, 2000, p.232).

Well-being: the feelings of pleasure, happiness, health, and comfort which is a subjective experience and differs from person to person (Schmid, 2005).

Young adult: a person aged between 19 – 40 years (Erikson, 1950 accessed from www.dean.usma.edu/ on 23/04/12)

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CHAPTER 1

1.1 Introduction

This chapter introduces the focus of this narrative study. I begin by sharing my background in an attempt to explain how my interest in exploring recovery from substance abuse among young adult Zimbabwean men started. This offers insight into the way in which my reasoning was shaped during this inquiry. By applying an occupational perspective, I illustrate the importance of this study for occupational science and occupational therapy. I conclude by stating the purpose, research question, aim and objectives.

1.2 Background to the study

During my two years of clinical experience as an occupational therapist at a psychiatric hospital in Zimbabwe, I worked with mental health service users with a broad range of psychosocial problems. I noticed, during this period, an increasing number of users who had abused substances being referred for occupational therapy intervention. The hospital statistics showed that as many as 60% of all readmissions during the period from January 2010 to December 2011 were secondary to substance-induced disorders, and that less than three percent of these service users moved into long-term recovery with follow-up (Annexe, 2012). This showed a very low rate of recovery from substance abuse. This situation was aggravated by the fact that the psychiatric rehabilitation team was faced with an unsupportive environment both in clinical practice and in the community where our clients were expected to recover.

The occupational therapy service we offered was limited to a skills-deficit perspective with no attention given to facilitating community reintegration. Our practice did not put much emphasis on occupation, despite the fact that the need to participate in occupation has been described as an innate human need; having the potential to address both the physical and mental health needs of an individual (Kuo, 2011) and being the core of occupational therapy practice (Gray, 1999). Furthermore, the absence of specifically designated substance-abuse rehabilitation facilities in Zimbabwe might have contributed to the high relapse rates reported (Ministry of Health and Child Care, 2008).

My passion to work with the population of people affected by substance abuse was also profoundly influenced by my personal experiences. I grew up in a large family and witnessed my uncle, who was an alcoholic, battling through relapses. The fact that he eventually

managed to successfully recover inspired me. As an occupational therapist, it intrigued me that he achieved this success without medical intervention. I began to wonder what I might learn from the success stories of those who experienced long-term recovery and were able to achieve sustained sobriety. I assumed that this knowledge would contribute to helping those faced with the problem of substance abuse by generating an understanding of substance abuse and recovery. It also occurred to me that although occupational science has shown the power of occupation as a means and end in intervention (Wilcock, 2006; Hammell, 2009), all occupational therapy practice did not always reflect this. I came to realise the important place of occupation in people's lives by simply analysing how people negotiated their daily living. In cases where occupation had been used for intervention, I also witnessed its transformative potential (Kielhofner, 2008; Wilcock, 2006). I began to wonder if occupations could play a role in influencing and sustaining recovery, and, if so, how the occupations of those in sustained sobriety influenced their recovery.

1.3 The magnitude and impact of the substance abuse problem in Zimbabwe

Substance abuse is a rising global health and social problem that has direct links to poverty, HIV/AIDS and crime in the developing world (UN, 2011). In international research, substance abuse has been shown to be associated with many serious medical, psychiatric, family (Martin, Bliven, & Boisvert, 2008), occupational, legal, financial and spiritual problems (Lowinson et al., 2005). Framed as a disorder, substance abuse affects the body structure and function, thereby altering the configuration of occupational participation, which negatively affects quality of life (Morgen, Astone-Twerell, Hernitche, Gunneson, & Santangelo, 2007; Martin et al., 2008). The dysfunction in occupational performance and participation caused by substance abuse can result in or be a result of occupational risk factors (Helbig & Mckay, 2003).

According to the African Union Plan for Action on Drug Control and Crime prevention (2011), the problem of substance abuse is increasing in Africa and has its roots in poverty. It has been predicted that alcoholism will be Zimbabwe's number one social problem by 2022 (Phiri, 2002). Reports in the media (In-Depth Reporters, 2011; Chimhete, 2010; Biriwasha, 2011) and country statistics (Index Mundi – Zimbabwe, 2012) show a Zimbabwean situation that is characterised by high rates of unemployment in the country (80%), poverty, HIV/AIDS, mental illness and discrimination against those with mental illness. Media reports have also highlighted an increase in substance-abuse-related problems that range from

individual abuse to drug trafficking. In addition to this, there have been reports of a rise in the incidence of illegal alcoholic drinks being sold on Harare's streets. Because of the accessibility, marijuana (locally known as mbanje), which is grown locally or illegally imported from neighbouring countries, and alcohol are the most commonly abused substances (African Union, 2011).

In Zimbabwe, the incidence of substance abuse has been found to be high among school-going adolescents with the highest prevalence being among male youths who are unemployed (Rudatsikira, Maposa, Mukandavire, Muula, & Siziya, 2009). Working with these young adults has the potential to provide depth of knowledge pertaining to recovery. In 2004, the prevalence of heavy and hazardous drinkers among Zimbabwe's male population stood at 5.8 % (Global Status on Alcohol, 2004). Some literature has shown a negative association between a high literacy level and antisocial behaviours such as substance abuse among the youth (Bentley & Conley, 1992). Health and media literacy have proved useful in disease prevention programmes, including substance abuse prevention programmes. And yet, despite an excellent literacy level of 98%, Zimbabwe still has a high prevalence of heavy and hazardous drinkers.

Poverty, low socioeconomic status, and an unsupportive environment were found to be risk factors for substance abuse among adolescents in Zimbabwe (Challier, Chau, Pre'dine, Choquet & Legras, 2000). However, these factors have not been thoroughly researched and are, therefore, not fully understood in the Zimbabwean context.

The impact of substance abuse in Zimbabwe can be seen through the increase in substance-abuse-related crimes, domestic violence and road traffic accidents (Zimbabwe Republic Police – Annual Report, 2012). It has been shown that alcohol consumption is often involved in cases of domestic violence in Zimbabwe (Armstrong, 1998). In addition to this an increase in sexually risky behaviour and HIV incidence has been observed in the population of those seeking treatment for substance-induced psychosis at the psychiatry referral centres (Ministry of Health and Child Care, 2008).

Those who engage in substance abuse do so for many varied reasons. Only those who develop substance-induced psychosis are eventually seen in treatment centres. Despite the well-documented negative effects of substance abuse, there are some positive consequences that the abusers seek in these engagements (Kiepek & Magalhães, 2011). In the Zimbabwean context, I have observed that social and cultural dissonance fuel engagement in substance

abuse activities, especially among males. In a study exploring the functional reasons why young people use drugs, the most popular functions included the need to relax, intoxication, socialising, enhancing activity performance, and alleviating depressed mood (Boys, Marsden & Strang, 2001). These reasons may hold true in Zimbabwe too.

This study focuses on Zimbabwean men between the ages of 19 and 35. This demographic is regarded as one of the groups most adversely affected by economic and political hardships – mainly unemployment, HIV/AIDS, and urban migration (Index mundi - Zimbabwe Demographics, 2012). By this age, most people would have passed through a psychosocial identity crisis (Fleming, 2004), which might include substance abuse problems, and are in a position to define their role identity positively (Fleming, 2004). While I assume that this group will include people who have recovered from substance abuse, I also acknowledge the complexity of the situations of many of the individuals in this group. Although most of the young adult men in this group are educated, they remain unemployed (Index Mundi – Zimbabwe, 2012) and, as a result of this, frustrated.

1.4 Recovery from substance abuse

Recovery from substance abuse involves a process of initiating and committing to abstinence from substances that were being abused, and making intrapersonal and interpersonal changes to maintain this change over time (Lowinson et al., 2005). The substances of abuse referred to in this study include alcohol, illicit drugs and prescription drugs. Recovery from substance abuse is a subjective experience (Laudet, 2007; Martin et al., 2008) that calls for team work involving the client, health team, family and society at large. The goal of recovery is to improve the client's quality of life, which, in turn, also benefits the family and society (Lowinson et al., 2005).

In further understanding why people continue to use or abuse substances, Chackfield & Lancaster (2002) listed some occupational reasons why people use or abuse substances: the substance's ability to enhance or disrupt human occupation; as a coping mechanism; to alter perception; for meaningful use of time; to develop meaning in life; and, for expression. To this end, substance use and abuse has been considered an occupation with both negative and positive consequences (Kiepek & Magalhães, 2011; Chang, 2008; Helbig & McKay, 2003). Further exploration of the transition from substance abuse to recovery will contribute to the way in which substance abuse is understood in occupational therapy

No research on the recovery from substance abuse among young adult Zimbabwean men has been conducted in occupational therapy or other disciplines. Related substance abuse studies in Zimbabwe have focused on the incidence, prevalence and causes of substance abuse, especially among adolescents (Gwede, Marty & Munodawafa, 1992; Eide, Butau & Acuda, 1999; Khan & Arnott, 1996). It has been proposed that to fully address recovery, occupational therapists must understand recovery from the client's perspective and emphasise skill development in activities that are most meaningful to the client or service user (Merryman & Riegel, 2007). Hence, there is a focus on occupation and its place or role during recovery. Occupational therapists are acknowledged to play a role as part of the health team in the recovery process. The skills-deficit perspective, which focuses on addressing the life skills needed to enhance health and well-being, is currently most prominent perspective in occupational therapy with this client or service user group (Martin et al., 2008). When occupational scientists and occupational therapists look beyond the skills-deficit perspective, an occupational perspective can be advocated as being of value. This perspective brings new understanding regarding addictive behaviours, doing and health (Helbig & McKay, 2003). Understanding the important place of occupation during recovery could inform the design of occupational interventions supporting recovery from substance abuse. The use of recovery testimonies in the form of life stories that explore the link between occupation and recovery could play a critical role in informing further research and contextually relevant practice.

1.5 Purpose

The purpose of this study was to build insight into the way in which recovery from substance abuse was successfully negotiated by young adult Zimbabwean men in Harare. In addition to generating knowledge through research for the field of occupational science, this study will support available literature on using occupation-based practice, specifically in the context of supporting recovery from substance abuse, and help to contextualise practice by highlighting what works best for recovery in Zimbabwe.

1.6 Research question

How does occupation play a role in the journey of recovery from substance abuse for young adult Zimbabwean men?

1.7 Aim

To describe how occupation was used in the journey of recovery from substance abuse.

1.8 Objectives

1. To determine the occupations that former substance abusers engaged in before and during recovery.
2. To explore how these occupations promoted recovery.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

The review describes research focusing on recovery as a process of change and studies investigating what influences recovery from substance abuse. In reviewing research investigating factors that influence recovery, I expose that an occupational perspective has not been sufficiently explored and discuss how this perspective can be of use. An intensive literature search¹ and review resulted in literature being discussed under the following headings:

1. Understanding recovery from substance abuse.
2. Factors affecting substance abuse recovery.
3. The role of occupation in substance abuse recovery.

2.2 Understanding recovery from substance abuse

There is evidence of multiple subjective understandings of recovery from substance abuse, (Henwood, Padgett, Smith, & Tiderington, 2012; Flora, 2012; McIntosh & Mckeganey, 2001) and, of these understandings, an occupational perspective of recovery is very limited (Martin, Smith, Rogers, Wallen, & Boisvert, 2011). Recovery from substance abuse is understood to be a change process, which has to be initiated and subsequently maintained (Henwood et al., 2012; Flora, 2012). The change process is tied to an element of life that requires continued exploration and is bound to change with circumstances: the development and reconstruction of identity. The development of a non-substance-abuser identity from beliefs, self-image and narrative explanations (McIntosh & Mckeganey, 2001) is of importance in successful recovery journeys.

In understanding recovery, disciplines such as psychology and social work have mostly drawn on narrative studies (McIntosh & Mckeganey, 2001; Racz, 2006; Flora, 2012; Hänninen & Koski-Jännes, 1999). Through a narrative inquiry, it is possible to explore how meaning is attached to life events or change processes, to address people's inner lives

¹The MEDLINE, CINAHL, PubMed, Academic Search Premier, ERIC, Psych INFO, Humanities International Complete, Google Scholar, Africa-Wide Information and OT Seeker were the databases searched for literature reviewed in this study. Mental health and occupational therapy text books and journal publications in the University of Cape Town library were also used as sources of literature. **Search terms:** substance abuse, recovery, occupation, occupational therapy, (rehabilitation and substance abuse), (treatment of substance abuse), drug abuse.

holistically, and to capture human experience, including recovery from substance abuse (Polkinghorne, 1995; Morse & Richards, 2002). Narrative inquiries to further the understanding of substance abuse recovery have not been conducted in Zimbabwe.

2.2.1 The subjective-multidimensional nature of the recovery change process

Recovery from substance abuse has been generally framed as a subjective process. A narrative study in Scotland explored 70 addicts' perspectives of their recovery from dependent drug use (McIntosh & Mckeganey, 2001). McIntosh and Mckeganey (2001) found that the former addicts joined recovery after their lives became dominated by negative experiences, which prompted them to reconstruct their identities and yearn for a change in the future. The turning point tended to be associated with an emotional crisis, negative life experiences, or an existential crisis (McIntosh & Mckeganey, 2001). Their need to reconstruct or repair their affected identities was recognised as central to their recovery process (McIntosh & Mckeganey, 2001). However, an understanding of the way in which this turning point and reconstruction of damaged identity is experienced from an occupational perspective is still missing.

In Finland, Hänninen & Koski-Jännes (1999) explored how people who identified themselves as recovered from their addictions interpreted their change process. Fifty-one participants who could speak about their experience of recovery were recruited through the media. There was uniformity in the narratives produced, which showed a journey towards the valued goal — a new life away from addiction. Hänninen & Koski-Jännes (1999) found that the need for recovery came after feelings of isolation and the sense of hitting rock bottom; recovery was perceived as the only way out. With regards to the recovery process, the participants indicated that recovery was a gradual change process during which new life was seen and experienced as valuable (Hänninen & Koski-Jännes, 1999). They found that a range of subjective interpretations of the recovery process existed. Five different story types of recovery emerged in their self-narratives, which supports the notion that the nature of recovery is subjective. These stories reflected the participants' understanding of their recovery journeys. The study categorised their stories as the AA story, the co-dependence story, the mastery one, the growth story, and the love story (Hänninen & Koski-Jännes, 1999). The stories, which served as personal interpretations of the change processes the participants went through, also revealed the driving forces in recovery: will-power, personal growth and love (Hänninen & Koski-Jännes, 1999). The recommendation from the study was

that those joining and in recovery should be supported from within the framework of their interpretations and views on recovery (Hänninen & Koski-Jännes, 1999), since recovery is largely a subjective change process towards a valuable end.

Similarly, a study in a residential treatment facility in Greece explored the recovery process of substance abusers using their own perspectives (Flora, 2012). The findings from their narrative analysis showed that understanding of recovery was based on treatment phases and identity changes that were related to the participants' past experiences, their present motivation, and their desire for future success in the change process (Flora, 2012). Although some of the participants' recovery journeys were marred by difficulties, the participants' changing identities – from addicts to non-addicts – helped to facilitate the recovery process (Flora, 2012).

In addition to the abovementioned studies, a qualitative study addressing how consumers understood their substance abuse recovery after experiencing mental illness and homelessness was done in New York City by a group of social workers (Henwood et al., 2012). The researchers used in-depth interviews for data generation and case study analysis as a data analysis method. They identified that the process of recovery involved achieving and maintaining recovery (Henwood et al., 2012). The process was influenced by both internal and external factors. Factors that were perceived as influential in the achievement of recovery included the presence of pivotal events and people, the process of maturation, and being institutionalised. For the maintenance of recovery, pivotal factors included finding housing, participating in self-help groups, and the influence of significant people (Henwood et al., 2012).

Twelve-step programmes that are widely used in recovery – such as those used by Alcoholics Anonymous and Narcotics Anonymous – position the overall goal of recovery as a life of total abstinence from substance abuse that can only occur after a gradual process of change. It is evident, from the reviewed literature and insights gained about recovery, that a change process is an integral part of the recovery process. This change process involves not only what people do every day, but also how these actions impact on identity and vice versa. Although these studies offer insights into the phenomenon of recovery from substance abuse, continued research into current and contextually relevant understandings of recovery is still necessary.

2.2.2 Theories of recovery from substance abuse

As lenses in understanding recovery, some theories have been suggested including the ‘maturing out theory’ (Winick, 1962) and the ‘sudden change theory of recovery’ (Waldorf, 1983). Winick’s (1962) theory states that people with substance abuse problems join recovery in their mid-40s, driven by the notion of growing up and assuming and recognising their roles and responsibilities in life. However, given that not all roles and responsibilities come with chronological age and that there are cases of individuals joining recovery before they reach their forties, this theory does not provide a total explanation for recovery. The sudden change theory of recovery by Waldorf (1983) views recovery as a process that results from the culmination of negative events affecting the individual to the extent that recovery becomes a basic need or the only option, which is similar to the McIntosh and Mckeganey (2001), Flora (2012) and Hänninen & Koski-Jännes (1999) studies discussed above. The events or experiences could include broken relationships, brushes with the law, diseases, homelessness and losing a job. The recovery process is aimed at addressing the areas affected by the negative experiences and is grounded on sustained sobriety.

2.2.3 Adapting to change during recovery

Adaptation through occupation has been theorised to be an ongoing process of occupational adaptation (Schultz, 2009; Schkade & Schultz, 1992). The occupational adaptation process has been defined as “the construction of a positive identity and achieving occupational competence over time in the context of one’s environment” (Kielhofner, 2008, p. 107). The occupational adaptation process happens in an interactive manner of adjusting to life’s performance demands and occupational demands thereby minimising disruption. If the occupational adaptation process is success it will enhance health and well-being (Schultz, 2009; Schkade & Schultz, 1992). In occupational science and occupational therapy it is assumed that ongoing adaptation is required to maintain health and well-being. Disease (*substance abuse*) or disability can disrupt this adaptation process and meaningful occupational engagement is the tool for adaptation (Wood, 1996).

In Ireland, Cahill, Connolly and Stapleton (2010) explored the process of occupational adaptation among seven women with multiple sclerosis using a mixed-method approach. The multiple sclerosis was found to affect the participants’ occupational identity and occupational competence resulting in the loss of some roles and occupations, which were no longer possible because of the severity of their condition (Cahill et al., 2010). To adapt, the participants opted for alternative satisfying occupations and roles, which, in turn, strengthened their occupational identity and occupational competence (Cahill et al., 2010).

Occupational adaptation for these women with multiple sclerosis was largely achieved by performing differently within capacity, but maintaining active engagement as much as possible.

In another study, which explored occupational adaptation by studying the experiences of older persons with physical disabilities in the Netherlands (Bontje, Kinébanian, Josephsson & Tamura, 2004); the importance of maintaining satisfactory occupational engagement was echoed.

The researchers behind this phenomenological study recruited eight elderly occupational therapy clients who had acquired a physical disability. The clients were interviewed about the occupational adaptation process that occurred following the disability. For these participants, occupational adaptation meant maintaining satisfaction and meaning by actively engaging in occupations of value (Bontje et al., 2004). Their occupational adaptation required active engagement, engagement in fulfilling occupations and maintenance of daily routines (Bontje et al., 2004). Occupational adaptation, which poses a way of responding to change and maintaining occupational functioning, has yet to be explored in the context of recovery from substance abuse. The general understanding from occupational science is that people adapt to change or transitions by doing things; what remains to be investigated is how occupation — framed as what people do every day — influences the change in the context of recovery from substance abuse.

2.3 Factors affecting substance abuse recovery

The area of recovery and the factors affecting recovery from substance abuse was investigated. Understanding recovery as an influenced process was an essential step in exploring whether occupation is linked to these factors, or if occupation is itself, an influencing factor. There is evidence that when recovery from substance abuse is examined from a psychosocial model of recovery — a model encompassing both the psychological and social issues of recovery — both the personal and contextual factors are said to play crucial roles in the change process (Kearney, 1998). The major factors contributing to the psychosocial perspective of recovery include: personal motivation (Nowinski, 2003), spirituality (Delaney, Forcehimes, Campbell & Smith, 2009; Cabassa, Nicasio & Whitley, 2013; Carter, 1998; Timmons, 2012), identity (Etherington, 2006; Anderson, 1993), employment, relationships, personal skills and general use of time (Cloud & Granfield, 2001; Christine, 2011). Of these factors, employment and relationships were perceived to be the most prominent.

Motivation and Spirituality

Motivation and spirituality have been shown to be central to facilitating recovery. In reviewing literature relevant to the facilitation of a twelve-step recovery-from—substance-abuse-and-addiction process, Nowinski (2003) identified ambivalence, better known as denial in recovery literature, as the chief hindrance to recovery. On the other hand, the individual's motivation in recovery was found to sustain sobriety (Nowinski, 2003). Motivation acted as an internal reinforcement as the person actively worked to sustain recovery. Furthermore, it was also recognised that one's values and goals in recovery were intrinsically linked to one's spirituality, with spirituality defined as “a force that provides direction and meaning to one's life” (p.36). The importance of spirituality in facilitating recovery was thus emphasised, with the whole recovery process being said to lead to a point of “spiritual awakening” (Nowinski, 2003, p. 36).

Similarly, Carter (1998), exploring the effect of spirituality on recovery from substance abuse, investigated how spiritual practices had an impact on recovery. The study was done in America using a quasi-experimental and descriptive design, which compared two groups of participants who volunteered for the study. The first group was made up of participants who had more than one year of sustained sobriety and the second group contained participants who had a history of multiple relapses and less than a year of sustained sobriety (Carter, 1998). He found that participation in spiritual activities was actually an indicator of recovery. The practice of spiritual activities was experienced as being intrinsic to the experience of recovery from substance abuse (Carter, 1998). Delaney et al., (2009) also conducted a qualitative study to investigate how spirituality influenced alcohol treatment and hence sustained sobriety. The researchers found that those who participated in spiritual activities, including meditation and prayer, had more sustained sobriety than their counterparts who did not participate in these activities. The participants reported an increased sense of purpose in their lives and the spiritual activities were said to shift their beliefs and values as ways of aiding recovery (Delaney et al., 2009).

Supporting the above contributions regarding the role of spirituality in recovery, Timmons (2012) developed a Christian-faith-based recovery theory titled ‘God as Sponsor’. This theory was developed from a qualitative study in the United States, which used the grounded theory methodology with ten African American participants who were purposively selected as experiencing recovery (Timmons, 2012). Data was generated through in-depth interviews that

were recorded and transcribed verbatim, after which the researcher applied a constant comparative methodology for data analysis. In the findings, the study came up with a recovery theory centred on understanding God as a sponsor (Timmons, 2012). The theory posits that the following spiritual elements are pivotal to the recovery process: acknowledgement that God was at the centre of their crisis awareness of self in relation to God, communication with God, and adoption of God's plan for one's life as one's own plan for one's life (Timmons, 2012). The study concluded that, for recovery to be successful, God has to be taken on as the sponsor. In practice, this means that the individual in recovery needs to participate in activities that enhance spiritual growth.

Spirituality was also shown to be a pillar of strength in recovery in a recent qualitative study by Cabassa et al. (2013). These researchers explored how recovery was envisioned or experienced by people who had a serious mental illness and a history of substance abuse and homelessness. These social work researchers used Photovoice as a participatory research method to generate narratives. Sixteen participants were recruited from supported housing agencies in New York City and the resultant data was analysed using pile-sorting, grounded theory and the deductive template analytic technique (Cabassa et al., 2013). From the findings, recovery was shown to be multi-dimensional and could be explored in participatory ways. "Spirituality, life achievement, and receiving and providing support" (Cabassa et al., 2013, p. 3) were important and interrelated dimensions that aided recovery and helped express recovery.

The role of spirituality in substance abuse recovery has also been investigated in the discipline of occupational therapy and occupational science. In Florida, a group of occupational therapists investigated the perceptions of those in recovery and the staff they were working with about spiritual well-being and the spiritual needs of those in recovery (Morris, Johnson, Losier, Pierce, & Sridhar, 2013). The researchers used a mixed-methods research approach. Participants were drawn from the Southwest Florida Addiction services where the AA programme of recovery was in use. The definition of spirituality applied in this study, adopted from the revised OT Practice Framework: Domain and Process, was "the personal quest for understanding answers to ultimate questions about life, about meaning, about relationship with the sacred or transcendent, which may lead to or arise from the development of religious rituals and the formation of the community" (Moreira-Almeida & Koenig, 2006, p. 844). The study was premised on the understanding that spirituality is a central component of being and plays a pivotal role in the development and expression of

identity and occupational choice (Cole & Tufano, 2008). Morris et al. (2013) used the Spiritual Well-being Scale to assess for outcomes of recovery and found that the participants reported an increased self-reported sense of spiritual well-being after participating in an AA recovery programme. This finding cemented the notion that spirituality needs to be considered as an important factor in recovery programmes.

Identity

Identity — an existing identity or the transformation thereof — is also regarded as an influential factor in the recovery from substance abuse. The way in which identity and or identity changes influences recovery has been researched. Anderson (1993) carried out a qualitative study using grounded theory with 30 purposively selected participants in the twelve-step recovery programmes in Washington. He explored types of identity transformation that substance abusers underwent on the journey to recovery. He found that identity change was very important, and that the conversion type of identity transformation — a sustained or maintained change from one identity to another — was common in recovery (Anderson, 1993). This conversion was associated with negating the old or reconstructing the past identity in a generally new social context (Anderson, 1993). Etherington (2006), who also emphasises the importance of identity in substance abuse recovery, conducted life-story research to identify how identity influenced recovery. This study, which involved mothers in recovery in New York, found that recovery from substance abuse occurred through a process of prioritising the socially acceptable identities over the identity of being a substance abuser. The mothers recovered by prioritising their mother and worker identities, and found meaning in their lives by becoming aware of what was happening in their environments (Etherington, 2006). The way in which everyday participation in occupations influenced this process of identity change in the recovery process had not been explored at the time of this review.

Relationships, employment and other factors

Employment and sound relationships for social support have also been found to be important in the recovery process. Christine (2011) conducted a narrative inquiry into the factors influencing women in recovery from substance abuse in America. The study focused on the women's sense of self and belonging in the community. The researcher purposively recruited ten women who were at least one year in recovery through addiction treatment organisations. Narrative interviews were used to obtain rich descriptions of the women's experiences, and a phenomenological hermeneutic interpretation was used for analysis (Christine, 2011).

Christine (2011) found that recovery was negatively affected by the women's experiences of marginalisation, including the discrimination as a result of stigma, and feelings of hopelessness. However, the women also reported a sense of belonging to the community of non-users, and that participation in employment opportunities provided through vocational or educational programmes contributed to this sense of belonging. They recognised that recovery support groups aided their recovery, particularly during the initial years of living sober and clean (Christine, 2011). In this study, Christine (2011) concluded that for successful recovery to occur, the concept of marginalisation should be addressed alongside basic recovery needs, which may include employment, education, treatment, housing, and family support.

American social scientists, Cloud and Granfield (2001) explored the factors supporting natural recovery from substance dependency using a narrative inquiry. The researchers employed snowball sampling to select their participants, who identified themselves as being in natural recovery (that is, recovering without treatment). The prospective participants were screened to make sure that they met the set of inclusion criteria, and 46 participants were included in the final sample. In-depth interviews were used to generate data and a narrative analysis was applied (Cloud & Granfield, 2001). In this study, recovery was mainly about practising total abstinence. The findings showed that the former substance abusers used strategies such as engagement in alternative activities, building relationships, and avoiding drugs and triggers to be successful in their natural recoveries (Cloud & Granfield, 2001). The participants reported that a combination of strategies was the most effective approach. Of interest to this present inquiry is the strategy of engaging in alternative activities. The findings indicated that most of the alternative activities were religious in nature and served to occupy their time and energy, as well as give them new meaning to life (Cloud & Granfield, 2001). Other alternative activities were in the areas of education, physical activity, reading or writing, work, and community participation. Another key finding reported was the need for 'recovery capital,' which referred to the personal attributes and environmental conditions conducive or supportive of recovery (Cloud & Granfield, 2001).

Although the topic has not been thoroughly explored, occupation is intrinsically linked to recovery from substance abuse because many of the reviewed factors involve everyday doings that could be considered occupations. The reviewed literature reflects that significant attention has been given to the factors influencing recovery. However, there has been little exploration of what exactly those in recovery do in their everyday lives — that is, the

occupations that they participate in — and how this influences their attaining and sustaining recovery from substance abuse.

2.4 An occupational perspective of the recovery process

In this section I aim to explore the existing occupational perspectives of substance abuse and recovery, although no studies have explicitly explored how occupation influences the negotiation of recovery from substance abuse among young adult men. I begin by identifying the importance of the occupational perspective and then discuss how occupation and occupational performance have been studied with reference to recovery from substance abuse. In doing so, I review the available literature.

In a recent analysis and synthesis of literature, Kiepek & Magalhães (2011) strongly posited that it is important to understand addictions and impulse control disorders as occupations. In their review, they showed that occupations are neither inherently positive nor negative, but are associated with both positive and negative consequences. They demonstrated that what are generally known as addictions and impulse control disorders actually fit the criteria to be considered occupations. Among others, the conditions they listed included pathological gambling, substance use disorders, and eating disorders (Kiepek & Magalhães, 2011). These activities were found to give meaning to life, which corresponds with the understanding that occupations hold potential for multiple meanings in different contexts (Kiepek & Magalhães, 2011). The addictions and impulse control disorders were shown to shape and be shaped by context, to organise behaviour patterns, to use time, to determine health, and to be closely related to identity; all of which are traditional aspects of occupations in general (Kiepek & Magalhães, 2011). This conceptualisation of the so-called problem activities or behaviours as occupations creates the space for them to be explored and understood holistically, even for their positive aspects.

2.4.1 Occupational outcomes in recovery

A quantitative study conducted by occupational therapists in Florida utilised the non-randomised pre-test and post-test design to evaluate occupational performance, self-esteem and quality of life changes among 75 participants who were completing a substance abuse recovery programme (Martin et al., 2008). However, there was no control group as it was deemed unethical to deny clients treatment. The recovery programme included occupational therapy services which focused on life skills training. To assess the changes as they occurred over four to six month intervals, the research team used the Occupational Performance History Interview, Rosenberg Self-Esteem Scale and the Quality of Life Scale. The analysis

of change in this study was done using t-tests and the Wilcoxon analysis of variance for statistical significance of the differences (Martin et al., 2008). The findings showed marked improvements in the assessed areas, which substantiates the premise that occupational performance is an important area of change in the recovery process and that occupational performance improves the most in a supportive environment such as the halfway house that was used for this study (Martin et al., 2008). The aspects of occupational performance reported to have changed in recovery were occupational identity, occupational competence, and occupational behaviour settings (Martin et al., 2008). Details on which occupations the participants engaged in and how they affect the above mentioned aspects had yet to be explored at the time of this study.

2.4.2 The role of occupations in substance abuse recovery

Building on the Martin et al. (2008) study, researchers from the department of occupational therapy and community health at Florida Gulf Coast University (Martin et al., 2011) undertook a narrative inquiry with thematic analysis of data to explore recovery from alcohol and other drug addictions from an occupational perspective. The study explored the impact of addiction on occupational identity, performance patterns, and performance capacity through the stories. It also examined the experience of recovery and factors considered important in this process (Martin et al., 2011). The ten women who took part in this study were mothers of at least one minor child, and were purposively selected through a residential programme in Florida. The participants were at varying stages in their recovery processes. The study found that the women had started using drugs as a result of exposure to opportunities for use, and that their desire for experimentation combined with an unsupportive environment meant that drug use provided an escape or a way of enhancing social participation, particularly during childhood years (Martin et al., 2011). After the drug use had evolved into an addiction, the mothers reported reaching a crisis point when change was needed. This point was said to be preceded by a negatively altered occupational identity, disrupted occupational performance patterns, and diminishing occupational performance capacity across major performance areas (Martin et al., 2011). Following intervention, their recovery journeys took a spiral route characterised by recovery and relapse episodes. In the journey, recovery was equated with the process of occupational adaptation, which was aimed at developing a positive occupational identity and improving one's occupational competency and capacity over time (Martin et al., 2011). The study also found that occupations such as work were tools for establishing stable recovery as well as productive use of time, especially leisure time, in meaningful occupations

(Martin et al., 2011). This was an important study in the context of my present study. I felt that it was worth adding to the understanding gained in the Martin et al. (2011) study by doing a similar study with a different gender population and in a different context.

Davie and Cameron (2010) used a mixed methods approach to explore the perspectives and views of those joining recovery through detoxification for drug misuse regarding their occupational competencies, limitations, and priorities to change. Thirty participants were recruited from a detoxification centre in the United Kingdom where Occupational Self-Assessment and semi-structured interviews were used for data collection. From the findings, these aspects were considered to be most important in recovery: being involved in valued roles such as a worker, working towards and realising goals, and taking care of others (Davie & Cameron, 2010). It was also evident from the findings that participants valued change when it was attached to occupations that gave meaning, purpose, and structure to their lives, instead of solely focusing on drug use problems and sobriety (Davie & Cameron, 2010).

2.5 Conclusion

Recovery from substance abuse is multidimensional in that the process is influenced by myriad factors, many of which are individualistic and subjective. The literature reviewed shows evidence of recovery as a change process. This change process can be more complex in challenging contexts, where there is limited recovery capital like in Zimbabwe. It is apparent that an occupational perspective of this change process has not been fully considered. How, exactly, occupations influence recovery has yet to be explored. In addressing this question, this study will contribute to a fuller understanding of the process of recovery. Although the evidence is limited and fragmented, occupation has been shown to be an influential factor in the process of recovery. How recovery from substance abuse is negotiated by young adult Zimbabwean men — which occupations aid recovery, how they participate in those occupations, and why they do so — has yet to be explored. The absence of specific occupational therapy or occupational science studies investigating the role of occupation in recovery among men and the use of an occupational perspective to understand this change process also necessitates this current inquiry.

CHAPTER 3

METHODOLOGY

3.1. Introduction

This chapter describes the research methodology applied in this study and justifies the appropriateness of the selected study design. The procedures involved in executing the study, how scientific rigor was achieved, as well as ethical considerations followed for the study are described in detail.

3.1.1. Study Design

A qualitative research design was selected because the study focuses on human occupation in context and appreciates the subjective nature of human life. Qualitative research focuses on describing and explaining individuals' experiences, behaviours, interactions and social contexts (Strauss & Corbin, 1990). I sought to understand negotiation of recovery from substance abuse among young adult Zimbabwean men, and this made a qualitative study an appropriate approach.

Through a narrative approach, I was able to explore how the former substance abusers' engagement in occupation(s) influenced their recovery journey. Narrative inquiry allowed for the "study of experience as story" (Connelly & Clandinin, 2006 p. 479); it allowed for the recognition that my participants, as human beings, lived storied lives and re-lived their lives by telling the stories. Narrative inquiry provided a powerful way of understanding because it allowed for sensitivity to the unique characteristics of human existence in the social world (Polkinghorne, 1988; Lieblich & Josselson, 1994). This was valuable in exploring recovery from substance abuse in context since the study called for the participants to reflect on their recovery experiences in relation to their past, present and futures, making a narrative approach well suited for this study.

Furthermore, the narrative inquiry allowed for the meaning and consequences of doings and events over time to be evaluated (Chase, 2008) and enabled the understanding of occupation through the life course (Wicks & Whiteford, 2003). In my study, the participants' occupations during recovery in Harare, and what it meant to them and their surroundings over time, was captured in the stories shared and analysed.

Three dimensions of human experience — temporality, sociality and place — are explored and considered important in narrative research (Clandinin & Huber, 2002). Barton (2004)

states that taking the three dimensions into consideration illuminates the key aspects of human experience, including identity, hopes, values, meaning(s) and intentions. This was important to understanding recovery from an occupational perspective as these aspects influence what people do. In my study I used the term narrative to refer to both the method of inquiry and to a story as a representational device of data interchangeably.

3.2. The research process

3.2.1. Gaining access to participants

Ethics approval was obtained from the University of Cape Town's Human Research Ethics Committee [HREC REF: 061/2013] (Appendix J) after which, the proposed study was reviewed and approved by the Medical Research Council of Zimbabwe [Ref: MRCZ/B/500] (Appendix L). I approached Harare Central Hospital for permission to access possible participants through their centre and this was granted (Appendix K). I also approached AA Zimbabwe, which gave me verbal approval. I was not successful in gaining approval from the Parirenyatwa Group of Hospitals.

3.2.2. Selection of participants

This study's focus was on young adult men who were recovering from substance abuse in Zimbabwe's capital, Harare. Harare has been the hardest hit by economic, social and political challenges that the country has faced in recent years (Index Mundi – Zimbabwe, 2012). In this context, I had observed and had read local media reports identifying substance abuse as a significant problem, especially among youths in the high density suburbs. However, I also observed a few cases of young adult men who are successfully recovering from substance abuse in Harare, whose stories had not been captured. I therefore deemed Harare a suitable community through which I could explore the stories associated with recovery from substance abuse. The need for a specific population of former substance abusers demanded that I use a purposive sampling strategy (LoBiondo-Wood & Haber, 1998).

3.2.3. Inclusion criteria

Participants were selected if they fulfilled the following criteria:

1. Young adult between the ages of 19 and 40. This was based on Erikson's stages of human development. With the teenage years of peer influence and prevalent substance experimentation behind them, the individuals in this group can largely influence their own way of life.

2. Had a history of abusing alcohol and or marijuana. Observations during my clinical experience indicated that these were the most commonly abused and easily accessible substances in Harare.
3. Those who once met the diagnostic criteria for substance abuse according to the DSM-IV. Potential participants were pre-screened to determine if they met this inclusion criterion through gentle questioning using DSM-IV criteria for substance abuse as a general guideline (Appendix G). This was done to ensure that participants who self-identified as former substance abusers met the diagnostic criteria prior to recovery.
4. Those in sustained sobriety (one to five years) or stable sobriety (more than five years). This meant that the participant would have had a reasonable time to experience recovery and tell their detailed recovery story.
5. English or Shona speaking. I needed the participants to share their stories in languages they were comfortable with, but that I could understand since the stories were generated from interactions between me, the researcher, and the participants. Because Shona is the language predominantly spoken in Harare, this was deemed acceptable.

3.2.4. Exclusion criteria

Those who met the above inclusion criteria, but had ongoing psychiatric problems affecting their functioning were excluded. This meant that those who were unable to tell their story because of an impaired mental state were excluded.

Participant selection and data generation occurred incrementally and concurrently. The emerging data was used as a measure of the need for more participants. Based on the scope of this study it was decided that three participants would suffice. This sample size allowed for in-depth exploration of the subject matter under study and the extent of data collected allowed me to answer the research question.

3.2.5 The sample selection process

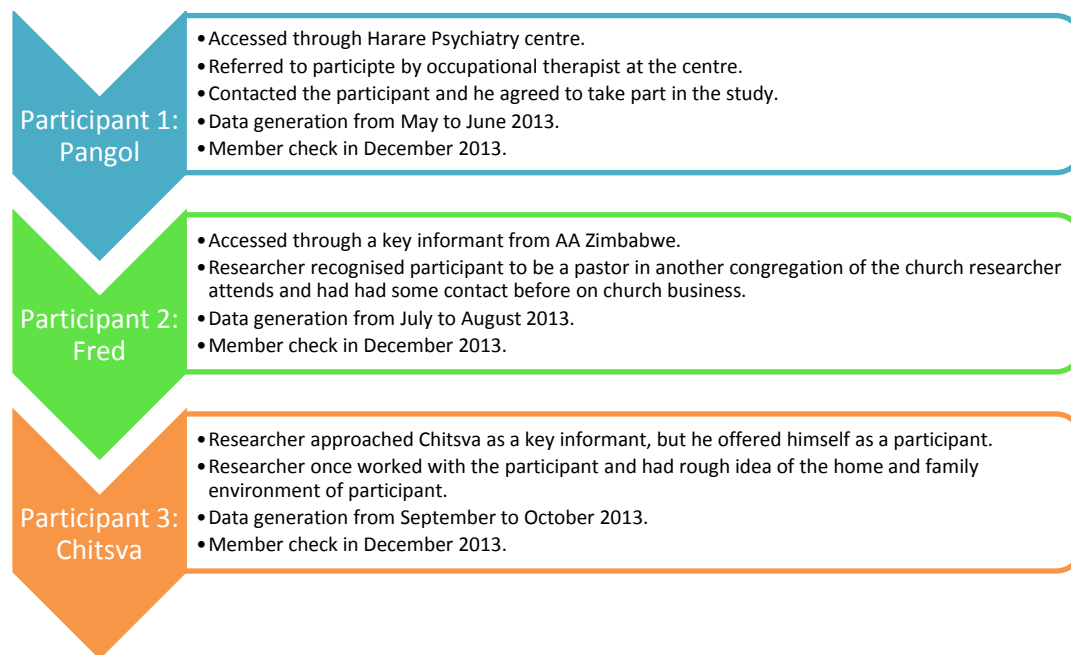
In the selection of participants, I aimed to include information-rich cases (Patton, 1990), which allowed for the capture and description of the phenomena of how young adult men negotiated recovery from substance abuse. To access participants, my first port of entry was Harare Central Psychiatric Hospital and Alcoholic Anonymous Zimbabwe (AA Zimbabwe) since these organisations worked directly with people abusing or recovering from substance

abuse. When I approached these two centres, I used the aforementioned selection criteria to identify potential participants. The three participants, Pangol, Chitsva and Fred², were identified at the end of this process.

The occupational therapy staff at Harare Central Psychiatric Hospital referred me to Pangol as a potential participant. The chairperson at AA Zimbabwe referred me to Fred, a local Pastor, as another potential participant. I had worked with the last participant, Chitsva, during my time as a clinician at one of the state's psychiatric facilities; at the time he was recovering from substance abuse. I had maintained contact with him and had approached him with the intention of asking him to assist me in identifying potential participants. After I explained the study to him, he indicated that he met the criteria and was eager to participate. Figure 1 depicts the process of selecting participants in chronological order.

² All names used are pseudonyms

Figure 1: The process of selecting participants and time frames for data generation



Although maximum variation sampling (Patton, 1990) was not sought, I endeavoured to find participants who were in recovery for different lengths of time as shown in Table 1, which summarises the demographic profiles of the participants.

3.2.6. Participants sample

I sought a diversified sample based on age, substance of abuse, years in recovery, current income level, educational level, and current work occupation. These are shown in Table 1 below. These diversifying factors were considered to have the potential to affect the negotiation of recovery from substance abuse among young adult Zimbabwean men. The diversified sample allowed deep understanding of the recovery process.

Table 1: Demographic profile of final participants list

Participant	Age	Substances abused	Years in sobriety/ recovery	Current income level³	Level of education	Current work occupation
Chitsva	Young adult	Marijuana, alcohol	6	average	diploma	Teacher
Pangol	Young adult	Marijuana, alcohol	3	low	Passed Ordinary level	Farmer
Fred	Young adult	Marijuana, alcohol	17	average	Failed Ordinary level	Pastor

3.2.7. Data generation

Data generation was through interactive in-depth narrative interviews (Polkinghorne, 1995). The in-depth narrative interviews allowed participants to open up and direct the flow of the conversation with minimum interruption from the interviewer. The in-depth interviews allowed the participants to direct how they told their stories and to select the aspects that they wanted to emphasise. The interviews focused on the recovery journeys, but also included their narratives prior to recovery, which showed how their pasts influenced the recovery journeys.

Each interview session took an average of one-and-a-half hours and three to four sessions were held with each participant.

3.2.7.1. The interview process

Before the interview process began, an information letter (Appendix A) was used to explain to each participant what the study was about and what he would be consenting to. Thereafter each participant consented to participate in the study. A convenient place to conduct the

³ Current income level was determined by asking about the participant's subjective view on income and material possessions, cultural possessions, and prestige; all judged against my observations. Those with a stable source of income and occupying positions in society were regarded as average. One participant was given a low socioeconomic status, largely because he did not have an effective income.

interview was selected. The venues selected needed to put the participant at ease and be free from interruptions in order to encourage good story telling (Atkinson, 1998). Thus, interviews took place in the participants' homes or community facilities convenient to them. This enhanced building of trust, especially when the same venue was used for consecutive interviews as the participants were more comfortable. In the instances where transport costs were incurred, participants were reimbursed to a maximum of \$10.00. Refreshments were offered where possible.

Narrative interviews (NI)

Narrative interview is a specific technique or method of data gathering or elicitation used in qualitative research (Jovchelovitch & Bauer, 2000). This method was used in my study as it placed importance on creating a setting that encouraged as well as stimulated the participant to tell a story of some important life event in a social context (Bauer, 1996).

The basic technique of NI that I used was to reconstruct events from the participant's perspective as directly as possible. I also believe that humans live storied lives (Polkinghorne, 1995) and hence assumed my participants could recount their stories naturally. The principles I employed for the facilitation of the production of the participants' meaning in story format included the following strategies suggested by Streubert Speziale and Carpenter (2003):

- use of open ended questions;
- eliciting stories;
- avoiding 'why' questions as these encourage intellectualism and can be threatening;
- and following up using the respondent's ordering and phrasing.

In all the narrative interviews, I respected that language is not a neutral medium of exchange (Jovchelovitch & Bauer, 2000). I avoided imposing any form of language on the participants during the interviews. All the participants chose to use Shona and English interchangeably. For each interview, I followed the basic phases of the narrative interview as suggested by Jovchelovitch and Bauer (2000) from Schutze's proposal, which were: preparation, initiation, main narration, questioning phase, and concluding talk.

Preparation

Upon familiarising myself with the topic of substance abuse and recovery, I formulated 'exmanent questions' (Jovchelovitch & Bauer, 2000) speaking to this topic (Appendix C).

My preparation and familiarisation involved preliminary inquiries about substance abuse recovery from peers and other people in the community, reading and reviewing documents written about the phenomenon locally and internationally, and taking note of rumours and formal accounts of events that were coming up in the preparation phase (Jovchelovitch & Bauer, 2000) regarding substance abuse and recovery. The themes, topics, and accounts that emerged during the actual narration are called ‘immanent’ issues (Jovchelovitch & Bauer, 2000). I distinguished the immanent issues from the already developed exmanent questions. As the interview progressed, I looked for immanent issues by listening to the participant’s language and using it to develop immanent issues.

Initiation

The initial topic of narration I formulated was: “Tell me about your story of recovering from substance abuse”. Characteristics of the initial topic included those suggested by Jovchelovitch & Bauer (2000):

- It was based on the participant’s experiences and this ensured interest and a detailed narration.
- It was personally and socially significant to the participant.
- It allowed a full story to develop.

No visual aids were used to support the participant’s narration (Bauer, 1996), but a timeline was mapped from the moment(s) of starting substance use/abuse to the time of telling the story.

Main Narration

Once the main narration started, I did not interrupt until there was a clear ‘coda’, where the interviewee paused and signalled the end of the story (Jovchelovitch & Bauer, 2000). During the narration, I used non-verbal signals to indicate active listening and to encourage the narrator to continue. I also observed and made field notes about possible further questions in the following phase and about the coda. I also subtly probed for more or missing information identified by judging the gaps between what had been raised and the research question.

Question phase

The attentive listening skills from the main narration phase produced fruits in this phase. In this phase I aimed to elicit new and additional information beyond the self-generating schema

of the story. This was guided by some rules on asking immanent questions (Jovchelovitch & Bauer, 2000).

1. I did not ask 'why' questions and also avoided questions about opinions or attitudes about causes, as these are known to call for justification and rationalisation.
2. I asked only the immanent questions, using the participant's words, as the exmanent questions were translated into immanent ones.
3. I avoided a cross-examination climate by carefully handling contradictions in the story.

The initiation, main narration and questioning phases were audio recorded using a digital voice recorder for verbatim transcription with the consent of the participants.

Concluding Talk

After the tape recorder is switched off at the end of the interview, an interesting discussion in the form of a small-talk often ensues (Jovchelovitch & Bauer, 2000). After the above phases with each participant we talked in a relaxed manner, which set a relaxed mood. The 'why' questions could be used where relevant at this stage as they helped me with contextual interpretations of the given accounts. I took notes so that I would not miss emerging important information. I also documented my reflections after each interview process. This captured details of what transpired during the interview including emotions expressed as the story was being told. In my journal, I documented my views, thoughts, beliefs, assumptions and uncertainties about what was emerging.

3.3 Data management and analysis

3.3.1 Data management

All narrative interviews were audio recorded and I transcribed the data verbatim in order to prevent data loss and preserve meaning so that nothing of importance would be overlooked (Tilley & Powick, 2002). I then saved the transcriptions on my personal computer for storage purposes and no other parties had access to these transcripts. The hard copies were stored in a locked cabinet in my office. Translation of all the research interviews did not occur in a verbatim fashion. Rather, to prevent loss of meaning, the full story of each participant was understood and then constructed in English as a meaningful whole during the process of narrative analysis.

3.3.2 Narrative Analysis

This study employed a *narrative analysis* (Polkinghorne, 1995) to analyse the actions, events, and happenings in order to produce emplotted narratives (Polkinghorne, 1995). The raw interview data was synthesised into a coherent story (Polkinghorne, 1995). Narrative reasoning encouraged me to notice the differences and diversity in the participants' behaviour as I attended to the "richness and the nuances of meaning in human affairs" (Carter, 1993, p.6). The emplotted stories that were produced as a result were what I needed for learning and maintenance of narrative knowledge in this study (Polkinghorne, 1995).

From an intimate association with my data, which involved listening to the audio recordings and reading and re-reading the transcripts, I discovered a plot linking the events, actions and happenings of each participant as parts of an "unfolding temporal development culminating in the denouement" (Polkinghorne, 1995, p.15) for each of the participants. In this study, I took a plot as was described by Polkinghorne (1995) to be "a narrative structure through which people understand and describe the relationship amongst the events and choices in their lives" (Polkinghorne, 1995: 16). The plot developed from summing up relevant events and factors surrounding occupations and their roles before and during recovery, and these events and factors had to be consistent with my research objectives. This process enabled the development of an understanding regarding how and why recovery from substance abuse came about amongst young adult Zimbabwean men. For the bounded system of study required, I took the recovery journey(s) of young adult men who recover or are in recovery from substance abuse.

In writing the stories, I used present historical tense and first-person narrative to add life to the stories. I acknowledged that past, present and future events were made mention of. This timeline enabled me to include human action and experience in its temporal nature. Configuring the events, actions and happenings into a narrative, gave them coherence and also organised them into a gestalt. I then looked over the written stories to further understand the diversities and similarities, an activity that was similar to some form of cross-case analysis.

3.3.3 The production of the Research Stories

I applied Polkinghorne's (1995) adaptation of Dollard's seven criteria for judging a life history as guidelines for developing the narratives. These guidelines helped me to organise the structure and content of the narratives.

- a) From the understanding that meanings of events, actions and happenings are linked to cultural heritage (Polkinghorne, 1995), I provided descriptions of the cultural context (Harare, Zimbabwe) in which the research stories took place. I paid attention to contextual features that gave specific meanings to events, actions and happenings, so that their contributions to the plot could be better understood (Polkinghorne, 1995).
- b) In generating the stories, I attended to the ‘embodied nature of the protagonist’ (Polkinghorne, 1995, p. 17). The person had to be located spatially and temporally. Bodily capacity and incapacity influences a person’s self-identity as well as productivity (Polkinghorne, 1995). I therefore included the necessary bodily dimensions in the stories.
- c) The importance of significant others in the recovery journeys was noted as influencing the actions and goals of the protagonist (Polkinghorne, 1995). Explanations of relationships between the protagonist and other people such as parents, siblings, spouse, children, friends and other personal antagonists were given in the development of the plot. This is because the reasons for occupational engagement and participation are not simply to fulfil a personal agenda, but for other people’s well-being too (Polkinghorne, 1995).
- d) Since the story is about the central character — the protagonist and his movement toward an outcome — I concentrated on the choices and actions of the participant. I zoomed in on the participant’s “plans, purposes, motivations and interests” as they brought important data in describing his interaction with the setting (Polkinghorne, 1995, p.17).
- e) The historical continuity of the characters was considered as people are considered to be historical beings influenced by their previous experiences, which manifest in the present as habits (Polkinghorne, 1995). Social, political and economic events experienced by the protagonists were noted as making their decisions and actions understandable and sensible. Using the present historical tense, I presented these events as consistent with previous experiences.
- f) There is need for a bounded temporal period of the stories generated, which is the need for a beginning, middle and an end (Polkinghorne, 1995). Recovery journeys from substance abuse are very subjective and it was the participants who informed this bounded temporal period of the stories; that is, from their experiences, they determined the beginning and the end of the stories. Detail used enabled participants

to be presented as unique individuals in the particular situations they faced (Polkinghorne, 1995).

- g) Efforts were made to make sure the story line or plot served to arrange the data elements into a meaningful explanation of the participants' actions and responses (Polkinghorne, 1995) around recovery and the role of occupation(s), and this was done throughout the narrative analysis process. With this final guideline, I aimed to make the research plausible and understandable (Polkinghorne, 1995).

I repeatedly drew on the audio recordings and transcribed data to find meaning and make sense of the participants, their occupations and their surroundings in the recovery journey. In selecting data elements for the stories, relevant events, actions and happenings in the journey became more apparent. Even though some aspects appeared contradictory, the way I understood those contradictions contributed to the construction of the stories. I presented the contradictions in such a way that they added meaning to the whole story. I used emplotment (Czarniawska, 2004) to select and transform simple successive events into a meaningful gestalt, which gave flow and life to the stories. I was also guided by my research objectives in doing this.

3.4 The scientific rigor of the study

3.4.1 Validation of narrative

Under this criterion, the persuasiveness, coherence and pragmatic use of the narratives are considered (Riessman, 1993). In enhancing the trustworthiness of the narrative, I aimed for a comprehensible, correct, complete and credible evaluation to all parties involved, hence a narrative truth (Polkinghorne, 1988).

- A. **Persuasiveness:** This was achieved when theoretical claims used were supported with evidence from research data and alternative explanations were taken into account (Riessman, 1993). I presented the reasoning behind the conclusions that I reached (Polkinghorne, 1988).
- B. **Coherence:** This is traditionally referred to as dependability in general qualitative research and is concerned with the fitting together of different parts of the story to form a complete and meaningful picture (Josselson, 1993). I was guided by my objectives, making sure that the stories existed at global level of coherence. Global coherence is concerned with what the story achieves as a whole (Riessman, 1993). For this study, global coherence revolved around the role of occupation in recovery

from substance abuse. To achieve local coherence, which is coherence within the narrative itself (Riessman, 1993), I used literary devices. By making sure there was sufficient data in the interviews for results and discussion, themal coherence — the development of the narrative around particular themes — was achieved (Riessman, 1993).

- C. **Pragmatic use:** This refers to the significance of the study and its ability to be a foundation for other studies (Riessman, 1993). I borrowed Riessman's (1993) advice about producing full descriptions of how interpretations were reached, which I included in the narrative analysis sections above. I provided clear descriptions, which made the process visible. I also included thick descriptions in the stories to show how interpretations in the discussion were reached.

The aspects of trustworthiness according to Guba's model for achieving trustworthiness, include credibility, dependability, transferability and confirmability (Lincoln & Guba, 1985). To enhance trustworthiness, I used the following strategies:

1. **Reflexivity:** As a researcher I acknowledge that I have personal biases that could influence the interpretations of data generated (Creswell, 1998). Reflexivity was thus very important in a study such as this. I undertook to uncover and disclose in writing my biases, assumptions and background (Carlson, 2010). In my research process, I kept a journal for recording my "thoughts, feelings, uncertainties, values, beliefs, and assumptions," (Carlson, 2010, p. 1104) which surfaced. These formed part of the exmanent questions, which were replaced with immanent issues during narrative interviews. As part of reflexivity, in the final write-up I also included a section on limitations and suggested ways to avoid similar shortcomings in future.
2. **Audit Trail:** For an audit trail, one needs to keep strict documentation or traces of all components or steps involved in the study process (Carlson, 2010). My audit trail illustrated the decisions I took and details of how these decisions had an impact on the study process. Areas under scrutiny included the recording of the design, data generation, data analysis decisions, and the theoretical basis of analytical decisions. This enabled me to trace my research decisions and determine their reasonability.

3. Peer debriefing: In enhancing the credibility of the study, my supervisors were involved in the study as second and third researchers. The supervisors helped by offering alternative views as the research progressed.
4. Member checking: This entailed giving participants an opportunity to approve or disapprove elements of what was emerging from interpretations of the data gathered from them (Doyle, 2007). Member checking can also be referred to as finding out if the analysis is a true representation of the participants' experiences (Curtin & Fossey, 2007). In this study, I used the narratives that had developed from analysis not just raw transcripts to do member checking. I took hard copies of the narratives to each of the participants and instructed them to identify themselves, edit, elaborate and clarify on their views in the narratives. Fred and Chitsva were very excited and identified with their narratives and only elaborated on some minor aspects. Pangol also confirmed that a true representation of his experiences had been analysed and reported when encouraged to be as honest as possible.

3.5. Ethical considerations

In order to prevent any harm to participants, certain ethical guidelines were followed. Ethical clearance was applied for and granted by the University of Cape Town's Human Ethics Research Committee (HREC REF: 061/2013) (Appendix J) and, because the study was being carried out in Zimbabwe, permission to do the research was sought and given by the Medical Research Council of Zimbabwe (Ref: MRCZ/B/500) (Appendix L).

In narrative research, my ethical duty included, but was not limited to, protecting the privacy and dignity of participants who shared their storied lives to contribute to knowledge generation.

3.5.1. Informed consent

The selection of participants included safeguarding their confidentiality and the right to participate on a voluntary basis. Potential participants were given the information sheet to read and I explained this in depth. This information detailed what the study was about using layman's terms (Appendix A). I made certain that the participants understood the content and what they were consenting to by reading and discussing the information sheet and consent form with them. I clarified where necessary and answered any questions raised.

Thereafter, if potential participants chose to participate they consented by signing an informed consent form (Appendix B) before commencing with the narrative interviews. I also

emphasised their right to refuse to participate by detailing in the information letter that no one should feel obliged to participate. The right to withdraw from the study at any point, without negative consequences, was also emphasised verbally and in writing. I made myself available to answer any questions relating to the research when obtaining informed consent and once the research process had begun.

3.5.2. Confidentiality

The principle of assurance of confidentiality and privacy needs to be adequately addressed in narrative research (Josselson, 2007). I also understand that whenever research is done with members of a specific community, confidentiality can be a problem (Flick, 2006) because people can identify the participants from the stories shared. In an attempt to protect their identities, I put in place protective measures such as using pseudonyms for the participants and changing small but particular details of the shared stories. However, major changes were not possible as that would have compromised the study findings. Nevertheless, I believe that I made sufficient changes to protect the participants' identities. I also recognised that, for them to tell their stories, my participants had to trust me with anonymity, which they did.

The areas of concern included what was to be done with data, who listened to audio-recordings, name changes of participants, who read transcripts, and data storing methods (Josselson, 2007). I did everything possible to safeguard the material, including using a locked filing cabinet for data storage in my office that only I could access. Data was also sent via secure internet lines only and all names used and referred to in the stories were changed to pseudonyms. The stories shared by my participants will be suitably disguised before use in public reports, especially in Harare — the geographical location from which the participants were selected. The consent forms with participant signatures were locked away and only I had access to these.

3.5.3. Potential for harm and benefits

According to the theory of beneficence and non-maleficence, Fontes (2004) proposed that beneficence operates in terms of the provision of benefits, balanced against risks. Non-maleficence refers to the researcher's ability or duty to do no harm to the participants (Yick, 2007). However, emphasising the potential for harm or the probability of participants being upset as a result of narrative interviews could be problematic. On the one hand, the participants might find the interviews to be denigrating; on the other hand, the interviews might result in personal growth by integrating what the participants already know about themselves (Josselson, 2007), the later happened in this study.

Although distress was not expected in narrating successful recovery stories for this study, caution was taken and referral for help in the form of psychotherapy or other support services was in place if necessary. I used empathetic listening skills with affective expression as comfort when the need for comfort arose in my participants. None of the interviews were terminated because none of the participants showed distress. Although referral for psychosocial support services were available should they be required or if the participant indicated that he was still abusing drugs or wished to abuse them, these services were not required during this study.

I ended all interview sessions on a positive note by asking the participant what it was like talking about recovery, which is an equivalent to debriefing (Josselson, 2007). There was no provocative use of confrontation to elicit more data. The participants were also given a chance to specify if they were not comfortable having particular information published. This occurred during member checking and no significant changes were made. Establishing trust through active listening, respect, and showing empathy with the participants was helpful in these circumstances.

The benefits of being involved in narrative inquiry include increased self-esteem, added meaning making, and the promotion of growth through reflection (Atkinson, 2007). Participants reported this to be the case in this study. In this study, as was confirmed by the participants, a clearer perspective on the recovery experience was gained, which brought greater meaning to life as a benefit of storytelling (Atkinson, 2007). An interview is an intervention (Josselson, 2007) and it encourages the fantasy of continuing relationships through the rapport developed and figures mentioned in the process. The study also gave a voice to the underrepresented population of those with successful recovery stories in substance abuse in the context of Harare, Zimbabwe.

3.5.4. Ethics of the report

In report writing, I acknowledged and ethically managed my skills as a narrative researcher in communicating my point of view with regards to participants' stories. I addressed this interpretive authority by faithfully reporting the participant stories and making sure they identify with their meaning in text (Josselson, 2007).

3.6 Conclusion

This chapter showed how a narrative inquiry as a qualitative research design was well suited and applied in this study. In this narrative inquiry, I used narrative interviews to generate data. I also applied narrative analysis as a data analysis strategy to produce the stories presented in Chapter 4. Further to this, the ethical procedures followed have been documented as well as the actions I took to enhance the trustworthiness of the findings of this study.

CHAPTER 4

RESEARCH STORIES

4.1. INTRODUCTION

In this chapter I present the study findings as co-constructed research stories. These stories or narratives emerged following a rigorous narrative analysis. The beginning of each story describes each participant's present life circumstances and occupational engagement before journeying into their past. In relating their recovery journey, the participants' entry into substance abuse is traced. Efforts are made to illustrate how the participants' occupational engagement influenced their recovery in relation to the key events, happenings, actions and significant people in their lives. In an effort to add life to the stories and bring the reader closer to the context in which these stories took place, I first give a brief description of Harare, Zimbabwe.

4.2. The context of Harare, Zimbabwe

Zimbabwe is a Southern African country and a former British colony which gained its political independence in April 1980. The country got its independence after an armed liberation struggle and the after-effects are still evident in social, cultural, economic and political challenges faced and experienced by Zimbabweans today. Zimbabwe's capital city, Harare, is the central and biggest industrial and administrative city. Harare is a beehive of activity as people of all walks of life flock in to search for ways to earn a living, many among them youths and young adults.

Historically and, until 2002, Zimbabwe had developed as a capitalist economy with a peaceful environment. Following a disputed election in 2002, a crisis emerged, causing the economy to begin to collapse amidst strained international relations and some sanctions from select Western countries. This downward trend continued until 2008 after a second disputed election characterised by political polarisation and inter-party conflicts. An inclusive government was formed in February 2009 under the Global Political Agreement. This government had to fight corruption, unemployment, politically motivated violence and a hyper-inflationary climate. Total foreign debt reached \$7.1 billion by December 2009 and official inflation had recorded an all-time high of 231 million percent in July 2008. This background continues to influence how the ordinary Zimbabwean lives, and is the context in which young adult men recovering from substance abuse are expected to thrive.

Since 2009, there has been a fair level of stability both economically and politically facilitated by the introduction of the multi-currency system in 2009. The inclusive government's term ended in August 2013 with elections that resulted in the Zimbabwe African National Union (Patriotic front) (ZANU (PF)) forming a government after defeating the major opposition party Movement for Democratic Change – Tsvangirai (MDC-T). However, unemployment rates have remained high since 2000 as the government fails to rehabilitate industry and eradicate corruption. An informal economy has since taken its toll with poverty remaining widespread even amongst the educated. These factors have resulted in limited occupational choices, which I have also experienced as a young adult man living in Harare.

Harare, serving as the centre of economic activity, has been heavily affected by all these developments as urban migration continues to increase. The health and social problems being faced in Zimbabwe, including substance-abuse-related problems, may be linked to some of the country's aforementioned economic, political and socio-cultural developments. Harare's streets are flooded with youths and adults engaging in informal trading such as vending to earn a living. This increase in informal traders and people in the city, who are desperate and frustrated, is associated with high and increasing levels of drug abuse. Some illegal drugs have also found their way on to the streets, especially in the high density suburbs.

Despite the economic and political challenges, Harare has remained notorious in the country as a place for partying. It also emerged from a survey conducted by the Centre for Disease Control and Prevention (CDC) that Harare is the 'hardest-drinking' city in Zimbabwe (Centre for Disease Control and Prevention, 2012). In Harare, alcohol and marijuana (locally known as 'mbanje') are the most commonly abused substances. The abuse of these substances seems to be high and socially acceptable among men. With context being known to influence people's occupational choices (Galvaan, 2012), the impact of this context is evident in different ways in the research stories shared hereafter.

4.3. Research Stories

The three research stories I present here represent the individuals' experiences of recovering from substance abuse over time in a Zimbabwean context.

The three recovery stories are titled as follows:

Pangol's story: "Tomorrow is made from today"

Chitsva`s story: “Revived foundation”

Fred`s story: “In search of ‘real’ life”

The stories have some similarities and seem to converse with one another; they can be read in any order. The stories begin with the participants in their present lives, who they were at the time of telling their stories. They then move into the past, tracking how the participants came to abuse substances and highlighting the key events, happenings and people around or associated with the rising action of substance abuse. The stories then draw to the climax and turning point showing how recovery was considered and negotiated. For Pangol and Chitsva, the turning point was a health crisis, and a spiritual awakening marked Fred`s epiphany that he needed to move away from substance abuse. The stories then trace the events, happenings and people and their meaning through the period of rebuilding the self and the role of occupations within the recovery journeys. The stories draw to a close by considering the participants` present lives in recovery and their future plans.

4.3.1. Pangol`s story: Tomorrow is made from today.

I am Mr Farmer. My wife and I toil the land together. We can afford to sell a bit of our produce. Now, unlike in the past, what I earn is for my family - not for self-destruction or bringing pain to others. I should be proud of what I do, and others should be proud of me too. It wasn`t always this way. There was a time when I scoffed at valuable employment opportunities. There was a time when all I cared about was getting high and getting drunk. This is my story to tell. It is a story about how I used to live, and a story of how I came to live in a more socially relevant way.

Just a taste

In 1997, I was living in the high-density suburb of Chitungwiza with my dad. My mother and my two younger brothers spent most of the time at our rural home in Mutoko⁴. I was 15 years old and completing form two at Seke 5 High School at the time.

Excelling academically was my thing. Books were my friends and I regularly received prizes. At prize-giving ceremonies, my parents were the proud parents ululating in the audience. It was my goal to make my parents proud.

⁴ Mutoko is a rural area in Zimbabwe located 149km to the east of the capital Harare

My dad was a soldier, who smoked cigarettes and mbanje. At the time, my mom seemed to be oblivious to the fact that he smoked mbanje. When I realised what my dad was doing, I thought that I was too smart to make the same mistake. I told myself that I would never do that. I wanted to stay clean. When I saw others doing drugs, I vowed to myself that I would rather eat bugs than do the same.

Believing that he was hiding something from me, I had taken to searching my dad's room when he was not at home. When I first discovered his stash of mbanje, I thought to myself: he is destroying his life; I will never do that to myself. Although I was firmly against drugs, I was also curious. I needed to know why other people found them so attractive.

One day, I was walking home from school with some guys who had been smoking mbanje. They seemed to be enjoying themselves, but I refused to try it because of my firm anti-drugs stance. When I got home, however, I decided to dip into my dad's stash. I just wanted to have a taste. Just to see how it felt. I wanted to understand what made it so appealing to everyone else. I found one 'stub⁵' in the drawer of the headboard. I lit it and took two puffs. Mission accomplished. I returned the stub to the drawer.

Suddenly, I was full of energy. I felt happy for no reason. I felt cleverer. I couldn't really explain what I was feeling. I was worried that my dad was going to realise what I had done, so I avoided him by going to bed early. I lay wide awake in bed, feeling funny. From that night onwards, my dad's late night returns became a thing to look forward to as I continued my 'tasting'. I was starting to enjoy it.

The search for peers and opportunities

After a reasonable period of 'tasting', I approached some guys from the 'hood who I knew did drugs. They told me that they had been waiting for me, as I was one of the few 'girl-like' boys who had not joined the trade for the 'wise boys' in the hood. To my surprise, they had some mbanje with them at school and so we smoked some on the way home. We hid in the bush near the school fence because we couldn't afford to get caught.

The new company I kept meant that I no longer needed to use my dad's stuff. I played it safe, making sure that my school work came first. I was bright, so I managed to get away with it. My dad didn't notice what I was up too – either he was too busy or he didn't expect it.

⁵ Mbanje rolled on khaki paper ready for smoking

The big mistake

One day, the leader of our group and our chief source of mbanje was not around. Hoping to please the guys, I offered to supply the mbanje that day. I went home and retrieved a sizeable amount from my dad's stash. Not surprisingly, my dad noticed that evening that his mbanje had been stolen. As punishment, I received a heavy beating. I was angry with myself for being so stupid, and angry at my dad for punishing me for smoking mbanje when he smoked it too.

Following that incident, my dad started watching me closely. He knew that I was doing something with mbanje, but he wasn't sure if I was smoking it or selling it. My mom was unaware of what was happening, and neither of us could say anything to her because we were both guilty. I decided to carry on, even though my dad was trying to stop me. After all, I was enjoying it. I wanted to be a man. I wanted to belong to the group of friends that I had joined. All the other boys were doing it.

Higher level...

I was too engaged to notice that my involvement with mbanje and cigarettes had gone beyond just 'tasting'. I stopped seeing the wrong in it, and it became natural to me. I did not question my increasing engagement with mbanje. By the time I had completed my O-Levels, I was drinking alcohol too.

During the school holidays, I spent most of my time drinking and doing drugs. My friends from school failed their exams, but we were still a team. We used all possible means to gain access to our stuff, including stealing from our own homes. As a result of the theft, I became my dad's worst enemy. By this point, my mom and other relatives were aware of my mbanje use and mischievous behaviour. Their attempts to discipline me had failed. I had found meaning in deviance.

The teaching post... no problem

In 2002, the family was preoccupied with trying to help me. By this stage, my dad had given up on me, so my mom carried most of the worry. My mom worried about me constantly, but I didn't care. My mom blamed my dad for using mbanje and failing to raise a son, and my dad responded with violence.

My mother's brother, Themba, was influential and well-connected. He had a political post in the ministry of education, sport, and culture. My mom approached Themba and asked him to find me something to do. She believed that I was misbehaving because I was idle and unemployed. At my mom's request, Uncle Themba visited our home and promised to help me find a job if I were willing to change. I was not worried about making such a promise. I'll cross that bridge when I get there, I told myself.

Uncle Themba managed to get me a temporary teaching post at a local secondary school in our suburb. My job was to teach history and Shona to the form two class. Accommodation was provided for teachers at the school, so I moved away from home. The work took me away from my home, my friends, and my idleness, but it did not change my drugging habits.

Initially I struggled with the changes, but this was soon offset by the promise of dependable paydays. When the first payday came, I spent most of my salary on cigarettes, drugs and alcohol. The new financial freedom meant that I no longer had a problem accessing drugs.

Still going higher...

By this stage, the Zimbabwean economy was collapsing. Financial stress plagued everybody, and I dealt with this stress by engaging further in the abuse of mbanje and alcohol. I decided that spending my money on drugs to alleviate my stress was better than trying to save money or spend it on other things. With the rising inflation, saving money became almost impossible. I decided to enjoy each day as it came. I didn't know how the other teachers – especially those with children – were surviving. The salary just covered my alcohol and mbanje expenses. The drugs brought me relief and enjoyment and allowed me to forget.

One night, I began to realise that I might be addicted. Having drunk too much, I spent the whole night vomiting. But, even as I was throwing up, I regretted the waste of beer and craved more.

During the three years that I was a teacher at the secondary school, I was drunk almost every day. I fitted in to the school well because some of the other teachers also smoked and drank. Mr Sibanda, the school head, was the worst of the lot – he was often absent from work and always drunk, so we didn't have to fear the boss.

The first blow

I only acknowledged the positives of my drug usage – the elation, the relaxation and the confidence it gave me. My negative behaviour – going to work drunk, being late, being absent, not doing work efficiently, and being anti-social – went unpunished and so I gave those who mentioned it little credit.

In 2005, the spotlight was suddenly turned on Dema Secondary School. That year, the school produced its worst O-Level results to date. The parents were furious and the authorities launched an investigation. Reports of our unprofessional behaviour emerged during the probe. All temporary teachers were fired and permanent staff members who were implicated in the scandal were suspended, without pay, for a year.

All the papers carried the story and, for the first time, I was ashamed of my behaviour. But I wasn't ashamed enough to consider changing my behaviour. I returned home and discovered that, without a salary, it was far more difficult to fund my drinking and drugging.

Lucky again...

Having discovered how difficult it was to fund my drinking and mbanje habits without a job, I decided that I needed to win over influential Uncle Themba. When I was around him, I always behaved well in the hopes that he would find me another job. In 2007, in a very corrupt Zimbabwe, Uncle Themba managed to get me a job as a deport monitor for the Grain Marketing Board of Zimbabwe.

I was not qualified for the job and it was not the sort of job where you could acquire on-the-job training. Nevertheless, I was given the job and my supervisor was supposed to train me. Because of the manner in which I was hired, the supervisor did not like me and he did not bother to hide his dislike.

Second blow...

Financially independent once more, I was free to indulge my drinking and drugging habits as I pleased. I also started hooking up with prostitutes when I was drunk at a bar or a club. I cared little for the job – I arrived at work late and drunk; I was often absent; I was anti-social; and often failed to do my work properly. But this time, my behaviour did not go unpunished. The supervisor was a no-nonsense sort of guy. Reasons why I should be fired piled up

quickly and soon even Uncle Themba, with all his influence, could do nothing to stop me from being fired.

Following verbal and written warnings, I was fired on 28 July 2008. I didn't take the warnings seriously – how could I when I was almost always drunk? I didn't just lose a job, I also lost the support of Uncle Themba, who decided that it was time for me to learn the 'hard way'.

This latest knock didn't force me to stop and reflect on my actions. Instead, I responded to new stressors with more drugging and prostitutes. I laid the blame on the managerial staff at the Grain Marketing Board of Zimbabwe, not on the drugs I was abusing.

No turning back...

I returned home to live with my mom. My dad, who had battled with tuberculosis (TB), passed away the year before. My mom allowed me to live in one of the rooms, but she was forced to rent out the rest to make ends meet. By this point, the economy had been dollarized⁶ and inflation had begun to stabilize. The opportunity to find money in crooked ways had passed, and this stressed me out.

Another stressor appeared in my life a month after I was fired. Nancy, one of the girls with whom I had had frequent sexual contact, told me that she was pregnant and came to live with me. I was suddenly expected to provide for two people. I tried to get rid of Nancy, but she had made up her mind to stay.

I did odd jobs to get money for beer and mbanje – I resorted to cheap opaque beer and illegal concentrated drinks. Nancy also did piecemeal jobs, for food for both of us. I used to hit her when I got drunk. I did everything I could to try and make her leave, but she stayed. I used to hear her crying to God for help. My mom, on the other hand, was no longer on my side. Whenever she saw me fighting with Nancy – or got to hear about it – she scolded me.

One night, my mom tried to intervene while I was hitting Nancy. I accidentally pushed her and she fell. My younger brother Shaky, who witnessed this, reported me to the police. I was locked up for days for domestic violence. Nancy, who was listed as the complainant, asked the police to drop the charges and set me free.

⁶ Use of the American dollar replacing the Zimbabwean dollar when the country adopted a multi-currency system.

The police made me promise not to hit Nancy again, but I was at it again within a matter of days. I was also arrested for public drinking and violence. I was finally beginning to realise that all the negatives in my life might be connected to the things I did, but every time the thoughts surfaced, I blocked them out with more mbanje and alcohol.

I began to neglect personal hygiene, but I didn't notice. Many people started to accuse me of neglecting my family, and I was increasingly socially rejected. It was during this period that my son was born. I named him after my late father, Alois. I loved him so much, but I still hated his mother. I felt that she had forced herself on me. Although I loved my son, I had no time for him.

The third (and last) blow... chisingaperi chinoshura [all things can come to an end].

Numerous knocks – job losses, marital problems, brushes with the law - had failed to have an impact on my substance abuse problem. However, when I was plagued by health problems, I eventually began to realise that my drugging way of life might be the problem. In February 2009, I was diagnosed with TB and substance-induced psychosis.

I rapidly became ill. I was coughing all the time and in a lot of pain. Because of my past sexual behaviour, I was worried that it was HIV-related, so I refused to go to the hospital. Over-the-counter medications had little effect, and, although I was coughing a lot, I continued to smoke because the cravings were too great.

Once I started hallucinating and became violent, my mom, Shaky, Nancy and Uncle Themba managed to restrain me in order to take me to hospital. At the Chitungwiza health centre, I was given a new and frightening label. I was told that I had TB and that I had developed a psychosis. I found it difficult to accept the diagnosis. I was a problem patient who refused treatment. I was bitter, confused, and full of regrets.

My cousin, who had experienced psychotic episodes, had told me about CPZ⁷. I refused to take it, but was eventually forced to do so when the doctor ordered that I be restrained and given the drug via injection. Once I was on the medication, I began to stabilize and slowly started to come to terms with what was happening. The doctor made it clear that I was my own worst enemy and that I needed to stop drinking and smoking. I was treated in isolation for the first two weeks, and was discharged after the third week. I was given tablets to take at

⁷ Chlorpromazine: an anti-psychotic drug commonly used in Zimbabwe

home and was told to return for a review. All I could see, as we left the hospital, was my crumbling world. *Ndanga ndatofa shuwa* [I nearly died], I said to myself.

Easier said than done

Quitting is easier said than done. I tried, but I could not do it. I stopped drinking alcohol relatively easily because I didn't have the money to buy any, but cigarettes and mbanje were giving me a harder time. People were more generous with cigarettes and mbanje, and my body kept telling me that it couldn't do without them. I endured the coughing and the sharp pains in my chest, but I could not resist the cravings.

The helper...

My salvation came in the form of Brother Andrew, a guy from my wife's church. Andrew, who had been in successful recovery for 10 years when we met, started paying me visits and sharing stories from his life with me. He was clever and his words were wise. I took him seriously because instead of just blaming me, he expressed concern.

One day we had an illuminating conversation.

"Willingness is the key to where I am today," said Andrew. "Are you willing to quit and change for the good?"

"Yes, I am," I responded.

"That [willingness] you should never lose. Take it gradually, through the ups and downs. Remain willing."

Willingness becomes the key

Willingness became the key to everything. I finally committed to the journey of recovery. Willingness anchored my gradual weaning journey, which was marred by minor and major relapses. Having experienced sustained sobriety since August 2010, I continue to practice willingness – I am willing to change for the better regardless of what I am facing. I am moving closer, every day, to being 'dry' and doing well. The journey is made easier by those who support me, especially Nancy, who was there for me even when I didn't want her in my life.

One change, many changes.

The journey to sobriety has not always been easy. For a while I was idle because I was scared of making the wrong choices. I struggled to provide for my family, and I found it difficult to defend my sobriety when challenged by old friends. I wanted people to see that I was changing, but without work, I would wake up and spend the day at home. I was dependent on other people for hand-outs, and was teased by my friends because of this. But through it all, I didn't lose the willingness to change for the better.

Now that I am on the other side, I can see that I never used cigarettes, mbanje or alcohol, I abused them. My health is recovering and I am awakening to a life free of substance abuse. It is time for me to attempt to correct the wrongs of the past, and to prove that things have changed and are changing. My time and energy is now naturally being put to better use. With the one big change, come many others. If I am to sustain my journey of recovery, I need to make many changes. In order to construct a new life in which recovery is possible, it is necessary for me to change choices, goals, roles and expectations. I need to author a new chapter in my life.

Proudly Mr Farmer...

I decided that as long as people were feeling sorry for me in any way, my recovery would not be successful. I realised that I needed to find work that puts food on the table and restores my sense of self-worth. Given the economic situation in the country – and the high rate of unemployment – finding formal employment with no tertiary qualifications was almost impossible. After a friend introduced me to the idea of peri-urban farming, I decided that it was an occupation I could take on. At least, as a farmer, I would be able to provide food for my family.

I am now Mr Farmer. My wife and I toil the land together. We are managing to sell a bit of our produce – not much, but it is working for now. Unlike in the past, what I earn is for my family. Farming can be physically demanding, but I think it is improving my health, which was compromised by the TB.

I also help my wife with tasks at home – for love, everything that speaks to change, I am doing. I am even prepared to wash the dishes. I spend a lot of time playing with my son Alois. Occasionally, I play social soccer with friends, and I enjoy reading novels during my spare time.

Feeding my soul

Soon after Brother Andrew started visiting me, I went along with Nancy to her church. I had never been a believer, so when Andrew told me I needed God above all else, I didn't take him very seriously. But, as my life started to take shape and I began to feel useful as a farmer, I realise that my life was missing a spiritual dimension.

I go to the Apostolic Church with my wife, and although I am not a full-time member, I enjoy every moment of it. Associating with the church has helped me to stay 'dry', because the church demonises drug use. If you want to be a part of the church, you need to adhere to the lifestyle it prescribes, which includes no drugs and working for God in all things. At times, Nancy and I read the Bible together, especially before praying and going to bed. I have found that it is very satisfying to do things together with Nancy, as a team.

What's next?

I have chosen to set goals towards furthering my education. I would like to train as a teacher so that one day I might be permanently employed in this stabilising economy. I have what it takes and I am willing to give it my all to train and become an employable teacher, a husband, and a father.

The daily newspapers have become my friends in my search for new opportunities. When I read the paper, I look for jobs and adverts for professional courses. I am making efforts to reconnect with my Uncle Themba – perhaps he can help me once more. I would like to train as a teacher, but if that is not possible, I would also be interested in receiving guidance to farm on a larger scale.

I know that tomorrow is made from today. I will continue to work towards staying sober and giving others the same hand that I received from Brother Andrew. I make the time to socialise with other youths so that I can tell them my story. Sometimes, those in need of help are referred to me, which is so encouraging. I have a mission to prove to all that it is possible and that recovery is a journey that I have embarked on, not a destination.

I aspire to help those who are still buried in mbanje, alcohol, cigarettes and other drugs. I hope to help them to resurrect their lives. I want others to draw positive learning from my life in recovery, and I urge those who have not experimented with drugs to stay away from them

because, for me, the curiosity to 'taste' set me on a difficult journey. Above all, I believe that it will always be easier to stay off mbanje, alcohol and cigarettes than it was to get off them.

4.3.2. Chitsva`s story: Revived foundation

I work as a primary school teacher, teaching the grade five class at Karoi Primary School. I am new, once more, to the world of doing to develop my life. I am actively using my qualifications as a revived foundation to better myself and others. Those who know me know of a teacher who makes a difference. I am careful, for I know what it takes to destroy one`s future with what was intended for betterment or development. I am a former substance abuser, but I am recovering and proud of myself. I don`t just teach the grade five pupils; I teach life to many.

‘I own my past’

I was not born with it. People did not ululate when I was born, to welcome a substance abuser. *Mazvokuda mavanga enyora* [It`s self-inflicted]. Sure, others played a role, encouraged me – “one pull, just one, feel the aesthetic satisfaction”. Others who have felt peer pressure would like to believe the same, but what would peer pressure say to a bold ‘NO!’? I own my past. I, and only I, could have closed the very door I opened to enter the realm of substance abuse. I take full responsibility. Engaging in substance abuse was the least salubrious thing I have ever done.

Paul, John and Kuda were not aliens; they were just teenagers, like me. To me, they were caring high school friends – no ‘substance abuser’ tags hung from their faces. When these friends invited me to try cigarettes and mbanje⁸, I couldn`t say no.

In 1997, we were in form two at Oriel High School. Towards the end of the year, the Zimbabwe Junior Certificate (ZJC) exams, which we were scheduled to write, were postponed after it emerged that the exam papers had been leaked at some school in the rural areas. We were idle and the teachers instructed us to spend the time studying or playing in the grounds. When instructed to play, soccer was the first port of call. I wasn`t good at soccer and, as no one would pick me for their team, I was forced to watch the others play most of the time.

I was not the only one who had two left feet – Paul, John and Kuda were all lacking markedly in this area. We would hang out together most of the time. My pals would sneak away to

⁸ Mbanje is the Shona name for cannabis also known as marijuana which is an illegal psychoactive drug in Zimbabwe consumed for its effects including euphoria, relaxation, increased appetite etc. (en.wikipedia.org/wiki/mbanje)

smoke cigarettes and mbanje and, at first, I managed to say no, although I felt left out. The need to belong called to me.

One lazy afternoon during that term extension, Paul, who could see that I felt left out as the guys were getting ready to go for a ‘*refresher*,’ said: “You can just come with us.”

“I will come,” I responded, “but not for the smoking”

We went to the gum tree plantation behind the boys’ hostel. There, they took turns to smoke, and I could see they were enjoying it. But I could not understand how smoking could be that enjoyable. Finally, I got the offer.

“Just try one pull,” John offered.

“No, no, no.”

You are not a man, they responded laughingly. I was pained, so I decided to give it a try. One pull and I was off coughing. They laughed some more. I needed the friendship. I needed to be a man. So I tried harder and, in doing so, trotted into substance abuse.

Schooling, company and drugs

When you do what you do with others, there is always comfort. It’s a boys’ group thing. We became the Rastaz at school. First I tried cigarettes, then mbanje. The school rules were tight, but we knew the loopholes. In 1998, after the popular “*penga udzoke*⁹” ZJC holiday, I was into smoking mbanje, but it was not an everyday thing. At this point, I could still hide my habit from my family because I didn’t do it at home. I knew how to cover up and be compliant by doing the house duties assigned to me. As my marks slipped, I was sent for extra lessons. I started spending more time with friends, which meant more time for cigarettes and mbanje. Had my mom known about my behaviour then, things might have turned out differently, but I managed to hide it from her.

My O-Level results in February 2000 – six low-grade passes with Maths and English - were a disappointment for my mom, but they met my expectations. I knew they could have been much worse. My mom, who was furious, punished me by making me a day scholar for my A-Level studies. Her so-called punishment was the freedom I had been longing for. My daily

⁹ A nickname for the school break students take after writing their Zimbabwe Junior Certificate exams.

commute to school allowed me to pass through town, where all the fun happened. My mom, who had to attend to work, could not be with me all the time.

We are the Rastaz!

I began to settle into the world of substance abuse – I had unlimited access to cigarettes and mbanje. Little by little my mom began to realise what was happening. She was concerned. It was almost as if I could hear her thinking: “My son should not be doing drugs!”

But I thought it was normal. We would share reports about our families and it would give us strength. After all, that is what friends are for. We would repeat the proverb: All work and no play makes Jack a dull boy. But none of us bothered to check the type of play, or whether there was any work involved.

We also knew that too much play and no work makes one a failure, but we didn’t give this much thought. When it came to exams, I still expected to reap where I had not sown. The exams were a disaster, a total disaster! Not a single pass. I had not worked for the passes, but I didn’t expect a failure of this magnitude. For the first time, I became worried.

As a result of my marks, my mom grounded me, but I paid her no heed. Only one of our friends had managed to pass, so we turned to more cigarettes, more mbanje, and alcohol.

Am I the problem? Surely not...

An overprotective single parent, my mom blamed the cigarettes, the alcohol and the mbanje. At the time, in the high-density suburb of Budiriro, this way of life was normal for unemployed, non-Christian guys of my age. It seemed normal, but now I see: kuti ndakadyara mukusaziva [I acted in ignorance].

I did nothing for the whole of 2002. It was difficult to find a job with just O-Levels. Besides, I wasn’t actively looking for a job. Paul, Kuda and I just stayed at home. We were still the Rastaz.

Because she was concerned, my mom was always fighting with me, but I couldn’t see why she was making so much noise. One night, when I came home very late and drunk, she told me that I was a problem and that I would suffer because of this. I walked out and promised never to return. Mom, who felt guilty because I am her only child, gave me mild warnings and asked me to come back. Making threats when I was confronted worked well for me.

At times I wondered about all the misunderstandings. Was I the problem or did the problem lie elsewhere? I was both confident and confused. As I went further and further into substance abuse, I continued to blame my mom for not finding something for me to do.

Giving it all for my drugs

Verbal fights between me and my mom became a regular thing. I began to steal and sell small items from our home – empty bottles and clothes not worn regularly – when it was my turn to fund our supply of mbanje and alcohol. My Aunt Rudo, my mother's sister who lived in the United Kingdom, loved me dearly and would often send me clothes. My mom, who was beginning to get fed up with me, began to lock away stuff that she thought I might steal.

One Saturday, when we were really dry [broke] and it was impossible for any of us to snatch something from home, we approached our mbanje supplier, Ras Midza, and asked him if he could give us some mbanje and if we could pay him back later. Instead, Ras Midza offered to pay us five stabs if we cleaned his yard. That became our routine. Whenever we didn't have cash, we would sweat a little in return for mbanje.

Can still do...

Aunt Rudo visited us during the Christmas holidays at the end of 2002. My mom gave her a report on my behaviour and I was called to answer for my actions. I was defensive, but respectful. Aunt Rudo is the kind of person you can't afford to disrespect. I blamed my mom for not finding me something to do. Aunt Rudo listened and convinced my mom to find me something to study.

I looked for something that I thought might be interesting and settled on a diploma in information system studies. My mom completed the applications for me, and in March 2003, I became a student at a polytechnic college in Harare.

College life presented the type of life we dreamed of when we were Rastaz in high school – Whatever! Whenever! However! There was the freedom to do and be as you pleased. My roommate in the residence was a first-year computer science student called Tinashe. He was well looked after financially and was more spoilt than me.

Tinashe, who was very bright, convinced me that mbanje could enhance academic performance. I didn't want to disappoint Aunt Rudo, so I managed to strike a balance between mbanje, alcohol and studies. Although Tinashe and I got along well, I noticed that,

because of my lack of funds, I had limited decision-making power in the friendship. At times, especially after disagreements, it became clear that Tinashe's money was his, not mine.

The realisation that without funds you are not at liberty to do as you please prompted me to work on my goal of pleasing Aunt Rudo. Or, rather, the combination of a lack of funds and a desire to please Aunt Rudo resulted in me focusing on my studies and reducing the frequency with which I used mbanje. In 2004, I graduated with a national diploma in Information Systems.

“Educated, unemployed and frustrated”

At this point, however, the economic and political situation in Zimbabwe was tough, and the country was riddled with corruption. You couldn't simply apply and get a job. Everyone demanded bribes. The corruption meant that even the uneducated could be employed in posts for the educated if they had the correct family connections.

I returned to Budiro educated, unemployed and frustrated. I felt that I had been conned – the previous two years were just a waste of time! I wasn't afforded the status that I thought I was due. This sense of having been conned was exacerbated by the fact that I returned to find Kuda in a far better position. Kuda's sister had left Zimbabwe to work in the UK and was sending money home. Because their parents were aging, Kuda was administering the account. He had money and all that he wanted. Paul, Kuda and I were still friends. The money had revived our friendship – we were Rastaz once more, but with cash in tough times. We ruled the 'hood.

Kuda's sister sent him a car and suddenly we were resourced Rastaz. Clubbing and drugging were the order of the day. Nothing could stop us. We became wilder by the day, but we thought of it as normal life. We saw those who considered our behaviour abnormal as the problem. They were the problem, not us. Everything was fun and enjoyable. We were too wild to be corrected. I didn't have time for anything that was not linked to drugging.

Violent drama

Late in 2006, I began to get headaches. It wasn't too serious. I felt it most once I got sober after smoking mbanje. It bothered me, but I acted as if everything was fine, especially when I was with my buddies. The headache seemed to subside when I was high, so staying high became the norm.

I was not getting along with my mom and other close relatives. As the misunderstandings worsened, so did my drugging. I opted to avoid confrontations. People would attempt to knock sense into me when I was sober, so my solution was to always be drunk. This approach helped me avoid people and manage my headaches, but without realising it, I was burying myself in drugs.

During this time of escalated drugging, I became involved in violent drama at home. Following a drugging spree, I arrived home late and drunk, aggressively shouting obscenities. The following morning, my mom locked me in my room for what she called “abnormal behaviour”. In response to this, I broke down the door and became embroiled in a fist fight with my mom. I refused to be restrained and, as I was protesting, damaged property. Finally, some men from the neighbourhood came to my mom’s rescue. They managed to restrain me, poured cold water over me, and locked me up. Eventually I calmed down and fell asleep. Hours later, I woke up and asked what had happened.

When the news of my violent outburst reached Aunt Rudo, the commanding ‘iron lady’ ordered that I go and see a psychologist. I was forced to go to Mandel Training Centre for counselling. I hardly listened to the psychologist and didn’t consider his suggested changes. Losing Paul and Kuda for what... sobriety? In response to the psychologist’s prescription, I replied: No, I’m not ready!

I saw no reason to quit. In my mind there was nothing wrong, despite all the so-called abnormal behaviours. I thought that I would rather die than quit joy and freedom. I had taken on mbanje, alcohol and my buddies to be my life. At this point, my drugs and my buddies were all that constituted a meaningful life to me. I was identified by that.

Despite my decision to avoid change, the headaches and violent outbursts continued. These symptoms were happening only to me, not to Paul or Kuda. Although we were doing everything together, only I was the victim of headaches and bizarre behaviour. While you can resist men, you can’t resist that which nature does to you. I kept wondering: what’s happening to me?

The mental breakdown

Towards the end of 2006, we were smoking Hashish¹⁰. I got confused every time we smoked it and the guys made fun of me. In an effort to defend my manhood, I tried harder, but it just got worse. I took too much and my system couldn't cope. I had a pretty major mental thing: I neglected myself; I was dirty; I heard voices; I was shouting at people; I was physically violent; I was aggressive without provocation; and I was seeing things that others could not see. This time around, restraining me and pouring cold water over me did not work. Against my will, and with the help of the police, I was admitted to a psychiatric hospital in Harare. Diagnosed with substance-induced psychosis, I stayed in the hospital for about three weeks.

The first week in the hospital was the most difficult. I was still psychotic and I refused to take medication, so I spent the time in and out of seclusion cells. The security guards were very tough on me after my attempt to abscond. I was medicated and made to see the psychologist and occupational therapist. These professionals, together with the psychiatrists and the nurses, helped me to gain insight and become compliant with regards to my medication. During my first week in hospital, my mom, who was angry with me, did not visit. By the second week, however, she visited me every afternoon, at times with other relatives. I improved markedly and, by the end of the three weeks, I was a candidate for discharge.

After being discharged, I managed to stay sober for about three weeks. I had been given tablets to take, but after the first review, I decided to stop taking the pills because they were not pleasant. I felt like a zombie – falling asleep, salivating and eating too much. Even Paul and Kuda advised me to stop taking the pills. My mom and Aunt Rudo were hurt, but I thought I had no option because I saw the pills as doing me more harm than good.

I felt better after I started consuming alcohol and a bit of mbanje, but my carers were beginning to give up on me. In March 2007, I had a relapse and was re-admitted to hospital. This time, I saw that my life was headed towards destruction. During my second stint in hospital, no one visited from home. I was not a difficult patient, but the hospital staff had no kind words for me. They said that they didn't have time to waste on people like me – people who destroyed their own lives.

I stopped to reflect, and saw the life of a mentally ill person – a vicious cycle marred by relapses. This frightened me and the thought of change became more necessary and

¹⁰ A concentrated resin cake or ball of cannabis produced from pressed cannabis flowers and leaves

meaningful. I kept thinking: I don't want to be like those other mental cases I have seen in the 'hood.

Giving it (sobriety) a try...

After being discharged for the second time, I decided to do things differently. I realised that nothing would change if I did not change. I realised that change was needed if I were to avoid the disaster I saw coming. The hospital staff made me see this. The stance my mom and relatives took made me open my eyes. I realised that I was destroying my life, and that my life was different to that of my friends and that we didn't need to do everything the same way. I kept thinking: I am becoming a mental case, and it's not a good thing! I am a laughing stock.

It is not easy to say no and actually mean no. I said it for the first time when Kuda brought me some mbanje, thinking that he was doing me a favour. I told him mbanje was not good for me. It was the most difficult time of my life. I had to decide not to do what I wanted to do because of something over which I had no control – my health. My failed life manifested as health problems and this told me that change was needed. At times I took sips of alcohol when the cravings became too strong, but then refrained after thinking about the worst possible happenings. By January 2008, with continued self-reflection, medical and family support, I was finally dry and taking my medication.

Learning to use my strengths

I remained an out-patient at Annexe Hospital, where I was reviewed on a monthly basis. I continued to see the need for change and actually implemented the changes. In addition to this, I saw an occupational therapist twice a week. The occupational therapists taught me to let go of regret – I was filled with regret and self-blame – and to use my strengths instead. They emphasised the importance of having a positive motive, fulfilling my roles and what is expected of me, taking care of myself, and exploring ways in which I could use the education that I had.

In June 2008, the medical team referred me to Alcoholics Anonymous (AA). The message of AA was: admit you have a problem, surrender to God and He will help you. I didn't attend AA meetings frequently. Although the teachings are strong, AA is not that big in Zimbabwe. Instead, I went to church – not as a willing Christian, but to fulfil the lessons I was being taught. I told myself: I have failed to run my race, so I deserve and need help.

Gradually, I saw less and less of Paul and Kuda. At this point, I was seeing the OTs once a month and they assigned me tasks to do at home, such as looking for a job. Seeing myself as incapable, I didn't do any of these assignments, despite my mom's encouragement. I had become shy and had lost touch with the world. My life had lost its rhythm. I just stayed at home, lonely. I felt that I was no longer an interesting person.

A new play area

The church became my new play area; it was not as appealing or interesting as doing drugs with my friends. During this period I was confused, but did not lose hope for a better tomorrow. I experienced some mild side-effects, but they did not last for long after the doctor reduced my medication. I became a mom's boy – I did what she assigned me to do without fighting. I was not happy with the way things were, but I didn't know exactly what was needed to bring about change. The OTs tried to help, but I was too lazy to follow their suggestions. I guess it would have been easier if we had practised their suggestions together with them – the tasks, such as 'go find a job', were easier said than done.

Discontented, I turned to God for help. I knew that something needed to be done, but I didn't know what exactly that was. I prayed to God, saying: God, please help me. I have regretted enough and I want to be somebody. As a result of this, I increased my participation in church activities. I began to volunteer for tasks that needed to be done, and as I did those tasks well, the leaders began to assign more tasks to me. As most of the tasks were ones that could be done alone, making new friends remained a challenge. I had become reserved and had lost trust in other people.

Back as new...

The gainful-employment dry spell continued into 2011. I wasn't doing anything productive or meaningful – just house duties that my mom assigned to me. House chores were the order of the day. I was woken up in the morning to sweep and tidy the house while my mom prepared for work. I prepared my breakfast, my lunch, and then supper for two around five. In between meals, I did the tasks assigned to me by my mom.

During the Christmas holidays, our family received long-distance visitors. That year, my cousin Jane, a teacher at All Souls Mission, visited us. I was unable to hide my discontent at having nothing meaningful or productive to do, and Jane, who noticed this, asked how I was

spending my time. When I replied that I wasn't doing much, she asked if I would like a teaching job.

Jane referred me to the Karoi District Education Offices. They were looking for teachers with post A-Level qualifications, and, with my Information Systems diploma, I was what they were looking for. My mom, who began for the first time to say something positive about me, joined Jane in encouraging me to see my strengths rather than my weaknesses. My mom was doing exactly what the therapists had taught her. I, too, was practising the skills I had learnt in occupational therapy: writing resumes, preparing for an interview, simulating work skills, social skills and many more. I saw an occupational therapist and my psychologist to discuss this work opportunity and that helped boost my confidence. For the remainder of the holiday, I practised the skills necessary to be a teacher. I could even see a teacher in myself. I was confident that something great lay ahead of me, but I still worried that traces of my mental thing would show and that this would disadvantage me. The support that I received from all corners surprised me. One of the questions that I asked myself was: Have I changed enough to deserve this?

Better positioned to be useful

After the holidays, I visited the Karoi Education Offices with my papers. The district education officer turned out to be a former lecturer at the college where I studied, and he recognised me. When he mentioned some of my positive attributes, it boosted my hopes for formal employment. I was asked to leave my papers and to return in two weeks for an interview.

I returned home, very excited. I thought to myself: At last I might be occupied productively and will be better positioned to be useful. Everyone at home was happy and encouraging. You have made it, they told me, always thank God for this. Two weeks later I returned to the education offices for my interview. After the interview, I was told that I was exactly what they were looking for and that I should start work immediately.

Ever since then I have been working as a teacher at Karoi Primary School. When I received my first salary, after three months, I bought myself a few items and spent the rest of the money honouring the heroes in my life. I bought them thank-you presents, starting with my mom.

I still consult others about how to proceed with certain areas in my life. It is easy to do so, as I have managed to share the story of recovery from substance abuse with workmates and even my pupils, some of whom regard me as a hero. This teaching job continues to affirm my successful recovery journey, and I am actively working to make sure I always do my best.

Not just doing for the sake of doing

Today I am a happy man. I thank God because he must have worked hard behind the scenes. Today I can boast of having travelled all the way to where I am now. I am dry, compliant, and doing well. I am no longer a problematic, dependent son. I do not feel guilty about my past because I believe I cannot change my past. I hope to continue doing well. I do not see any reason why I would revert to doing drugs. If I do, *ndinenge ndaita imbwa chaiyo, kudya marutsi ayo* [I would be like a dog going back to eat its own vomit].

I am not just doing for the sake of doing. Now, I pause to see the whole picture of what I am doing or am about to do. How does it affect my health? How does it affect others around me? I am a bit overly conscious and others may say that I think too much, but I know that it is helping me sustain my journey in recovery.

I think that the change has happened from within. For it to become meaningful, the lessons I was taught had to be put into practice in real life. Doing that which is acknowledged by others as right, and doing that which has a positive effect on my life, particularly my health, just cements the change. I grab every opportunity that I get to show my changed life. I use every opportunity to do the right thing in the right way, where I used to do wrong. As a result of this type of doing, I see the same change in others, especially my friends. I am prepared to help because I am a product of other people's hands. I appreciate that one needs the support of others to make the recovery journey a success.

To the world, and Harare in particular, I say: Society is rapidly turning for the worse, but at whatever stage one is in drugs, there is hope of reviving the foundation for the better. Just try doing it differently. It's not easy, but it can be done. It has always been easier to stay off drugs than it was to get off drugs.

4.3.3. Fred's story: In search of 'real' life

They call me Pastor. At times I look around to see if they are referring to me. I cannot believe I have changed this much. My old friends – drunkards in the community - are all proud of me and what I am doing. I continue to associate with them, but now I aim to make them see the need to quit a drugging life. I am a Pastor. All the past has gone, and I work in the present and for the future.

As a teenager, I was too clever, very experimental, and still vulnerable. At the time, Salisbury – now Harare – was not a nice place to raise a child. In the high-density suburbs, where the young behaved like the old, Shona cultural practices were being lost. Telling you my story will be a mammoth task. *Zvimwe zvinotoda kuzvionera pamhuno sefodya* [Only seeing would make you believe.] Nevertheless, let me try.

Being 'smart' about it

In the late 1970s, the liberation war forced my parents to move away from the rural areas to Harare. The high-density suburb of Glen Norah became our new home, and one of my uncles, Samson, lived with us. At the time, I was eleven, and the much older Uncle Sam and his friend Shepherd seemed so smart. They seemed to be enjoying life. Young and ignorant, I saw the right in the wrong they did, and I admired parts of their lives, not realising that it was a package deal.

Uncle Sam and his buddy Shepherd were so friendly. I admired them and they accommodated me. After spending some time with them, I realised that my heroes often used mbanje and alcohol. This led to a period of shilly-shallying. I kept asking myself: Is this what makes them 'smart'? And do I still want to be like them?

However, the period of indecision was short-lived. Soon I began to admire everything that they were doing. My admiration was so strong that I could not see the real wrong in what they were doing.

Every time I saw them smoking and drinking, I would ask: "What is it like?"

"It's great as long as you are smart about it," they would reply.

I longed to feel the greatness in a 'smart' way as my heroes did, but dared not say so out loud. They noticed my interest and offered to let me try it out. I never thought that the offer would come from Uncle Sam, who was supposed to be protective of me, and I couldn't resist the

opportunity to feel such greatness. I started with alcohol and mbanje because that is what my heroes were using.

The House of Freedom

Uncle Sam looked very humble, but his looks were deceptive. No one in the family suspected he was doing drugs, let alone leading me astray. My mum and dad trusted him to be my role model, but they didn't know him very well.

It is easier to travel a path that others are already travelling, and because it was unexpected, my parents did not quickly pick up on my new habits. Shepherd had a job and rented a place – the 'House of Freedom', I called it. Alcohol and mbanje were always readily available at the House of Freedom. I didn't know how the alcohol and mbanje were being acquired, but that was not my baby to carry.

Still a family mystery...

I failed to remain 'smart'. I could not hide some behaviours after smoking mbanje. My dad started to complain about how argumentative I had become. My schooling was not a priority for me and my grades started slipping. My mom would defend me, so I tried to avoid clashes with her.

My family could not understand what was causing the change. My young age acted as a cover. I was just eleven. No one expected someone my age to be taking drugs.

Some days I would go home high on mbanje, and I would just laugh at everything. On such a day, when I was served supper, I started laughing at my Sadza¹¹. My mom asked me why I was laughing like an ill-mannered person, but I did not reply. I continued laughing.

I thought that my mom must have been thinking along the lines of drug abuse, but that she chose to brush it aside because she could not believe such a thing of her beloved son. The family was engulfed by a period of wondering, but my parents chose not to dig any deeper to uncover the mystery. After all, they had agreed to let my Uncle Sam take care of me.

¹¹ A starch meal prepared from Zimbabwe's staple food; maize

Still a school boy

My parents expected me to do well in school. I went to school, but I did not take it seriously. Because I spent so much time hanging out with Uncle Sam and Shepherd, I started finding it difficult to associate with my peers at school. I started to feel as if I did not belong, and my school performance suffered.

As my results worsened, I began to hate school more and more. My heroes said nothing about my schooling. They didn't encourage me; they didn't discourage me. They just supported whatever I wanted. At school I tried to find suitable company: I tried to influence others to join me, but, at the same time, was afraid that they would report me to the authorities.

Going deeper...

In 1983 I was in form two at Glen Norah High School. I was no longer a normal student: half my mind was on schooling, the other half on drugs. As my life at home became more complicated, I became more involved with drugs. Drugs served as a way out of the confusion.

Once it became clear that I was using drugs, how I had come to use mbanje and alcohol at such a tender age became a topical issue. Those who knew about my role models told my father: "That uncle of his is your real enemy; he planted all of this in Fred."

By the end of the year, Uncle Sam was banished from our home and returned to the rural areas. However, Uncle Sam's departure was not the only disruption to family life. It was my dad's promiscuity that eventually catapulted me towards mbanje-and-alcohol-use as a way of life. He had girlfriends and eventually left us for his second wife.

One Friday, I arrived home from school to find him verbally abusing my mom, and then beating her up. This scene changed my life for the worse. I made it my goal to displease and punish my father and to prove to him that I didn't care what happened in his life anymore.

The bitterness over my father's abuse of my mom, his neglect, and his promiscuous behaviour prompted me to be rebellious. I was disappointed by my father's hypocrisy – before his promiscuous behaviour became known, he was an admired man in the neighbourhood. Even I desired to be like him and did things for his approval.

Aware that I took drugs, my dad was always trying to reprove me. I made the decision to do that which he didn't want, that which pained him. My father hated smoking and drinking so

much – he was only interested in women. I stopped hiding my alcohol and mbanje use because I wanted it to pain my father. In my efforts to punish my father, I went deeper into the realm of substance abuse.

Going deeper with company...

By the time I was in form three, I had two close friends my own age – Peter and Ngoni. After Uncle Sam left, I kept in touch with Shepherd, so I introduced my new friends to him. Our link to Shepherd meant that we had a steady supply of mbanje and alcohol. Shepherd, who was still working as well as selling mbanje in the ‘hood, gave me the ‘stuff’ for free as I would introduce him to new clients.

Amid our family crisis, any motivation to do well at school had been replaced by the desire for fascinating experiences promised by mbanje and alcohol. Because we had easy access to mbanje, Peter, Ngoni and I began smoking it every chance we got – in the morning, afternoon and evening. Within our friendship circle, we rarely disagreed on when, where or why to smoke or drink. It became a part of us. We were no longer planning; just doing. I was more experienced than my peers, so most of what we did was a result of my initiative.

Self Defence

We were not that likable. When we were drunk, we would start fights with others on our way to or from school. I attended school irregularly, and mom was called in to disciplinary hearings at my school often. Many people wanted to punish us for our truancy, and we wanted to fight back. So we started doing weight lifting. In the morning, on our way to school, we would smoke mbanje and then do weight lifting.

Peter was not interested in weight lifting. He found it painful, so he would watch us instead. The rest of us would do our thing in the bush near our ‘hood. We became muscular, animal-like, for self-defence. We were really like wild animals, living in the here-and-now, not worried about tomorrow. We thought life was just perfect.

People were afraid of us and what we were doing. With the much-needed muscle, we would fight when there was a need to fight. Even Peter relied on our muscle for cover when things got violent. During all of this, I could see the pain in my parents as they faced a reversal of expectations, but I didn’t care.

A lot is happening...

When I was supposed to be doing form four, I was defined by substance abuse: where I am, who I am with, why I am there, what I am doing, and how I am doing it. Mbanje and alcohol had assumed a central position in my life; substance abuse occupied all of my time and energy. Because of my preoccupation with substance abuse, I sacrificed my schooling. As a result of this, I failed my O-Levels. I only managed to get two passes – two C¹²'s in Shona and English.

Of the three of us, only Peter, who was bright, passed well. Peter progressed to advanced level schooling and no longer hung out with us as much. With school completely out of the picture, trivial things that go well with substance abuse began to occupy more of my time – weight lifting, playing social soccer, clubbing, writing music, dancing and dating. My goal was to date at least 100 women before I got married.

I saw nothing wrong with what I was doing and refused to take any correction. With the new activities, my social circle grew larger. Those who condemned my behaviour became problems in my life. I grew pissed off with those who asked me why I was doing what I was doing. My reply to them was: I am doing it because I am doing it.

Musical dream

After I failed my O-Levels, I began to entertain the idea of a career as a musician. Whenever I was high on drugs, especially mbanje, I would write music, mostly love songs. I dreamt of my musical career flourishing in America, but when I attempted to have my songs recorded, established groups would tell me that the songs could only be recorded under their names. Without funds and support, I found it difficult to pursue my dream. Those who were supposed to be supporting me said: “*zvipiko zvembanje izvo*” [there is nothing in it; it's all because of mbanje].

The bitterness of failing and being let down fuelled my mbanje and alcohol use to the extent that it became a way of life.

¹² A 'C' is a grading symbol for an Ordinary level pass mark between 50% and 59% in Zimbabwe

In the night clubs

After Shepherd got arrested for selling drugs, his friends Blaz and Kule took us under their wing. Kule was a good fighter and Blaz was very rich. Blaz and Kule would cover our drugging and clubbing budget and, in exchange, we would find them girls. At the time, the robot dance was very popular in clubs, so Ngoni and I would perform the dance at the clubs and win over the prostitutes.

We would often come home very late or spend the whole night out. I had become very disrespectful and aggressive and would harass my mom and sisters if they tried to reprimand me. Unlike other boys who were employed and lived with their parents, I would contribute nothing to the home – I would just eat and be of no help.

The first knock

Although failing my O-Levels opened my eyes a little, it was not enough of a shock to awaken me. When I received my results, I spent much of the day kicking and punching stuff in misdirected anger. The next day when Ngoni – who also failed dismally – arrived at my place, we agreed to continue with mbanje and alcohol as a way of life. This time we were running away from reality.

We blamed our fathers, who failed us and failed to be there for us. Support from Kule and Blaz made us feel as if we were lacking nothing, but the question “*ndichazova ani?*” [Who am I going to be?] bothered me every now and again, usually when I was sober or at home. In response, I evaded reality by drugging again.

The second knock

The second knock was harder to ignore, but I still could not change. I had become violent and anti-social and had a few brushes with the law. I was arrested for public violence, public drinking, and for possession of mbanje.

I should have been in trouble, but Kule had friends in the police force who were always coming to my rescue. I took it for granted that there would always be a way out, so I stayed in the realm of substance abuse. Being in and out of custody is not a good thing, so I turned to mbanje and alcohol once more to run away from reality. It is the escape route I chose. When you are drunk, you live in a fantasy world where everything flows. When you sober up again, reality shows up. So staying drunk becomes the answer.

The health knock

During the period when my life was dominated by substance abuse, I began to get a headache after smoking mbanje. It felt as if I were being hit by a stick. Just above my eyes, it went: knock, knock, knock! The pain was so intense that I would ask my younger brother to put a towel in cold water and wrap it around my head. It was difficult for anyone to help me because I refused to go to hospital – I knew what was causing the headache. Friends, who could see how much pain I was in, advised me to stop smoking mbanje. My response was: Oh what! That which you are suggesting, I just cannot do.

I was confused by the signals my body was sending. My body was telling me that it still needed mbanje, but the headaches were saying the opposite. It pained me to think that I might need to stop smoking mbanje – the thing that had been keeping me going – and I also suspected that some guys were saying that you are not man enough if you get a headache from smoking mbanje.

Despite my reluctance to change, the knock for change persisted deep inside me – perhaps simply because I wanted the pain to go away. I perused magazines and popular media for a solution to my headache problem. I was not looking for ways to stop smoking mbanje, but rather for way to relieve the pain after smoking. One of my favourite magazines was a magazine called Plain Truth. Although it was a religious magazine, it had a section on health tips.

...and then the spiritual knocks!

I was raised by a Christian mother, who always placed a religious value system above personal and scientific value systems. I spent a lot of time defying that: my personal values were in control, followed by scientific ones. However, as I read the religious magazines, I began to consider attending church programmes – not for religious reasons, but for the fun I had read about in the magazines.

During the late 1980s, David Newberry and Leonard Bong, evangelists from Europe, were holding open-air crusades in our neighbourhood. Together with Ngoni and other guys from the ‘hood who were into drugs, I would attend the services. Our intentions were to proposition church girls and disrupt the smooth running of their programmes. No one liked to see us near their gatherings. The ushers would chase us away because we were drunk, and we

would find the chases fun because we were disturbing the peace. At times we were successful in our attempts to lead the church girls astray.

While I attended the services for fun, what was being preached made sense when I thought about it properly. What I didn't like about the church is that it made me the problem. It emphasised my guilt, shame and personal uselessness. I didn't want anyone else to decide that for me. I didn't like to be told what to do or to be forced to follow.

The then 'hidden – good decision' I made was to continue listening to the pastors and reading religious magazines. Although what was being preached didn't sit well with my habits, it was starting to make sense. The headache that I experienced after smoking mbanje also made me consider Christianity in a new light. I was a slave to my headache. Why me, I would ask myself. Why only me among others?

At the time I had a friend called Isaac, whose health was deteriorating as a result of drug use. He started going to church with some of his flatmates and gradually began to quit using drugs. It was working out well for him, so he invited me to come along to church with him on Sundays. At the time, I was still clinging to my bold NO!

Then, one day when I was paging through one of the religious magazines – enslaved by my headache after two or three puffs of mbanje – I came across a picture of a husband and wife. With this dream of a happy family in my head, I began to observe more of those happy and joyful moments in pictures and movies. I started to like pictures of pregnant women, and began to feel more positive about women as my dating spree came to an end. I started thinking that I would like my sisters to be happy like the women in the pictures. These thoughts all came about as a result of the material that I was reading during that period of being enslaved by headaches.

Shortly after this change began to take place, I came across a picture of Jesus in one of my favourite magazines. It grabbed my attention in a way that I cannot explain. There was a statement written in small font below the picture: *There is more peace than you desire in the presence of the Lord.* Even today, I cannot explain how I felt after reading this. There was a different kind of warmth in the room – as if something were melting inside me. What is really going on with me, I wondered.

Despite my unrepentant stance, my mother continued to pray for me. At times, I would hear her whispering softly to God: “*Mwari ivai nemwanakomana wangu arasika Mwari muponeseiwo Mwari wee!*” [Please Lord, be with my lost son, save him oh Lord.]

I would laugh and think: Poor lady, you think I am lost. But the spiritual knock was so persistent and irresistible that eventually I opened the door. Repenting was my first step towards change.

No longer able to bear the headaches, I submitted to the spiritual push from within. On Thursday the 4th of July 1986, I went with Isaac’s friends to church. I was the only visitor for that evening service and it felt as if the preacher were speaking directly to me. It was as if he knew all about me and my problems. I felt so exposed; as if God were talking directly to me. The preacher concluded the sermon by calling on people to give their lives to Christ. Without hesitation, I was at the front of the queue, repenting and giving my life to God so that I could start to live a real life. Everyone was celebrating and praising God – the praise team burst into song. After that, some of the elders from the church began instructing me on how to move forward. I noticed that this was a new beginning, that something different was happening.

Turning to the light

I managed to stop smoking mbanje and limited my alcohol intake for the first few weeks after I repented. I was zealous about turning to the light. I decided that, contrary to what the churchgoers were telling me, repentance does not mean cutting past ties, so I continued to hang out with Ngoni, Kule and Blaz. While socialising with them, I managed to say a firm ‘no’ to mbanje – maybe because of the headaches – but I continued to occasionally drink alcohol with them. I was on both sides of the coin: going to church and drinking.

I tried to be a loyal follower and I tried to avoid the girls. I went to church on a Sunday and went out drinking afterwards. I didn’t see a problem with it, but when the people at church realised what was going on, it became hard to belong to the church.

Adjusting to a Christian life proved to be a challenge. I wanted to, but I couldn’t adjust. I didn’t want to go to the church youth camps because they seemed too rigid and devoid of fun. I considered the camps to be too much of a commitment. I didn’t want someone to tell me what to do, so I remained behind and resorted to drinking instead. After that I felt guilty and repentant, so I returned to church.

Darkness and light interchanging

For some time, it was difficult to find a way to sustain life away from alcohol. I had started to hear the word of God through the Bible and church services, but I still hadn't fully committed to a Christian way of life. I was on a stop-start-stop-start kind of path, failing to move in either direction.

At times, I questioned whether God was really calling me. I wanted God to speak to me directly. When this didn't happen, I decided to give up on being a Christian, lest others laugh at me for not making it. I felt that I did not belong. Why not return to what I was satisfied doing, what I was used to doing, and what my friends expected me to do? By the end of 1992, I had returned to my old life of drugging.

I knew that I was reacting to what I perceived to be God's disappointments. When I resumed my drugging life, I was just drinking alcohol – the 'heavy /strong stuff'¹³. I hung around Kule and Blaz because my other friends had rejected me.

They said: "We were actually admiring you when you were working to leave alcohol and mbanje, so we cannot let you down. Actually, we need your hand to get out of this too."

In addition to this rejection, I also faced a new woe: whenever I drank too much alcohol, I would vomit a lot. Although I no longer attended church, I still found reading the Bible to be a delight.

Refocusing

Eventually, I realised that new Christian habits could not be formed by Fred the Drunkard. I told myself that a new Fred needed to be constructed. New thoughts, new choices, new goals, and new doings were necessary. I realised that the old could not coincide with the new me I was aspiring to be. I began to realise that it would not be an easy road; maybe it would be a very rough one.

My life started to change bit by bit. *Zvakatanga kundinakidza ndikada kuita zvizhinji* [I started to get satisfaction in the new life and desired to do more]. I started to see my thoughts, choices, goals and doings being modified, replaced and in some cases even abandoned. Nothing from my past life flowed smoothly anymore, and I was pained as the old continued

¹³ Refers to alcoholic drinks with high percentage of alcohol by volume

to battle with the new. I realised that there was more to be gained by looking ahead than by turning back. Slowly, with the encouragement of my mom and even some of my old friends, I began to change small things. Bit by bit, I started becoming a new person. I began to join a new life; a life away from substance abuse.

I chose the following words to be the central driving force of change: *I will look to you, God, the reason for my living; I have failed myself and I need your hand*. These words helped sustain the change. God – through his word and the use of other people – became my counsellor in this journey of change. Life became easier when I accepted that “*the fear of the Lord is the beginning of all wisdom*”. I wanted to forgive myself and others; I wanted to love myself and others; I wanted to be a recognised member of society and do things that were socially valued. I wanted to be the person the scriptures were telling me to be – a loving person.

Now that I was no longer investing my time and energy in mbanje and alcohol abuse, I suddenly had an abundance of both. I wasn't sure what to do with my time and I soon became lonely. So I joined the church again. This time I went to a church called the Glad Tidings Church. The leadership at the church saw something valuable in me that I could not see myself and started asking me to volunteer to do certain tasks. They even assigned me tasks that involved leading others.

I became more committed as I heard God's calling and I managed to successfully carry out the duties assigned to me. I climbed through the leadership ranks and, in a short space of time, I became the acting youth pastor. This new church was very accommodating and it managed to suck me in rather than alienate me because of my shortcomings.

I continued to change. Some people from the 'hood laughed at these changes because they thought that I was at church simply for the girls. But I was busy going through a divorce with my past drugging life. I even led a youth group of about 600 members – a marked sign of change in me as I would never have previously contemplated responsibility of that magnitude. These positive changes helped me to cement my new self.

Light wins

I eventually realised that the things I was trying to run away from were what society actually needs. Love, compassion, responsibility and regard for others can't be blown off or housed under a life dominated by substances such as alcohol and mbanje.

As the light, the new way of life, began to triumph, I continuously reminded myself that: *My life is worth more. I am supposed to be someone.* I also began to see that trying to run away or hide never works, so I decided to rededicate my life to God instead. I quit drinking alcohol and, since then, have been clean and a child of God. I say that I discovered ‘real life’ – where what you do is not viewed as a problem by others, but actually helps society.

Mufundisi (Pastor)

In 1998, the following chorus was sung by the church’s leadership: “*Mwari vari kukudana pabasa ravo*” [God is calling you to his Ministry]. I sang along by enrolling in a fully-funded Bible College programme. I graduated with a diploma in Theology at the end of 2000.

“*No more turning back, for I have found the reason for living,*” became the words to my new life’s song. During my studies, I became the youth pastor and a church co-pastor. Once I graduated, I became a fulltime pastor and that has driven my life ever since. I enjoy every bit of my work in the Ministry.

Outside Ministry work, I help with house chores and maintain our garden. I also sit on the school development committee at the local primary school. I take up any roles that will make me significant in the lives of others.

Mai Mufundisi (Pastors wife)

In 1998, love, responsibility, and regard for others combined, as I became involved in my first ever serious relationship with sweet Fari. Love! Love! Love! Wonderful real love. I met Fari in church. I liked her and tried to move closer to her heart by doing good things in her presence. I wanted to please her and, finally, I won her heart. We dated for two years and married at the beginning of 2001, after which she became Mai Mufundisi. Together we had two children, our son, Josh, and, five years later, our daughter, Rufaro.

Now I am a pastor, husband and father of two. I am a community changer and leader. I thank God for all he has done – showing me the need to change and realising real life.

I hang out with the other pastors, and take time to win over souls whenever I can. Sometimes I take a taxi to town or to places where people gather – such as the hospital – to practice open-air evangelism. I get satisfaction from this.

I still love reading, but now I no longer read pornographic magazines. There are some things I simply cannot do as a pastor – I am expected to behave in a certain manner. Instead, I read my Bible, informative books, and the local newspapers.

Ramangwana rangu (My tomorrow)

I am a product of God's mercy given to me through multiple means. I want to be an instrument for changing and transforming society from its ill ways of being and doing. In so doing, I soldier on in recovery. I continue to develop and grow.

My testimony and God himself bears witness to the world of possibilities. I have an identity to protect. I have to do it, and through my choices and goals, I will. God willing I will always be a good role model; I know many are learning from me.

Being a hand and a positive one is my dream. I envision pulling many out of the mostly self-created mess of substance abuse. I continue to seek for platforms to share my story — the pride of my life, my recovery journey. I incorporate it into my sermons as I preach, and I have no problem telling and retelling this story because it is the truth. I am the evidence.

If you think you can do it on your own, you should brace for relapses. *Mwari mubatsiri* [God is the helper]! I am on my recovery journey; it is not a destination and I see real life in this.

4.4 Conclusion

The three stories illustrated the cogent influence of occupations associated with identity reconstruction. The occupations associated with spirituality, work and fatherhood were particularly salient. These occupations were used in an ongoing process of change, where the occupations worked to replace the preoccupation with substance abuse, to express the recovering self, and to attain goals that were being set in recovery. With the new view of life and within the confinements of the participants' contexts, some occupations were carried on into recovery with some modification of ways of participation as well as meaning and value attached to the occupations. The three stories also show future goals, which were being set and influenced by their new identities and occupational opportunities the young adult men were seeing.

CHAPTER 5

DISCUSSION

5.1 Introduction

In this chapter I discuss the findings generated through my interpretations of and insights into the young men's stories. I begin by discussing how recovery from substance abuse can be conceptualised as an occupational transition. I highlight this occupational transition as ongoing and discuss the role of occupations therein and in the reconstruction of a person's positive occupational identity. Throughout this discussion chapter, I illustrate the pervasive influence of context.

5.2 Recovery from substance abuse: an occupational transition

The participants' stories evidenced recovery as an ongoing process of change. In that ongoing change process, there was evidence of change and development linked to engagement in meaningful occupations. Occupations that were generally and socially understood to contribute to enhancing health and well-being, in this case paid work, spiritual activities, and those to do with building relationships facilitated the recovery processes for these participants. Partaking in substances or participating in occupations related to substance abuse hindered the recovery process by increasing the risk of relapse. Occupation played a central role in creating and sustaining what the recovery process came to be among these participants. The leaving behind of the occupation of substance abuse and transitioning into recovery, which was negotiated and expressed through occupations, can therefore be conceptualised as an ongoing occupational transition.

The way in which recovery was experienced corresponds to a large extent with what has been written about occupational transition in occupational therapy and occupational science literature (Scornaiencki, 2012; Peters, 2011; Hon, Sun, Suto, & Forwell, 2011; Jonsson, Kielhofner, & Borell, 1997; Jonsson, 2010). The findings about the recovery process showed a major change in the participants' occupational routines involving abandoning, modifying and adopting occupations, which is compatible with Jonsson's (2010) definition of an occupational transition. Jonsson identified that an occupational transition involved "a major change in the occupational repertoire of a person in which one or several occupations change, disappear and/or are replaced by others" (Jonsson, 2010, p. 212). Other examples where occupational transitions have been investigated and reported include resettlement of refugees

(Hon et al., 2011), work (Leyshon, 2009), dropping out of school (Peters, 2011), and leaving homelessness (Heuchemer & Josephsson, 2006).

There was evidence of occupational changes in the participants' recovery processes as was the case in each of the referenced studies. This supports the notion put forth in this study that the recovery process, as a change process negotiated through occupation in context, can also be conceptualised as an occupational transition. The occupational transition of retirement (Jonsson, 2010; Jonsson et al., 1997; Jonsson, Borell, & Sadlo, 2000) is one well researched area showing the abandonment, modification and replacement of occupation(s) in the occupational transition. The occupational transition of recovery from substance abuse largely followed the transition outlined for retirement except that the latter seemed to have a defined beginning and ending. Recovery, on the other hand, seems to be an ongoing occupational transition.

The entry into this occupational transition was marked by a conflict between the need to change and the need to continue in previous engagements and belong. This was exemplified by all three participants. Fred's health problems (the headache he felt after smoking mbanje) were not strong enough to start the occupational transition into recovery. This differed from retirement (Jonsson, 2010; Jonsson et al., 1997; Jonsson et al., 2000) and immigration (Hon et al., 2011) where it was clear that the occupational transition had a definite cause and a definitive start. In recovery from substance abuse, the participants in this study experienced a tussle between health and social factors at both personal and environmental levels. After the headaches, Fred experienced spiritual convictions that were coupled with advice from other people. He vacillated between these convictions and substance abuse before the actual transition started to flow, signifying recovery. For the other two participants the tussle that preceded the occupational transition was largely between deteriorating health and the continued craving for drugs and need to belong among substance-abusing peers. In addition to this, the participants' accounts revealed that during this period of vacillation substance abuse was not always considered to be a negative engagement. Rather, it was seen as having some positive benefits: enjoyment, a means of coping, a key to belonging, and a way to spend time and expend energy. Substance abuse was actually a meaningful occupation, although, in each case, there came a time when the negative consequences outweighed the positives, which resulted in the participants entertaining the idea of abandoning the occupation.

The recovery process involved addressing or achieving some of the positive outcomes of substance abuse, which were highlighted in the participants' stories, through other occupations that were largely socially valued. A very particular kind of occupational engagement was therefore required to fill the void that materialised when substance abuse was removed from the participants' occupational repertoires. Occupations that were favoured or successful in replacing substance abuse included, but were not limited to, relationship building, productive work, and spiritual activities.

Occupations that supported and were supported by the recovery process were experienced as better situated at that point in time to positively influence the participants' health and well-being, which is one of the core understandings of the function of occupation in occupational science and occupational therapy (Wilcock, 2006).

Occupational transition or recovery started when the intensity of engagement in substance abuse seemed to produce more negative than positive outcomes. The participants were forced to stop engaging in substance abuse and, in so doing, to start to 'do' differently. In continuing to 'do' differently, they became dissatisfied with their previous participation. This encouraged them to look for more satisfying occupational engagement, which contributed to prolonging the occupational transition. This sequence of events differs from that of Scornaiencki (2012) who suggests that it is the lack of satisfaction that leads to desire for being in an occupational transition. However, the beginning of the occupational transition of recovery from substance abuse was not always linear as was demonstrated in the participants' narratives of their recovery processes.

When the dominance of substance abuse over other occupations had risen to a point where it directly affected function or the outcomes of their engagements – including health problems – change was triggered. Or when sufficient awareness, usually as spiritual self-knowledge, had developed, change was triggered. This differs from occupational transitions described in occupational therapy and occupational science literature that frame the occupational transitions as anticipated, voluntary and planned for (Scornaiencki, 2012; Jonsson et al., 1997). The findings of this study contend that not all transitions are anticipated, voluntary and planned for; some are unplanned, as was shown in a study on school dropouts (Peters, 2011), and demanded.

Other factors that came into play during the participants' occupational transitions included self-knowledge and honesty, the desire for individual growth and change, demands of time in

life stages, necessity, courage and dedication. This was supported by Scornaiencki (2012). All these factors pushed the occupational transition to begin or to trigger it. However, not all triggers were successful in igniting the occupational transition process. From the stories it was apparent that the actual occupational transition of recovery resulted from the interplay between some of the abovementioned factors in their close relationship to occupation.

After the occupational transition had started, it was evident from the participants' narratives that a continuing change process ensued and was closely tied to everyday doings and the changes in identity that were also taking place Peters (2011) in her study on the occupational participation of men who dropped out of school in South Africa, argued that the occupational transition of dropping out of school continued to influence participants' occupational lives. This was similar to the way that recovery from substance abuse was experienced by the participants, in that the thought of being in recovery continued to influence their occupational participation. As an ongoing process, the participants continued to engage in ways that would help them shape and express their changed and changing selves. This is supported by the transformative power of occupation — people continue to change by engaging in occupations (Townsend, 1997). The change was also evidenced through occupations, hence the ongoing occupational transition of recovery.

The occupational transition of recovery experienced by these participants was also about developing and having a positive occupational identity as a lifetime goal. All three participants talked about their aim to have a positive occupational identity and to have an impact on the lives of others in relation to their doing as recovering from substance abuse. This finding demonstrates that what people do in life defines who they are. This was also illustrated by Vrkljan & Polgar (2007) in their study on how driving cessation influenced occupational identity among old people. They argued that, “occupational identity is closely linked to the activities in which one engages” (Vrkljan & Polgar, 2007, p. 32). This appreciation of the relationship between occupation and identity, which came to the participants in recovery, has also been emphasised in literature (Unruh, 2004; Phelan & Kinsella, 2009). The continued search for a positive occupational identity through engagement in occupations contributed to making their occupational transition of recovery a continuing process. There was an interesting relationship between occupation and identity in this ongoing recovery process: who they were and who they wanted to be continued to influence the occupations pursued, and those occupations continued to perpetuate who they were.

The men's need to develop a positive occupational identity from their everyday participation in occupations supported the continuous nature of the occupational transition of recovery. The development or reconstruction of occupational identity in an iterative process was also reported by Vrkljan & Polgar (2007), who found that the loss of a significant occupation (such as driving) resulted in occupational disruption that negatively affected one's occupational identity. The reconstruction of this occupational identity was achieved through the process of occupational adaptation and the participants' sense of well-being improved as a result (Vrkljan & Polgar, 2007).

To avoid relapsing into a life dominated by substance abuse, all participants revealed that they had to work to sustain recovery throughout their lives. As such, they continued to negotiate an ongoing occupational transition through occupational adaptation. The participants largely had to work against the addictive nature of substance abuse by managing cravings and avoiding situations that would put them at risk of relapsing into substance abuse. This differed from other occupational transitions such as retirement because one is not continuously retiring (Jonsson, 2010); in this case, they were in recovery as a new way of life.

Contrary to the continuous nature of the occupational transition of recovery from substance abuse among young adult Zimbabwean men, occupational transition has been characterised as having defined life stages or situations with a definite beginning and ending (Shaw & Rudman, 2009). Shaw and Rudman (2009) highlighted this in their work on how occupational science was positioned to study occupational transitions in the realm of work. This notion of occupational transition having a definite beginning and end was also found in a study on occupational transition from work to retirement in which the participants left work and were then identified as retirees; they went through occupational adaptation, seeking out new alternative occupations to adjust to the change that had taken place (Pettican & Prior, 2011; Jonsson et al., 2000).

5.3 Changes in participation in occupations during the occupational transition.

The ways of participating in occupations during the occupational transition interacted with each other in an iterative process bringing forth the desired change as was shown in the recovery processes. The key ways of occupational participation within this occupational

transition included the processes of abandoning, modifying and adopting occupations that will be discussed below.

5.3.1 Process of abandoning occupations

The occupational transition progressed gradually, but in a complex way involving the process of abandoning the occupation of substance abuse and its associated occupations. In the occupational transition (of recovery), some occupations were abandoned (Shaw & Rudman, 2009) to facilitate the change process. After experiencing the negative outcomes of engaging in substance abuse, Chitsva and Pangol started to make inroads into abandoning the occupation of substance abuse and its associated occupations such as clubbing. In a context such as Zimbabwe, the participants had to abandon occupations judged to be deviant for someone recovering from substance abuse. Unlike in the study by Vrkljan & Polgar (2007) on driving cessation, abandoning the major occupation of substance abuse did not result in occupational disruption. In fact, the abandonment of the occupation of substance abuse was experienced as a necessity for the success of the occupational transition. This helped the participants to start to think of themselves as recovering former-substance-abusers.

For Pangol and Chitsva, the abandonment of occupations in their occupational transition was facilitated by medical advice, supportive families, and personal conviction. In Fred's case, the process of abandoning engagement in the occupation of substance abuse was also evident. This tallies with what has been said about occupational transition where it has been recognised that a major change occurs in the occupational repertoire. This included the abandonment of some key occupations (Jonsson, 2010). This process of abandoning occupations was similar to the changes that took place in other occupational transition such as dropping out of school, during which formal education was abandoned (Peters, 2011), and in retirement, in which case the major occupation abandoned was work (Jonsson et al., 2000). In recovery, the major occupation that was abandoned was substance abuse. The occupation of substance abuse had a defining impact on the lives of the participants before the occupational transition of recovery began because they used to value engagement in substance abuse.

However, because of the addictive effects of substance abuse, the process of abandoning substance abuse and its related occupations was characterised by relapses. The lack of social value among non-abusers and stigma attached to the occupation helped for the participants in this study to abandon the occupation. When the participants were lucky enough to quickly

find a socially valued and health-enhancing occupation, instead of simply being idle, it was also key in abandoning substance abuse.

In the participants' stories, there came a time when the occupation of substance abuse had to be abandoned largely because of its perceived negative consequences. For example, in the case of Chitsva and Pangol, the health problem they developed from their engagement in substance abuse triggered the occupational transition where substance abuse was abandoned. For Fred it was a combination of health problems and spiritual conviction that spurred the abandonment of substance abuse. The influence of the occupations associated with substance abuse in the person's life determined how it was abandoned. The participants affected by health problems were compelled to leave substance abuse, but the addictive nature of the substances resulted in a tussle, largely because of withdrawal effects such as cravings. Pangol opted for gradual weaning, which could be likened to the way in which work was left in the study on retirement, and so the process was one of gradual tapering off (Wiseman & Whiteford, 2009). The difference between the two studies is that while the substance abusers experienced a forced gradual weaning because of the physical effects of withdrawal, the gradual weaning in the retirement study was planned to help maintain identity (Wiseman & Whiteford, 2009).

While the process of abandoning some occupations was occurring, other occupations were carried on into recovery, although these occupations had to be modified to fit and support the occupational transition of recovery.

5.3.2 Process of modifying occupations

Because occupation has the ability to organise behaviour (CAOT, 2008) the abandonment of one major occupation consequently affected other occupations and general time use. As in other occupational transitions, not everything changed and participants continued with some occupations and fitted new occupations into existing occupations (Shaw & Rudman, 2009). In the occupational transition of recovery from substance abuse some occupations were maintained. These occupations were mainly those that did not have direct links to the occupations being abandoned. The maintained occupations could speak more to the goals being set and occupational identity pursued. Some of those occupations maintained were also modified to suit the new goals that were being set. Reading and church-going were maintained in Fred's transition, but with modified engagement and changed value and meaning.

The modification of the occupations which were maintained was in line with the participants' emerging roles and occupational identities. To sustain recovery, roles were modified as occupations were modified, and participation in occupations was used to effectively fulfil the expected roles as a way of sustaining the occupational transition. This was because roles were strongly associated with particular sets of occupations (CAOT, 2002). For Pangol, reinterpretation of the father role meant that he modified and experienced the occupation of work in relation to his role as a father. This differs from the perpetuated ways of occupational engagement seen in the school drop-out study, in which the meaning and value of previously engaged-in occupations did not change (Peters, 2011).

Modification of occupations in this occupational transition of recovery was done with reference to past engagements. In retirement, the meaning and value of occupations gradually changed as the retirees tried to maintain connection with their past (Wiseman & Whiteford, 2009; Jonsson et al., 2000). In a similar way, the connection that the participants in this study had with their past was evident in the way that they constantly had to define themselves differently. However, the quest here was defining oneself differently whereas in the retirement study it was about defining oneself similarly, and modification of occupational engagement supported the quest to define oneself similarly or differently.

The element of maintaining components of the occupation was not possible for the participants in this study, possibly because the participants wanted to dissociate themselves from the occupation of substance abuse to demonstrate that they had changed and not doing so might have been considered a failure in the recovery process. The element of maintaining some aspects of the occupation being abandoned was, however, evident in the occupational transition of retirement where the positive purposes of work were emphasised (Wiseman & Whiteford, 2009; Kielhofner & Borell, 1997) and hence the need to continue in some form of the same occupation on part-time basis was prevalent among retirees.

5.3.3 Process of adopting occupations

Once the participants had abandoned and modified other occupations, they still had to undergo a process of adopting new occupations to support the change for the occupational transition to be complete. As substance abuse was being abandoned, other associated occupations such as clubbing, stealing, and prostitution were left too; the participants considered these occupations to be triggers of their substance abuse relapses. This abandonment created a void, and thus other occupations were taken up in order to sustain the

occupational transition. The taking up of occupations was largely circumstantial as the participants opted for occupations that were available and possible to them. The occupations adopted by the participants were also individually and socially understood to promote health and well-being and could help convey the recovering identity that was being pursued.

When occupations were abandoned, the positive outcomes related to those occupations were also lost, and this determined which occupations were chosen as replacements. In the case of substance abuse, the positive outcomes were enjoyment, socialisation, belonging and expressing identity. Once the occupation of substance abuse was abandoned, the new occupations that were taken on needed to in some way replace these positive outcomes. However, it was important that the new occupations did not also cause the same negative outcomes as the occupation of substance abuse.

From the participants' stories, it was apparent that the changes in their occupations were accompanied by role changes. From an occupational perspective, role refers to "culturally defined pattern of occupation that reflects particular routines and habits" (CAOT, 2002, p. 182). One of the chief roles of the occupation of substance abuse was being a friend to other substance abusers. The participants' stories indicated a change in this role as they focused more on roles such as father and worker. This might have been because of the life stage transition (adolescence to young adulthood) that the participants found themselves in during the occupational transition of recovery. In other instances, this role of being a friend did not completely change, but the type of friends changed and the occupations done with friends had social value.

The adoption of occupations influenced the recovery process by organising behaviour into roles and habits, which is supported by the notion that people's roles and habits are interlinked with their occupational engagements (Kielhofner, 2002). All participants used their occupations to fulfil their roles of being a worker, father, son, husband and community member. Occupations helped by creating new routines outside substance abuse and hence aided the progress of the occupational transition of recovery.

Although Pangol previously had other roles that were expected of him – father and husband — he did not fulfil these roles while he was engaged in the occupation of substance abuse. Because he over engaged in the occupation of substance abuse, Pangol failed to develop and maintain other role obligations. For Pangol, this over-engagement in substance abuse also resulted in absenteeism and poor performance at work. However, during the process of

occupational transition, he started to prioritise his expected roles and took up occupations that helped him to assume and fulfil these roles, such as productive work in the form of farming.

Social participation was important in the process of adopting new occupations. Participation in shared and socially valued occupations meant a recovery process had an impact on more than the individual — for Chitsva, his mother and aunt; for Pangol, his wife and child; and for Fred, his wife, father, and members of the church. All of these people contributed significantly to what the recovery process came to be and what occupations were engaged in during recovery. The influence of recovery on the occupations of the individual and significant others can be explained by the fact that humans have ability to influence others and be influenced through occupation; other people played a part in influencing occupational form and meaning (Eakman, 2007). In recovery, occupation also worked as a tool for communication and relating to others.

This adoption of occupations was to some extent aided. A supportive social environment was evident in all three stories as a facilitating factor for the adoption and modification of occupations. In this supportive environment, interdependence was a marker of a successful recovery process. Significant others needed to be people who were accepting, accommodative and supportive. Rebuilding relationships with significant others such as parents and spouses helped to signify recovery. In an attempt to rebuild these relationships, participants engaged in occupations that they could do with significant others. Pangol, for example, engaged in farming with his wife. This finding tallies with Mackie's (2007) finding that social support, which is a building block for sober living, was needed for change of identity and relationships in the cases of women who were trying to achieve sobriety.

Social support was important in adopting new occupations and aiding recovery because the negative consequences of substance abuse had also affected the substance abuser's family and community (Nordfjern, Rundmo & Hole, 2009). Acceptance and support allowed Fred to undergo an occupational transition and assume his role as a pastor. For Pangol and Chitsva, it was the treatment and advice from health professionals as part of a supportive environment that aided in facilitating their occupational transitions of recovery. Overall a supportive and affirming environment proved to be important for the adoption of new occupations and hence the success of the occupational transition in these substance abuse recoveries.

To take up new or modified occupations, participants seemed to draw on skills that they already possessed. The skills and capacities held by the individual facilitated the occupational

transition of recovery, or placed the individual in better position to adopt new occupations. For example, the educational qualifications the participants held put them in a position for paid work-related occupations as was evident in the case of Chitsva, who went into teaching. The lack of educational qualifications was evident in the case of Pangol, who wanted to go into teaching, but was not suitably qualified for a permanent post. Pangol then utilised farming skills, which were inherent, and took up farming as a major occupation, even though he still hoped to train to become a teacher because he regarded farming as inferior to teaching. For Fred, the case was not very clear, though his success in pastoring could have been facilitated by his good public speaking skills and spiritual gifts. This demonstrated that, for a successful occupational transition from substance abuse, it was necessary for the participants to build on skills and capacities that they already possessed and to do so through occupations. This finding concurs with those of Peters (2011), who discovered that a lack of education restricted the occupational participation, for school dropouts and that the occupational histories of the participants continued to influence their lives.

The occupations that were taken up by the participants could be likened to the ‘engaging occupations’ from the studies on retirement (Jonsson, Josephsson, & Kielhofner, 2001; Jonsson, 2010). These occupations in the areas of paid work, spiritual activities, and relationships helped to sustain the occupational transition of recovery. They gave the participants motivation to continue the recovery journey because they were infused with both individual and collective meaning (Jonsson et al., 2001; Jonsson, 2010). These adopted occupations called for intense participation, structuring of energy and time resources, and the need to participate in secondary supportive occupations, all of which helped to distance the participants from substance abuse (Jonsson et al., 2001; Jonsson, 2010). The work, spiritual and relationship-oriented occupations these participants took up also helped to construct an identity around them and called for commitment and responsibility, which was also the case in the work on retirement (Jonsson et al., 2001; Jonsson, 2010).

In sustaining the occupational transition of recovery, other occupations were taken up or modified to support engagement in the ‘engaging occupations,’ resulting in recovery. This taking-up of other occupations to support others became more of what was happening before joining recovery, where substance abuse was an engaging occupation, calling for other occupations like clubbing to support it. For Chitsva, reading supported the occupation of teaching; it influenced and was influenced by his role as a teacher. For Fred, reading supported the occupation of pastoring.

However the adoption of occupations in the occupational transition of recovery did not take place in a vacuum for these men. There were barriers, and some of those barriers – such as the country’s economic and political challenges – existed at a macro level. Participation in work-related occupations, which were pivotal in shaping the participants’ occupational identities and even the opportunities to take up these occupations, seemed to be influenced by general economic and political trends. In the cases of Chitsva and Pangol, for example, high unemployment levels and corruption were shown to hinder the onset of occupational transitions by not awarding opportunities for participation in paid work.

5.3.4 The changing occupational identity and meanings

The changes in the ways of occupational participation during their ongoing occupational transitions of recovery were evident in occupations being abandoned, modified and the adoption of new occupations. The experience of these occupations changed at meaning and value level, while the participants’ roles consequently changed. The changing roles had an impact on the occupational identity and bringing forth the change in recovery. Occupational identity is defined in literature as “a composite sense of who one is and wishes to become as an occupational being generated from one’s history of occupational participation...” (Kielhofner, 2008, p.106). Positive occupational identity as a measure of success of the recovery process was the goal of the occupational transition.

The findings of this study showed that substance abuse was considered to be an occupation that gave meaning(s) to life. As is the case with meanings that other occupations give to life, these meanings were subjective, multiple and varying at personal, family, group and community levels (Hocking, 2009). However, excessive engagement ended up compromising health and well-being. The meanings given to occupations were influenced by contextual factors. During the occupational transition of recovery, these meanings were changing even for occupations other than substance abuse as the context was now recovery focused.

For all three participants, substance abuse changed its meaning from a social occupation — aiding belonging and defining identity — to one that was health-threatening and deviant just prior to and during the occupational transition. The new or changing occupational meanings were based on a combination of past experiences and the new self being developed. For example, in the past, Fred went to church to while away the time, chase girls, and disturb proceedings, but in recovery going to church took on new meanings of connecting with God, fellowship with others, spirituality, and an opportunity to express his recovering self. The

same happened with work for Pangol: he used to go to work to fund his substance abuse occupation, but in recovery farming became an occupation to provide for family, connect with family, and express recovery. This shift in the meaning of occupations can be traced to the shift in roles and occupational identity. The change in how they viewed their roles influenced the meaning attached to or gained from occupational engagement. This was similar to the way in which meaning and value attached to occupations changed during the occupational transition of retirement (Wiseman & Whiteford, 2009).

As the meaning of occupations changed, some occupations became more valued and prioritised than others, and this influenced engagement in all spheres. These occupations served a defining role and were the occupations that emerged to address the bulk of the individual's occupational needs and organised his behaviour. The spiritual occupations, relationships or caring, and work-related occupations were the ones that cemented the differing occupational identity from the one that the participants had before joining recovery. For Fred, the cementing occupation was pastoring; for Pangol, farming; and for Chitsva, teaching. These occupations carried weight in what came to be the participants' occupational identities. These occupations served the same purpose as the 'engaging occupations' that enhanced satisfaction in the occupational transition into retirement (Jonsson et al., 2001; Jonsson, 2010) and the 'anchoring occupations' that stabilised the life trajectories of school dropouts (Peters, 2011).

The productive or work-related occupations, relationships or caring and spiritual occupations were instrumental in the construction and expression of the positive occupational identities, bringing out recovery and consequently enhancing the health and well-being of the participants. This notion that through occupational engagement and participation there will be construction and communication of identity is supported in literature (Christiansen, 1999). In addition to this, the work-related, caring or relationship-oriented and spiritual occupations were important as they also enabled social interaction, which was an essential component of identity (Griffith, Caron, Desrosiers & Thibeault, 2007) and consequently recovery.

As the participants continued to participate in occupations of great meaning and value to the individual and society, they began to embrace their established roles and develop positive occupational identities. The satisfaction resulting from positive occupational identities gave the participants a sense of accomplishment, a foundation for familiar routines in their roles, and allowed for the realisation of potential, limitations and desires (Kielhofner, 2002).

Chitsva identified as a teacher, Fred as a pastor, and Pangol as a farmer. The same thing happened with engaging occupations among retirees (Jonsson, 2011); they helped to define the retirees. As with other studies, spiritual and productive or paid work occupations proved to be better positioned than other occupations for the construction, reconstruction and expression of positive occupational identities (Unruh, 2004) during the process of recovery from substance abuse.

The participants aimed for the construction and/or reconstruction of a worthy and positive occupational identity. With a change in occupation, identity changes (Vrkljan & Polgar, 2007), and occupational identity is an outcome of occupation in context (Shaw & Rudman, 2009). The participants' roles as part of the context were also changing. As has been shown in the changed ways of participation, while the occupational identity was being developed and refined, there was also a reclaiming of roles or acquisition of new roles that fed into the occupational identity and this was an ongoing process. For example, Pangol's developing occupational identity as a recovering substance abuser was evidenced by him taking up roles — being a father and a husband — that he had previously neglected.

This finding is congruent with the conceptualisation of identity development as a lifelong process and a response to life stages and situations (Marcia, 1966).

5.4 Conclusion

In this discussion I have shown how recovery from substance abuse was conceptualised and experienced as an occupational transition. I also traced how the occupational transition was linked to the fact that substance abuse was experienced as an occupation with both negative and positive outcomes. This illustrated that there is more to occupation than the traditional conceptualisation that it always promotes health and well-being. Occupation played an important role in the continuing occupational transition of recovery from substance abuse. In this chapter, the occupational transition of recovery has been framed to involve abandoning occupations, modifying occupations and adopting occupations. The built-in changes of occupational identity within the occupational transition have also been shown.

CHAPTER 6

RECOMMENDATIONS, LIMITATIONS AND CONCLUSION

6.1 Study limitations

- The study size was small in terms of sample used, although this is the nature of narrative research. The small size of the study was compensated for by the extensive information generated from in-depth narrative interviews. This study was a mini dissertation completed for degree purposes with a limited scope. There is room for generating greater insights if the scope of the study is enlarged.
- Storytelling is influenced by memory, trust, and the language used. The study sample consisted of men who spoke English or Shona, which means that insights that could be generated from men who speak other languages were missed. However, Shona and English are the most common languages in Harare. In cases where translations were done, the use of member checks helped to safeguard interpretations. Ability to recall might have affected the trustworthiness of the stories shared by the participants. Spending time with my participants to build trust and using settings that I had worked in helped a lot in the sharing of truthful stories. Despite all this, narrators can still lie, exaggerate or add actions to events after they have happened (Plummer, 1995).
- Productive or paid work-related occupations, relationship or caring occupations and spiritual occupations were found to have greater influence in the reconstruction and construction of a positive occupational identity as an outcome of recovery. However, as a mini-thesis, this study didn't fully explore the roles of these occupations; hence, further research into this area would be worthwhile.

6.2 Recommendations

6.2.1 Recommendations to occupational science and occupational therapy

Occupational science is understood to be the new source of scientific power for occupational therapy (Yerxa, 2000), which is geared towards the understanding of human occupation (Clark, 2006).

This study has conceptualised recovery from substance abuse as an occupational transition experienced by individuals and influenced by both personal and environmental factors. Given that substance abuse is a rising global problem, conceptualisation of recovery as an

occupational transition warrants further research in other contexts. There is also need for further exploration of the value of the processes involved in occupational transition.

By framing recovery from substance abuse as an occupational transition, occupational therapists may use this insight to structure their interventions in line with facilitating and sustaining the occupational transition. Since occupational transitions are understood to be influenced by many factors, occupational therapy to aid recovery should also take a holistic approach instead of the traditional skills-deficit approach. Therapy will have to consider how occupation influences recovery and also intervene at the level of factors that affect occupations, including personal, socioeconomic, political and cultural factors.

Quantitative studies with people who have recovered or are in recovery to generate profiles of the occupations they engage in are also recommended.

6.3 Conclusion

In this qualitative narrative inquiry to explore how young adult Zimbabwean men's occupations influenced recovery from substance abuse an interactive and interpretive process was used to produce narratives illustrating how recovery was negotiated through occupation.

The most significant finding from this inquiry was that the occupational nature of the recovery process equated to an occupational transition. This ongoing occupational transition of recovery from substance abuse was facilitated and sustained by occupation in context.

In the occupational transition, the processes of abandoning, modifying and adopting occupations were shown to contribute positively to the manner in which the participants experienced and negotiated recovery. This signalled the need to consider such processes during occupational therapy intervention with substance abusers. The study has highlighted that if recovery is framed as an occupational transition, then those in recovery can be supported to engage and participate in occupations to promote the occupational transition from substance abuse to recovery.

Appendix A

Information Letter

Dear Participant

My name is Clement Nhunzvi; I am a student at the University of Cape Town, South Africa. I am doing a research study as part of my Masters in Occupational Therapy degree.

The title of this research study is “**AN OCCUPATIONAL PERSPECTIVE ON THE JOURNEY OF RECOVERY FROM SUBSTANCE ABUSE AMONG YOUNG ADULT ZIMBABWEAN MEN**”. An occupational perspective refers to a view of what people do in their everyday lives in terms of what is meaningful for the person and within the culture that they find themselves. This study is important because it will help people to understand substance abuse recovery from the viewpoint of the person who is recovering or has recovered.

The purpose of this study is to build insight into the choosing and doing of daily activities among participants who successfully recover or are in recovery from substance abuse in Harare, Zimbabwe. Study of occupations which aid successful recovery from substance abuse may inform mental health occupational therapy practice in a Zimbabwean context.

Participation in this study is on voluntary basis. If you agree to be part of the study you will be required to give your consent. This means that you understand what is required of you and that you give your permission for the information you provide to be used. You have the right to withdraw from the study at any point, without any negative consequences.

For participation in the study, you will need to attend 3 – 4 one and half to two hour interview sessions during which you will share your story in relation to your recovery journey from substance abuse. The venue for the interview will be decided together with you. No one else but the interviewer will be present.

The entire interview will be tape-recorded and no-one will be identified by name on the tape. Information recorded will be confidentially handled, that is efforts shall be made so that it will not be possible to identify you in particular in the study writings by not including any personal details and using pseudonyms so that you will not be recognisable. Your name will not be used in any reporting of the research unless you would like your real name included. In addition to that, all material collected will be kept in a secure location either at University of

Cape Town or University of Zimbabwe, where it shall be held for ten years before being destroyed.

Once the narratives have been completed and written up you will have an opportunity to have a look at it or have it read to you and you will be given the opportunity to make any necessary changes.

There are no major identified risks linked to participating in this study. The risk of psychological distress may arise from being reminded of your past experiences especially when there are depressing events in your recovery story. Others have reported of psychological distress in sharing life stories especially associated with negative life events. Although distress is not expected in narrating successful recovery stories, caution will be taken and referral for help in the form of psychotherapy or other support services will be in place.

A good experience of sharing a life story has been reported by others who have taken part in this kind of research. Benefits included greater meaning to life, greater self-knowledge, a stronger self-image and self-esteem.

All your transport costs will be covered during interview sessions (R100.00 maximum reimbursable per session).

Any questions that you have will be answered by the researcher in person or via telephone. The researcher and supervisors can be contacted on:

The Researcher	Supervisor 1	Supervisor 2
<p><u>Clement Nhunzvi</u> University of Zimbabwe College of Health Sciences Department of Rehabilitation Private Bag A198, Avondale Harare. Cell: <u>+263775814587</u> or <u>+27839732104</u></p>	<p><u>A/Professor R Galvaan (PhD)</u> Assistant Head: Department of Health and Rehabilitation Sciences Zone F45, University of Cape Town. Old Main Building. Groote Schuur Hospital, Observatory 7925 Tel: <u>+27 21 406 6042</u></p>	<p><u>Liesl Peters</u> Senior Clinical Educator Division of Occupational Therapy Department of Health and Rehabilitation Sciences. University of Cape Town Tel: <u>+27 21 406 6404</u></p>

You can also contact the Chair of the Human Research Ethics Committee:

Professor M. Blockman

Health Sciences Faculty

Human Research Ethics Committee

Room E52-24. Groote Schuur Hospital. Old Main Building.

Observatory 7925, University of Cape Town. South Africa.

Tel: +27 21 406 6338 OR

Medical Research Council of Zimbabwe, Josiah Tongogara/ Mazoe Street. P O Box CY 573, Causeway, Harare. Tel: 791792/791193. Email: mrcz@mrcz.org.zw.

If you agree to participate in this study please fill in the following consent form.

Appendix B

CONSENT FORM

I agree to participate in the research study “**AN OCCUPATIONAL PERSPECTIVE ON THE JOURNEY OF RECOVERY FROM SUBSTANCE ABUSE AMONG YOUNG ADULT ZIMBABWEAN MEN.**”

I have read and understood the information sheet and understand my rights as a participant and what is required of me to participate in this study. The study has also been explained to me verbally by the researcher. I understand that my name will not be used in any reporting of the research. I have had all my questions answered.

Name in Print: _____

Signed: _____

Date: _____

Appendix C

Interview Questions Guide

Study title: AN OCCUPATIONAL PERSPECTIVE ON THE JOURNEY OF RECOVERY FROM SUBSTANCE ABUSE AMONG YOUNG ADULT ZIMBABWEAN MEN

Time of interview:

Date:

Place:

Main question: Tell me about your story of recovering from substance abuse?

Guide questions

1. What was happening just before you decided to join recovery?
2. What was happening then during the recovery process?
3. Tell me about what used to be your routine during the time you were abusing drugs or alcohol?
4. What has changed during your recovery and how has it changed?
5. How has what you have been doing contributed to your experience of your recovery?
6. How do you view yourself or viewed by others with reference to what you have done in your life?

Conclusion: Can you tell me how you felt telling me about your life story?

Thank you.

Appendix D

Information letter (Shona Version)

Mudikani Participant

Zita rangu ndinonzi Clement Nhunzvi; Ndiri mudzidzi kuUniversity of Cape Town muSouth Africa. Ndirikuita tsvakiridzo dhoma sechikamu cheMasters yangu muOccupational Therapy dhigiri. Musoro we ino tsvagiridzo dhoma i **“AN OCCUPATIONAL PERSPECTIVE ON THE JOURNEY OF RECOVERY FROM SUBSTANCE ABUSE AMONG YOUNG ADULT ZIMBABWEAN MEN”**.

Rino dhoma rakakosha nekuti richabatsira vanhu kunzwisisa kupora kana kuona kunoita varwere vezvinodhaka zvichibva mumaonero nemanzwisiro evari munzira yekupora kana vakapora. Chinangwa cherino dhoma kuvaka zivo yezvitwa zvezuva nezuva zvakabatsiridza vakakwanisa kukunda kana varikukuda dambudziko rechirwere chekushandisa zvinodhaka pavarume vechidiki muHarare muZimbabwe.

Zvichabuda mutsvakiridzo ino zvinotarirwa kubatsiridza mufundo yeoccupational sayenzi uye hwaro hwemashandiro angaitwa muoccupational therapy. Kuongorora mabasa amazuva ose anobatsiridza pakupora kwevarwere vezvinodhaka kunogonawo kupa zivo mukushanda nekurapwa kwevarwere vepfungwa munyika yeZimbabwe.

Kuva chikamu cheino tsvakiridzo kunobva pakuzvipira kwenyu zvisina kusungirwa. Kana mazvipira kupinda mutsvakiridzo ino, muchakumbira kuipa bvumiro yenyu muchinyorwa. Zvichibva pakuti munonzwisisa zvichadiva kubva kwamuri uye mashandisirwo achaitwa zvamuchataura. Muchinge musisawirirane nezvinenge zvoitika, ikodzero yenyu kubuda mutsvakiridzo ino pasina chakaipa chingaitika kwamuri.

Mukuva chikamu cheino tsvakiridzo, muchakumbirwa kuzvipa panguva yemibvunzvo kwehour nechidimbu kusvika mahour maviri katatu kana kana, apo muchapa nyaya yehupenyu hwenyu yererano nekupora kubva mudambudziko rekushandisa zvinodhaka zvakapfurikidza mwero. Pachaitirwa hurukuro idzi pachasarudzwa muwirirano nemi. Ini nemi chete ndisu tichange tiripo pahurukuro idzi, kusiya kwekunge imi muine wenyu wamungada kuti avepo

Hurukuro dzedu dzose dzichange dzichitapwa parekodha. Tepu yecho ichazochengetedzwa pasina kushandiswa mazita kana mimwe minongedzo ungabudisa kuti ndiani akataura muhurukuro yacho. Muchapiwa mukana wekuteerera zvinenge zvarekodhwa uye kuverenga kana kuverengerwa zvichanyorwa kubvamo. Izvi zvichaitwa muine mukana wekugadzirisa pamunofunga kuti panoda kugadziriswa. Muzvonyora zveino tsvakiridzo, zitarenyu harizi kuzoshandiswa kusara kwekunge imi makumbira kuti zvidaro. Hakuna chakaipa chinofungirwa kana kutarisirwa kuitika kwamuri mutsvakiridzo ino.

Zvose zvingadiwa pamari yekufambisa musi wehurukuro yega yega muchazvibhadharirwa nemari isingadariki zana rimwe remaRands (R100.00). Vamwevo vakambopinda mutsvakiridzo dzakaita seino, vanoti zvakasimudzira kuzviziva nekuzvikoshesa kwavo.

Chero mibvunzo yamungava nayo inogona kupindurwa pameso kana panhare nemutsakiridzi kana vano supavhaiza pamanzvimbo nenhare dzinotevera:

The Researcher	Supervisor 1	Supervisor 2
<p><u>Clement Nhunzi</u> University of Zimbabwe College of Health Sciences Department of Rehabilitation Private Bag A198, Avondale Harare. Cell: <u>+263775814587</u> or <u>+27839732104</u></p>	<p><u>A/Professor R Galvaan (PhD)</u> Assistant Head: Department of Health and Rehabilitation Sciences Zone F45, University of Cape Town. Old Main Building. Groote Schuur Hospital, Observatory 7925 Tel: <u>+27 21 406 6042</u></p>	<p><u>Liesl Peters</u> Senior Clinical Educator Division of Occupational Therapy Department of Health and Rehabilitation Sciences. University of Cape Town Tel: <u>+27 21 406 6261</u></p>

Munogona kubata sachigaro weHuman Research Ethics Committee:

Professor M. Blockman

Health Sciences Faculty
 Human Research Ethics Committee
 Room E52-24. Groote Schuur Hospital. Old Main Building.
 Observatory 7925, University of Cape Town. South Africa.
 Tel: +27 21 406 6338 OR

Medical Research Council of Zimbabwe, Josiah Tongogara/ Mazoe Street. P O Box CY 573, Causeway, Harare. Tel: 791792/791193. Email: mrcz@mrcz.org.zw.

Kana matenderana nekuva chikamu cheino tsvakiridzo, munokumbirwa kuzviratidza nekusaina fomu rebvumirano rinotevera.

Appendix E

Consent form (Shona version)

Ini ndinobvumirana nekuva mutsvakiridzo inonzi “**AN OCCUPATIONAL PERSPECTIVE ON THE JOURNEY OF RECOVERY FROM SUBSTANCE ABUSE AMONG YOUNG ADULT ZIMBABWEAN MEN**”.

Ndanzwisisa zvinodiva kubva kwandiri uye kodzero dzangu mukuitwa kweiyi tsvakiridzo. Tsvakiridzo iyi yatsanangurwa kwandiri, ndaverenga kana kuverengerwa nezvayo. Ndinonzwisawo zvekare kuti zita rangu remazvo harisi kuzoshandiswa neipi nzira mukunyora kwezvichabuda ndichinge ndisingade kuti zvidaro. Mibvunzo yangu yose yapindurwa zvandigutsa.

Zita rangu ndi:.....

Siginecha:.....

Zuva:.....

Appendix F

Interview questions guide (Shona version)

Bepa remibvunzo yehurukuro

Zita retsvakiridzo: “AN OCCUPATIONAL PERSPECTIVE ON THE JOURNEY OF RECOVERY FROM SUBSTANCE ABUSE AMONG YOUNG ADULT ZIMBABWEAN MEN”.

Nguva yehurukuro:

Zuva rehurukuro:

Nzvimbo yehurukuro:

Mubvunzo mukuru: Ndiudzeiwo nyaya yekupora/kupona/kurikavha kubva mudambudziko rekushandisa zvinodhaka?

Mibvunzo yehungamiro

1. Zvii zvaitika pamakange musati mapinda murwendo rwekupora/kupona/kurikavha?
2. Ko zvii zvaitika pamakange motora matanho ekusiya zvinodhaka?
3. Ndiudzeiwo nezvemaitiro ezuva nezuva panguva yamaishandisa zvinodhaka?
4. Zvii zvakachinja mukupora kwenyu uye zvakachinja sei?
5. Zvamanga muchiita parwendo rwekupora zvabatsira sei pakunzwa kupora/kukunda?
6. Imi munozviona sei/saani uye vamwe vanokuonai sei/saani maringe nezvamaita muupenyu hwenyu?

Pfigiso: Manzwa sei muchindiudza kana nekutaura nezvenyaya yehupenyu hwenyu?

Ndinoteda

Appendix G

Substance abuse screening questionnaire (adapted from DSM-IV)

Did your previous pattern of substance use lead to one or more of the following, occurring within a 12 month period?

1. Recurrent substance use resulting in a failure to fulfil major role obligations at work, school, or home. (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)
2. Recurrent substance use in situations in which it is physically hazardous, (e.g., driving an automobile or operating a machine when impaired by substance use)
3. Recurrent substance-related legal problems, (e.g., arrests for substance-related disorderly conduct)
4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance, (e.g., arguments with spouse about consequences of intoxication, physical fights)

Appendix H

Substance abuse screening questionnaire (adapted from DSM-IV) (Shona).

Munguva yenyu yekushandisa zvinodhaka, makambosanganawo here nezvimwe zvezvinotevera mukati menguva yemwedzi gumi nemiviri?

1. Kutadza kuzadzikisa zvinotarisirwa kubva kwamuri pabasa, kuchikoro kana kumba zvichibva pakushandisa kwenyu zvinodhaka.
2. Kushandiswa zvinodhaka muzvimbo dzine mikana yenjodzi, sekuchaira motokari makadhakwa.
3. Kutya mitemo nemhosva dzine chekuita nezvinodhaka.
4. Kuenderera mberi nekushandisa zvinodhaka zvisineyi nematambudziko ehupenyu aikonzwerwa kana kuwedzerwa nekushandisa zvinodhaka izvi.

Appendix I

Proposed Budget for the study

Financial Category	Estimated Amount Required in Rands	Estimated Amount in US\$	Stage when funding is required
1. Research data gathering <ul style="list-style-type: none"> • Transcribing of interview audio recordings 	R18 000,00 (R45 per min x 400 min)	\$1 914, 90	Data Collection, Analysis and
2. Research Materials and Supplies <ul style="list-style-type: none"> • Printing of proposal; information sheets, interview guides, thesis and binding of thesis • Call costs and emails when communicating with research sites, participants and supervisors 	R2 530, 00 R1 800, 00	\$269, 15 \$191, 50	On going
3. Research Equipment <ul style="list-style-type: none"> • Tape recorder and accessories for data gathering (interviews) 	R2 000, 00	\$212, 80	Data Collection and Analysis
4. Participants <ul style="list-style-type: none"> • Transport costs for participants to and from interview venues • Lunch for participants on interview days 	R500, 00 R800, 00	\$53, 20 \$85, 10	Data Collection and Analysis
5. Researcher Travel Expenses To and from study centres for ethical clearance, recruiting participants, interview venues and to the participants homes for member checking	R700, 00	\$74, 50	On going
6. Final thesis submission fee	R1 000, 00	\$106, 40	On submission
<u>Total Budget</u>	R27 330, 00	\$2 907, 40	

Appendix J

Ethics Approval UCT HREC

UNIVERSITY OF CAPE TOWN



Faculty of Health Sciences
Faculty of Health Sciences Human Research Ethics Committee
Room E52-24 Groote Schuur Hospital Old Main Building
Observatory 7925
Telephone [021] 406 6338 • Facsimile [021] 406 6411
e-mail: sumayah.ariiefdien@uct.ac.za
www.health.uct.ac.za/research/humanethics/forms

11 March 2013

HREC REF: 061/2013

Mr C Nhunzvi
c/o A/Prof R Galvaan
Health & Rehab
OM3

Dear Mr Nhunzvi

PROJECT TITLE: AN OCCUPATIONAL PERSPECTIVE ON THE JOURNEY OF RECOVERY FROM SUBSTANCE ABUSE AMONG YOUNG ADULT ZIMBABWEAN MEN

Thank you for addressing the issues raised Human Research Ethics Committee.

It is a pleasure to inform you that the HREC has **formally approved** the above mentioned study.

Approval is granted for one year till the 15 March 2014.

Please submit a progress form, using the standardised Annual Report Form, if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please quote the REC. REF in all your correspondence.

Yours sincerely

PROFESSOR M BLOCKMAN
CHAIRPERSON, HSF HUMAN ETHICS

Federal Wide Assurance Number: FWA00001637.
Institutional Review Board (IRB) number: IRB00001938

sAriiefdien

Appendix K

Harare Hospital Approval Letter

Telephone: 621100-19
Fax: 621157



Reference:

HARARE CENTRAL HOSPITAL
P. O. Box 5T 14

SOUTHERTON

Harare

09 May 2013

Mr. Clement Nhunzvi
University of Cape Town
College of Health Sciences
Department of Rehabilitation

Dear Clement,

REF: AN OCCUPATIONAL PERSPECTIVE ON THE JOURNEY OF RECOVERY FROM SUBSTANCE ABUSE AMONG YOUNG ADULT ZIMBABWEAN MAN

I am glad to advise you that your application to conduct a study entitled: **An Occupational Perspective On The Journey Of Recovery From Substance Abuse Among Young Adult Zimbabwean Man**, has been approved by the Harare Hospital Ethics committee.

You are advised to avail the results of your study whether positive or negative to the hospital through the committee for our information.

Yours sincerely,

DR. C. B. SITHI
P. O. Box 5T 14, SOUTHERTON
HARARE
Chairman Harare Central Hospital Ethics Committee

Appendix L

Medical Research Council of Zimbabwe Approval Letter

Telephone: 791792/791193/792747
Telefax: (263) - 4 - 790715
E-mail: mrcz@mrcz.org.zw
Website:- www.mrcz.org.zw



Medical Research Council of Zimbabwe
Josiah Tongogara / Mazoe Street
P. O. Box CY 573
Causeway
Harare

APPROVAL

Ref: MRCZ/B/500

03 June, 2013

Clement Nhunzvi
University of Cape Town
School of Health and Rehabilitation Sciences
F45 old main building
Groote Schuur Hospital
Cape Town

RE: AN OCCUPATIONAL PERSPECTIVE ON THE JOURNEY OF RECOVERY FROM SUBSTANCE ABUSE AMONG YOUNG ADULT ZIMBABWEAN MEN.

Thank you for the above titled proposal that you submitted to the Medical Research Council of Zimbabwe (MRCZ) for review. Please be advised that the Medical Research Council of Zimbabwe has **reviewed** and **approved** your application to conduct the above titled study. This is based on the following documents that were submitted to the MRCZ for review.

- Research proposal and summary
- Informed Consent Form (English and Shona)
- Interview questions guide (English and Shona)
- Substance abuse screening questionnaire (English and Shona)
- Recruitment advert (English and Shona)

- **APPROVAL NUMBER** : MRCZ/B/500
This number should be used on all correspondence, consent forms and documents as appropriate.
- **APPROVAL DATE** : 03 June 2013
- **TYPE OF MEETING** : Expedited
- **EXPIRATION DATE** : 02 June 2014

After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the MRCZ website or our website should be submitted three months before the expiration date for continuing review.

- **SERIOUS ADVERSE EVENT REPORTING:** All serious problems having to do with subject safety must be reported to the Institutional Ethical Review Committee (IERC) as well as the MRCZ within 3 working days using standard forms obtainable from the MRCZ website: www.mrcz.org.zw
- **MODIFICATIONS:** Prior MRCZ and IERC approval using standard forms obtainable from the MRCZ website is required before implementing any changes in the Protocol (including changes in the consent documents).
- **TERMINATION OF STUDY:** On termination of a study, a report has to be submitted to the MRCZ using standard forms obtainable from the MRCZ website.
- **QUESTIONS:** Please contact the MRCZ on Telephone No. (04) 791792, 791193 or by e-mail on mrc.zimbabwe@yahoo.com or mrcz@mrcz.org.zw

Other:

- Please be reminded to send in copies of your final research results for our records as well as for the Health Research Database
- You are also encouraged to submit electronic copies of your publications in peer-reviewed journals that may emanate from this study.

Yours Faithfully

MRCZ SECRETARIAT
FOR CHAIRPERSON
MEDICAL RESEARCH COUNCIL OF ZIMBABWE



PROMOTING THE ETHICAL CONDUCT OF HEALTH RESEARCH

Appendix M

Study Advert

Study Title: “AN OCCUPATIONAL PERSPECTIVE ON THE JOURNEY OF RECOVERY FROM SUBSTANCE ABUSE AMONG YOUNG ADULT ZIMBABWEAN MEN”.

Did you recover from substance (alcohol or drug) abuse with or without treatment or professional help? A researcher at the Health Sciences Faculty of the University of Cape Town is interested in interviewing anyone who has a minimum of two years of recovery. If you are such a person, I believe you can provide me and the mental health field with valuable information that could help improve existing treatments for solving problems of alcohol and other drug use. Total confidentiality is guaranteed.

If you are such a person and interested in participating, you can leave your contact details with the principal researcher (Mr Clement Nhunzvi) in the therapist's office, occupational therapy psychiatry department at Harare hospital psychiatry unit. Alternatively you can contact me on 0775 814 587.

Thank you.

Appendix N

Study Advert (Shona)

Musoro wetsvakiridzo: “AN OCCUPATIONAL PERSPECTIVE ON THE JOURNEY OF RECOVERY FROM SUBSTANCE ABUSE AMONG YOUNG ADULT ZIMBABWEAN MEN”.

Munozviona makapora kubva padambudziko rekushandisa zvinodhaka zvakadarikidza mwero here? Zvichida nekurapwa kana pasina robatsiro kubva kune waka dzidzira basa reutano.

Pane mutsvakiridzi wepa University of Cape Town anodawo kuita hurukuro nevaya vakakwanisa kusiya zvinodhaka kwemakore maviri kana kudarika. Ndinokutenda kwekuti nhau yemafambiro amakaita mukusiya zvinodhaka nekushandura hupenyu hwenyu inezvinobatsira pakurapwa kweiri dambudziko muruzhinji. Kodzero dzenyu mune zvetsvakiridzo dzinenge dzichikosheswa zvakanyanya.

Kana muri uyo arikutsvakwa uye muchida kuva chikamu cheino tsvakiridzo, siyirai mui weino tsvakiridzo (Clement Nhunzvi) nhare dzenyu kana dzira yamungada kubatwa nayo. Munondiwana muhofisi yaoccupational therapist wepa Harare hospital Psychiatry Unit. Munokwanisa kundiridzira runhare panhamba dzinoti 0775 814 587 kana muchikwanisa.

Ndatenda

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