THE NARRATIVE ACCOUNTS OF RECOVERING DRUG USERS

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Declaration

The work contained in this document has not been submitted previously as part of any other degree. The work produced is my own unless otherwise indicated. Any research contained in this work, which is not my own, has been referenced and cited accordingly.

Signature:_____ Date:_____

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Abstract

This study aims to provide pertinent information regarding the widespread use of methamphetamine occurring in South Africa. This study explores how individuals who were addicted to crystal methamphetamine (CM) create meaning of their experiences of addiction and recovery. Since most studies regarding CM use provide a quantitative focus this study provides a socially and culturally informed account of the subjective experiences of CM addiction. The researcher obtained access to a community-based organisation for recovering addicts and the snowball method of sampling was used to recruit 11 research participants. Participants were interviewed about their experiences of recovery and ethnographic field notes were written about the researcher's observations of and participation in the support group. The data were analysed using a narrative approach. This study adds to the current literature in the field of addiction. It particularly found that religion plays in integral role in assisting those recovering from the use of CM. The findings suggest that the experience of addiction and recovery is unique and that it occurs within a particular context that is continually evolving.

Key concepts: crystal methamphetamine (CM), narrative, identity, meaning, stories, religion.

CHAPTER 1: INTRODUCTION

1.1 Background

Substance use and abuse is an international phenomenon that has reached epidemic proportions. Substances (whether illegal or legal) are easily accessible. There are a number of illegal drugs that have become popular, such as marijuana, heroin and cocaine. The drug that has found popularity in South Africa, and specifically in Cape Town, is crystal methamphetamine (*CM*), which is commonly known as 'tik' in this country. Given the unique cultural and social influences in Cape Town, it appears that the use of this drug is associated with social problems, such as gangsterism and violence. The use of this drug by local gang members thus further exacerbates this pandemic (Legget, 2003; Science in Africa, 2005). Gang members were found to use the drug to assist them in staying awake for prolonged periods. It enables them to remain alert and prepared in the case of gang warfare. Broader social issues, including unemployment and poverty, were also found to be associated with the prevalence of gangs and associated drug abuse.

The South African Community Epidemiology Network of Drug Abuse (SACENDU) was established in 1996 by a joint initiative between the Medical Research Council (MRC) and the University of Natal (Broman, 2007). SACENDU is a network of researchers and professionals who study drug abuse trends by establishing a system to monitor the use of alcohol and other drugs (AOD) every six months. They are operational in all of the nine provinces in South Africa. They found that methamphetamine remains the primary substance of abuse for treatment centres in Cape Town in 2008 (Plüddemann, Parry, Bhana, Dada & Fourie, 2009).

Barlow and Durand (2005) reveal that the effects of using *CM* include behavioural effects (agitation, increased speech and panic), physical effects (loss of weight and appetite), psychological effects (impaired judgement) and neuropsychological effects (changes in the structure of the brain). Allies-Husselman (2007) looked at one community's response to this growing epidemic in the Western Cape: the article produced highlighted the growing discontent among the members of the Bonteheuwel community, who took to the streets in protest against known drug dealers. Similarly, Kassiem (2008) examined the impact of *CM* use on mothers who had used the drug for a prolonged period and how this affected their

children. It was found that the effects of *tik* have reached such proportions that even teachers at schools are battling to educate learners who are affected at birth by mothers who used the drug while pregnant. This article further reveals that learners born to mothers who use *CM* during pregnancy display symptoms that are similar to Foetal Alcohol Spectrum Disorder (FASD). These children were found to experience learning difficulties and behavioural problems.

1.2 Definitions of key terms

'Addiction' is a label applied by an outsider who is looking at and observing certain behaviour with the goal of identifying either cause or effect. Accordingly, the academic discourse offered by available research is based on the definition of substance dependence and substance use, popularly referred to as 'addiction' contained in the Diagnostic Statistical Manual for Mental Disorders (DSM-IV-TR) (American Psychiatric Association, 2000).

According to the DSM definitions substance dependence is defined by a pattern of substance use that leads to clinically significant impairment or distress. It is manifested by 3 (or more) of the following symptoms of dependence occurring at any time in the same 12-month period. Firstly, these symptoms include the display of behaviour as indicated by a level of tolerance as defined by either a need for an increased amount of the substance in order to achieve intoxication or the desired effect or the display of markedly diminished effect with the continued use of the same amount of the substance. Secondly, the user displays dependence on a substance and displays symptoms of withdrawal when the substance is used to relieve or avoid the experience of withdrawal symptoms. Thirdly, the substance is taken in larger amounts and over a longer period than intended. Fourthly the user displays symptoms of dependence when he or she is unsuccessful in their attempt to control or cut down the use of the substance. Fifthly, the user spends a great deal of time on acquiring the substance and using the substance. Sixthly, the user gives up or limits important social, recreational and occupational functions. Lastly, the user continues to use the substance despite the knowledge of physical or psychological distress that is known to be related to the continued use of the substance.

On a similar note the DSM defines substance abuse as a pattern of substance use that leads to clinically significant impairment or distress occurring in the same 12-month period. These are indicated by three of the following: Firstly, the recurrent substance use results in the failure to fulfil major role obligations. Secondly, the user continues to use the substance in physically hazardous situations. Thirdly, the user encounters numerous legal problems. Lastly, the user continues to use the substance despite persistent social and interpersonal problems.

As these definitions show, the effects of prolonged use of a substance effects the users social, occupational and interpersonal functioning. Therefore the effects are not limited to the user alone. Rather the family, friends and colleagues of the user of a substance suffer the effects of the persistent use of the substance too.

1.3 Studies on addiction

Addiction studies focuses on the effects of the prolonged use of the drug on the lives of the users. Scholars have particularly focused on identifying trends related to the pattern of drug use in the Western Cape (Myers, Louw & Fakier, 2007). However addiction studies have shown that methamphetamine addiction is not only a South African phenomenon but an international one too. Methamphetamine abuse has become a more widespread problem internationally, not only because of the physical and psychological effects of its prolonged use but also because of its association with violent and sexually risky behaviour (Pinhey & Wells, 2007; Sommers & Baskin, 2006). These have detrimental consequences for the transmission of HIV/AIDS.

Past research looks at the aetiology (cause) of addiction and the specific effect of the use of a substance for the user. These studies focus specifically on identifying the biological, psychological and social causes of addiction (Barlow & Durand, 2005; Hart et al., 2008). In addition it identifies those variables that play an integral role in the development of an addiction. These theories of addiction lead us to believe that there are forces beyond the control of the user at play. As a result the user is relinquished of taking responsibility for their addictive behaviour. However, in contrast to these views researchers have found that the nature of addiction is more complex than these theories would like us to believe. An alternative view of addiction is offered that considers the role of risk factors that make an

individual vulnerable for the development of an addiction (Anderson and Mott, 1998). In addition, further studies reveal the role of protective factors, such as religion, in preventing the individual from using a substance (Moiseeva and Pozniakova, 2009; Vanderheyden, 1999; Wills, Yaeger & Sandy, 2003). These studies bring to light the controversy inherent in the field of addiction that ultimately questions the role of autonomy in the addiction process (Allamani, 2007).

1.4 Rationale

A combination of personal and statistical factors motivated the researcher to conduct this study. As a recovering drug user, I have struggled to reconcile conflicting roles and identities throughout my own journey from addiction to abstinence and recovery. As a student pursuing a tertiary education, I have struggled to incorporate the addict identity into my self-concept. Many attempts were made on my part, to hide my history of addiction from others, because of the shame attached to these experiences. In writing this thesis, I am also attempting to reconcile this past with my current self-concept as a student and academic. As a result, I have chosen this topic not only with the goal of contributing to studies within the field of addiction but also as part of my own healing process.

A combination of the above-mentioned factors including the pattern of substance use, the increased occurrence of criminal activity, related to the increased use of drugs and the growing rate of children suffering with FAS is a cause for concern. In addition, the fact that *CM* is the primary substance of use in the Western Cape has resulted in the increased demand for treatment centres in Cape Town. Statistics South Africa (2005) (as cited in Myers et al., 2007) revealed that 300 000 individuals require treatment for substance-related problems. In addition Dewing et al. (2006) (as cited in Myers et al., 2007) found the proposed number to be inaccurate since there are 15 000 heroine users alone in Cape Town. As a result a growing concern relates to those substance users who do not access treatment and those who are unable to access formal treatment facilities. These substance users are then left to face their addiction themselves. As a result some users continue to use the substance and others might consider alternative treatment options.

The statistical information regarding substance use informs us of the extent of this alarming problem in the Western Cape. However, it does not account for the experiences of the addiction, especially from the perspective of the user. This study aims to fill this gap in current literature by looking at the stories of addiction from the perspective of the user.

1.5 Research question

The key research question emerging from the literature and guiding this study can be articulated as follows:

> How do recovering drug addicts involved in a community-based support organisation, create meaning of their stories of addiction and recovery?

Secondary areas of concern:

- I aim to analyse the participant's narratives of addiction and recovery.
- I aim to explore how narratives are shaped by specific religious contexts.

1.6 The use of narrative in research

A turn to narrative is explored within the context of Alcoholics Anonymous (AA). AA is a self-help that uses the 12-step model to overcome addiction (Davis & Jansen, 1998). It is popularly successful as an alternative treatment option for those living with an addiction to alcohol. This group offers users the opportunity to offer each other support during the process of recovery. However the study previously mentioned exposes the conflict inherent in this group as it is criticised for transferring the dependence from a chemical substance to a group of people. It furthermore exposes the controversy surrounding the effectiveness of this 12-step philosophy in the treatment of drug addiction.

Recent literature has sought the awareness of the need to focus on the experience of addiction (Ajodah, 2008; Etherington, 2006; Hanninen & Koski-Jannes, 1999; Van der Westhuizen, 2007). Unlike the theories of addiction these studies do not focus on identifying cause and effect. Rather they look at the social and cultural resources drawn upon in creating meaning of the stories of addiction from the perspective of the user. Gaining a first-hand account of

the experiences of addiction assists us to understand the processes involved in addiction. These studies found that there is more than one way to understand addiction. Rather each user experiences the addiction process as unique within the context of their lives at a specific point in time. The manner in which the user constructs their experiences of addiction is revealed to provide meaning to the lives of the users.

This study is in line with past research as it seeks to understand the experiences of addiction and recovery by studying the narratives of recovering drug addicts. The need for qualitative research in this regard has motivated the present study. This enquiry is conducted to gain insight into the processes involved in addiction and recovery and the cultural and social resources drawn upon in making sense of otherwise chaotic stories.

Conducted in the South African context, it focuses on substance users that attend a community-based organisation located on the Cape Flats. This community is characterised by an increased level of unemployment, gang violence and substance use. Users draw on the support of a support networking, community-based organisation in creating meaning of their stories of addiction. This organisation provides substance users with an alternative treatment option. Consequently, this study offers a qualitative focus that reveals the role of a religious organisation, which users draw upon in making sense of their experiences of addiction and recovery.

1.7 Thesis structure

This chapter provided a background understanding of the growing phenomenon of *CM* addiction in the Western Cape. It offered a summary of the literature within the field of addiction. By looking at past research it argued for the relevance of this study by looking at how this study would contribute to the field of addiction studies. It concluded with the research question that guides the topic under investigation. Chapter Two provides an in-depth look at the literature that was briefly discussed here. Chapter Three looks the specific methodology employed in conducting this study. Chapter Four, Chapter Five and Chapter Six presents the analysis of the research data. Chapter Seven outlines the conclusion and visions for future research within the field of addiction.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter firstly considers the origin and effects of the prolonged use of the drug on the user. This is followed by a look at the trends inherent in the use of *CM*, the race and gender of *CM* users, and the factors intersecting with the use of the drug. In addition, particular views of addiction are considered. These include the biological, psychological and social theories of addiction. Consideration is given to alternative explanations of addiction with a particular focus on risk and protective factors. Furthermore, the role of Alcoholics Anonymous and Narcotics Anonymous and studies that focus on the experience of drug users are further considered. This literature review ultimately exposes some of the gaps in past studies, in that they fail to take account of the personal and subjective experiences of drug users.

2.2 Introduction to methamphetamine

Methamphetamine was developed in the early twentieth century from amphetamine (Doweiko, 1993; Watanabe-Galloway et al., 2009). It was used during World War II to combat fatigue and increase endurance. It was later used medically for treating nasal decongestion and attention deficit hyperactivity disorder (ADHD).

Methamphetamine is a stimulant, which falls into the class of drugs known as amphetamines (Barlow & Durand, 2005). This drug may be ingested by many means. Methods of ingestion include smoking the drug, snorting it, injecting it and ingesting it anally. It has many names, but on the Cape Flats, it is commonly known by the street name *'tik'*. It is most popularly smoked out of a light bulb, when the fumes are inhaled through a straw. Similarly, it is also smoked out of a glass pipe, similar to those used in laboratories, in which case it is referred to as a *'lolly'* (as revealed in this study). Once the drug has been purchased, the crystal form of the substance is placed inside the bulb or glass pipe. It is heated with a lighter, which then produces fumes that are inhaled through the straw, resulting in an immediate feeling of euphoria (Science in Africa, 2005). The user may also use multiple substances (including alcohol, marijuana, crack, cocaine and ecstasy), especially when the first drug of choice is unavailable (Harker et al., 2008). Other substances (such as alcohol, marijuana, heroine and

mandrax) are used to counteract the effects of the drug in order to come down from the experienced 'high'.

2.2.1 Effects of CM use

The use of *CM* stimulates the central nervous system by enhancing the activity of norepinephrine and dopamine, and it inhibits the reuptake activity of these neurotransmitters (Barlow & Durand, 2005; Koob & Simon, 2009). The use of this drug results in reduced appetite and therefore causes weight loss (Barlow & Durand, 2005; McNeece & DiNitto, 1994; Schlaadt & Shannon, 1994; Watanabe-Galloway et al., 2009). It also causes euphoria, changes in sociability, anxiety and impaired social and occupational functioning. In addition, extensive use of *CM* may cause tremors similar to Parkinson's disease and strokes that cause memory loss (Science in Africa, 2005; Watanabe-Galloway et al., 2009). Furthermore, Myers Parry, Karassellos and Jardine (2006) found that one of the extreme effects of this drug was crystal methamphetamine (MA) -induced psychosis. Symptoms related to this state of psychosis include paranoia, auditory hallucinations, well-informed persecutory delusions and labile or inappropriate affect.

Current literature espouses the view that substance use disorders and chemical addictions have negative effects and outcomes for the individual user (as illustrated above). However, an interesting study conducted by Lende, Leonard, Sterk and Elifson (2007) reveals contrasting findings. Even though the prolonged use of *CM* results in particular negative effects for the user, the drug is also used to assist people in the normal functioning and routine duties of life. Findings reveal, for instance, that many individuals who use methamphetamine enjoy the heightened levels of energy as it assists them to increase their productivity (for instance, it helps specific types of employees, especially those who are employed in the media industry, to work long hours). In addition, it assists individuals with losing weight (in other words, it is used as a quick solution to weight problems), and it helps mothers to manage the multiple, daily tasks for which they are responsible (e.g. taking care of their families, taking care of their children and ensuring that their husband's needs are met). However, *CM* use is a problem, despite these benefits having been identified – the risks outweigh the benefits.

2.2.2 Trends related to the use of CM

Myers et al. (2007) conducted a study that investigated factors influencing access to treatment facilities. They collected information from 989 substance users who had either been in treatment or were unable to access treatment. They found that barriers to treatment determined whether individuals accessed treatment centres. These barriers were related to the admission to treatment centres, affordability and the community perception of treatment centres. In addition Statistics South Africa (2005) (as cited in Myers et al., 2007) revealed that 300 000 individuals require treatment for substance-related problems. However Plüddemann et al. (2006) (as cited in Myers et al., 2007) found that treatment service providers could only accommodate 2 500 to 3 000 individuals per year. As a result these figures highlight the fact that treatment centres are not able to accommodate the large amount of users that require these services.

Methamphetamine is amongst the substances found as primary drugs of abuse in the Western Cape treatment facilities. Findings from research reveal that, from 2004 to 2006, there has been an increase in treatment admissions for *CM* use (Plüddemann, Myers & Parry, 2008b). In the second half of 2008, the treatment admissions for *CM* increased by 35% in proportion to other drugs of choice. In addition, figures reveal that 52% of those who report using tik are now under the age of 20 years (Plüddemann et al., 2009). These figures, coupled with the inability of treatment centres to provide for the needs of substance users, exposes the urgency of dealing with this social epidemic in the Western Cape and South Africa.

2.2.3 Race and gender related to the use of CM

It is indicated that it is mainly the 'coloured'[1] community, especially males, who access treatment for *CM* use in the Western Cape (Harker et al., 2008). However, these findings are not found to be a true representation of those who are actually in treatment or of those who are seeking treatment for *CM*. Myers, Plüddemann and Parry (2004), as cited in Harker et al. (2008), found that the black female population experiences great difficulties in accessing

[1] The term coloured moves beyond perceiving individuals as being of mixed race. Rather it is seen as a cultural identity comprising bodies of knowledge, cultural practices and ceremonies. The coloured identity is a product of subjective realities that are shaped and re-shaped by people under conditions given to them by history that involved slavery, colonialism and cultural dispossession (Erasmus, 2001).

treatment. Other factors that could interfere with the statistics in terms of race and gender are related to the fact that many treatment facilities have reached their capacity. As a result, individuals have to utilise alternative means of treatment for *CM* addiction. Consequently, it is inaccurate to assume that *CM* use is a 'coloured' problem as other races also experience the effects of *CM*. Nonetheless, the statistics, which do indeed reveal that *CM* use exists predominantly within the 'coloured' community, cannot be rejected. It does, after all indicate the extent and nature of *CM* addiction in the Western Cape.

2.2.4 Intersecting factors

The most prominent features inherent in identifying intersecting factors include the focus on the intersection and pattern of alcohol use, the use of drugs and risky sexual behaviour and the detrimental implications for the transmission of HIV/AIDS. Simbayi et al. (2006) (as cited in Harker et al., 2008) revealed that *CM* users are more likely to have exchanged sex for drugs, more likely to have multiple sexual partners and more likely to have unsafe sex. However, there exists much controversy surrounding the relationship between drug use, risky sexual behaviour and the transmission of HIV/AIDS (Broman, 2007; Fergusson, Boden & Horwood, 2008; Shoptaw & Reback, 2007; Wong et al., 2007). Findings reveal that although drug use is related to risky sexual behaviour it is hard to specify the direct effects of drug use on the transmission of HIV/AIDS. Such findings reveal that risk factors are broad and complex, and that the unique contexts need to be considered.

2.3 Explanations for addiction

Barlow and Durand (2005) offer an understanding of the causal explanations for those living with a substance use disorder. No single theory can fully account for the occurrence of addiction. However, if the different theories are considered in conjunction with each other, they may offer a holistic view and understanding of the various mechanisms involved in the development of an addiction. The biological, psychological and social theories will be broadly outlined.

2.3.1The biological model

The most popularised research conducted in the field of addiction is the focus on identifying the pathology (causes) of addictive behaviour. The traditional view of understanding the mechanisms for developing a substance use disorder is concerned with the neurobiological basis of addiction. These studies look at the interplay between the administration of the drug and the biological effects thereof (Hart et al., 2008; Homer et al., 2008; McKetin, Kelly, McLaren & Proudfoot, 2008). These studies found that methamphetamine has significant physical and physiologic effects. Drug users experience physical effects, such as changes in physical appearance and blood pressure, weight loss and muscular weakness, as well as overall negative effects on their general health. In addition, since the drug interferes with the normal functioning of the body's organs, drug users tend to experience illness more frequently often than others do.

There remains much controversy surrounding the interplay between genetics and the role of neurotransmitters in the addiction process (Koob, 2006; Koob & Simon, 2009; Volkow, Fowler, Wang & Goldstein, 2002). Studies found that specific neurotransmitters are implicated in the addiction process; they include dopamine, opioid peptides and Gamma aminobutyric acid (GABA). It was further found that the effects on these neurotransmitters of using *CM* include effects on users' mood, their cognition and their behaviour. Because of impaired cognition, for instance, the user experiences impaired cognitive abilities, such as memory, attention, perception and thinking. Furthermore, these studies conclude that the reward system in the brain mediates behaviour of reward and addiction. It is therefore suggested that anomalies of the brain cause the drug user to participate in compulsive drug-seeking behaviour that is beyond the control of the individual (Homer et al., 2008; Koob & Simon, 2009; Leshner, 2001; McCusker, 2001). This view explains the existence of the uncontrollable urges experienced by the addict (West, 2006). Proponents of the neurological view of addiction thus believe that addiction is a brain disease.

It is further revealed that, in line with the disease model, there exists a genetic predisposition that may be inheritable (Hirschman, 1992; West, 2006). This, coupled with physical dependence, is at the root of the biological view (Hirschman, 1992). This view absolves the user from accepting responsibility for their behaviour and posits that the user does not have a

choice in using the addictive substance.

2.3.2 A psychological theory of addiction

Only considering the biological view of addiction is one-sided and provides a narrow view on the complex processes involved in addiction. Therefore, one has to consider further theories to provide a holistic view of addiction.

The psychological theory of addiction posits that drug use is attributed to the escape of negative feelings, stress, anxiety and the general unpleasantness of life (Barlow & Durand, 2005). In an attempt to escape such feelings, addicts first begin using the drug; the addiction then develops, and leads to an increasing dependence on the feelings of pleasure associated with the use of the drug. The positive reinforcing effects (i.e. the reward of feeling pleasure) of the initial use of this psychoactive substance serve to ensure its continued use (Feltenstein & See, 2008; Gifford & Humphreys, 2007). Conversely, the use of the drug also depends on the attached negative psychological effects experienced when the drug is withheld.

As discussed earlier, pleasure pathways in the brain, which control the experience of reward and punishment, are implicated during the consumption of drug. With prolonged use of the drug, however, a state of tolerance is reached. This has a negative impact on the rewarding experience of using the drug. In other words, the individual who uses the drug for a prolonged period becomes accustomed to the effects of the drug. An increased dosage of the drug is then used to compensate for this. In addition, if the use of the drug is withheld, it results in the experience of negative physiological effects, which further maintain the drug use (negative reinforcement/punishment). Consequently, because of the impact of increasing tolerance on the neurological functioning of the user, the use of the drug is maintained.

Cancrini (1994) and Hirschman (1992) offer an alternate view of addiction. They regard addiction as a disorder of the individual personality structure. Accordingly, the use of drugs is defined as a developmental progression that changes with time and age (Bahr & Hoffman, 2008). Furthermore, certain personality traits may increase the individual's vulnerability for developing a state of dependence on a substance.

2.3.3 The social theory of addiction

The individual who experiences compulsive drug-seeking and drug-taking behaviour may be better understood by accounting for the social environment in which he or she exists. Society attaches certain values and consequences to the label of addiction. In other words, since the effects of using a chemically addictive substance are detrimental for the user (as well as their family, circle of friends, co-workers, and society in general), society views its use as predominantly negative and thus labels the experience as an 'addiction'.

People in society determine what behaviour is socially acceptable and what is not. In most societies, the consumption of alcohol is accepted. We also cannot ignore the fact that society enables and permits the advertising and sale of prescription medications, alcohol and cigarettes. Alcohol consumption forms part of rituals and celebrations and is viewed with minimal condemnation. However, illicit drug use is viewed as negative behaviour that has moral consequences: the addict is viewed as an individual who lacks self-control and the moral fibre to resist the temptation and the lure of drugs (Barlow & Durand, 2005).

Not all individuals who use drugs will become addicts. The social learning theory espouses the belief that the drug use behaviour is learnt through the interaction between the drug user and the environment in which they exist. The particular environment includes other individuals who use drugs, including peers, parents, and any significant role models (Bahr & Hoffman, 2008; Hirschman, 1992). Identification with the drug subculture may result in the development of drug dependence (Hirschman, 1992). During adolescence, individuals may identify themselves with a group of drug users or a drug subculture in order to decrease the experience of negative feelings surrounding particular life experiences (Anderson & Mott, 1998). They then turn to drugs to escape these negative life experiences.

With repeated use, a habitual pattern of use develops, as the individual is motivated by the initial feelings of pleasure (West, 2006). This view is an extension of the instrumental learning theory of punishment and reward, which was discussed earlier. Proponents of this view espouse the belief that the individual is an active participant who consciously chooses their behaviour. As a result they posit that the drug user plays an active role in choosing their drug using behaviour.

2.4 Alternative explanations for addiction

From the discussion above, the controversy related to the understanding of the causes of addiction is evident. Rather than just focusing on the theoretical explanations for addiction, alternative explanations suggest that addiction is more complex than these theories ask us to believe.

2.4.1 Risk factors

Research on risk factors, focus on the mechanisms involved in the development of addiction. Studies reveal that drug misuse begins during early adolescence and that it is accompanied by a sense of marginalisation related to various negative childhood experiences within the family of origin (Anderson & Mott, 1998). These experiences were found to be related to incidences of violence, loss, neglect and household dysfunction (Calafat, Gomez, Juan & Becoña, 2007; Hirschman, 1992; Sullivan & Farrel, 1999). The use of drugs is initiated in an attempt to escape negative feelings associated with these experiences. In addition recent studies explore the origins of addiction and highlight the controversy related to whether childhood trauma, especially physical and sexual abuse, is a precursor to drug use (Cattapan & Grimwade, 2008; Etherington, 2006; Whitfield, 1998). It follows that, the drug is used to counteract the negative feelings associated with such experiences. However, further studies reveal that childhood abuse predicts the continual use of drugs and does not play a role in the initial drug use (Perez, 2000). This controversy has not yet been resolved.

The intergenerational transmission of addiction has been well documented (Cattapan & Grimwade, 2008; Messina et al., 2008). In line with the social learning theory it follows that when a child is exposed to or lives with a parent/s that uses an illicit substance the chances for that child developing an addiction is much higher. Within this environment the normalisation of the drug using behaviour, exposure to the drug and the opportunity for using a drug increases the likelihood that the child will develop an addiction.

Peer pressure is found to be closely related to drug use (Anderson & Mott, 1998). As a result of the negative life experiences previously mentioned the adolescent turns to external agents, especially friends in an attempt to escape. Users learn how to use the drug from more

experienced peers (Doweiko, 1993; Gifford & Humphreys, 2007; Hirschman, 1992; Levinthal, 1996; Schlaadt & Shannon, 1994). In addition Imlah (1970) found that stress may also result in the use of drugs.

Besides risk factors, precipitating factors serve to hasten the addiction to the drug. In this regard, users who have a history of abusing other illicit substances are at further risk for developing an addiction (Brecht, Greenwell & Anglin, 2007; Sheridan, Butler & Wheeler, 2009; Sullivan & Farrel, 1999).

2.4.2 Protective factors

A number of protective factors exist that protect individuals from the use of drugs. Religion is amongst one of these protective factors. Moiseeva and Pozniakova (2009), Vanderheyden (1999) and Wills et al. (2003) explore the role of religion and its impact on substance abuse. These studies reveal the conflict surrounding the effectiveness of religion in combating drug use. One the one hand, religion is applauded for offering individuals protection against the influence of drugs and the drug culture (Wills et al., 2003). On the other hand, religion is criticised for being too rigid and for espousing a negative concept of human beings by viewing the individual as weak, bad and in need of God to be strong. In addition, reliance on an external institution such as religion can be viewed as an attempt to avoid facing up to internal pain. Research in this regard further revealed that religious faith plays a role in preventing the use of drugs in the first place. However there is no conclusive evidence available in support of the role that religion plays in recovering drug addicts abstaining from the use of the drug. In other words religious faith is more effective before the user starts to use the drugs than after he or she has already started using the drug and is trying to stop using the drug.

The nature of the relationship between parent and child acts as a deterrent against the use of drugs. Following this, a relationship between parent and child that is characterised by warmth, trust, understanding, discipline and effective limit setting serve to prohibit the use of drugs (Van der Westhuizen, 2007). School attendance, positive adult and adolescent relationships and family structure acts as additional protective factors from drug use (Sullivan & Farrel, 1999).

2.5 Applying Alcoholics Anonymous to Narcotics Anonymous

Research within the field of addiction is no longer solely concerned with pathology. Instead, a turn to discourse and narrative is evident. The use of narrative is explored within the context of the famous self-help group Alcoholics Anonymous (AA). AA provides a platform for those living with alcohol addiction to offer each other support during recovery. Adherence to this model means participating in the group and working through the 12-step model for recovery.

On the one hand, the AA philosophy is criticised for transferring dependence from a chemically addictive substance to a group. This promotes psychological dependence on the group and does not in fact lead to recovery (Lemanski, 1997). On the other hand, it is applauded for focusing on the use of discourse, metaphors and narrative (Davis & Jansen, 1998). These group meetings provide an opportunity for addicts to make meaning of, negotiate and construct their identity. Davis and Jansen's (1998) study suggests that the NA (Narcotics Anonymous) /AA programmes are misunderstood and that the narrative perspective would provide a unique view to counteract any misunderstandings. They propose that the group meetings should be seen as a platform for participants to tell and re-tell their stories, as they provide coherence, a sense of history and new goals for the future.

The principles of the 12-step model are also applied to the treatment of drug addiction. However, there remains much controversy surrounding the effectiveness of this 12-step philosophy in treating *CM* addiction (Laudet, 2003). Following this, research regarding the effective treatment of NA is far from unified. On the one hand, it is criticised for being ineffective (Lemanski, 1997). For example, Donovan and Wells (2007) further found no conclusive evidence that *CM* addicts using the 12-step approach were cured of their addiction. On the other hand, their evidence in support of these groups is provided by cocaine and alcohol users who both attended and engaged in the 12-step activities, and who are associated with declining substance use and improved outcomes.

The concept of addiction as a disease is visited by other researchers (Moore, 1992). This disease model views addiction as a biologically inherited trait. However, it is argued that we are individuals who live life through stories (Neuhaus, 1993). An alternative view of reality

and practices for language is thus sought to counteract this traditional view of addiction (Neuhaus, 1993). Accordingly, the term 'disease' should not be viewed as something that can be inherited biologically, but it should rather be viewed as a metaphor that offers alternative interpretations. These interpretations should be viewed in the context of the individual's life in order to provide meaning and understanding.

2.6 Experience of drug users

Recent literature focuses on the experiences of addiction from the perspective of drug users (Ajodah, 2008; Etherington, 2006; Hanninen & Koski Jannes, 1999; Van der Westhuizen, 2007). These studies found that there are many ways of experiencing addiction and that there is no single true account for the experience of addiction. In addition, findings suggest the use of social and cultural resources in understanding and making meaning of stories. Furthermore, recurring themes throughout the research reveal the evolving and changing nature of the drug user's identity. These studies reveal that retrospection allows the teller of the story to reconstruct, reconsider and provide a sense of coherence to the story. The paucity of research concerned with the subjective nature of addiction has presented the need for this study.

Van der Westhuizen (2007) explored the experience of chemically dependent adolescents in order to determine their experiences after they had received treatment for addiction. Her qualitative, exploratory and descriptive study looks particularly at the risk factors for relapse, and it provides guidelines for social workers to understand these experiences. Her study reveals that adolescents view parental and social support as positive elements after treatment and prior to relapse. In addition adolescents are of the opinion that the experience of social, parental and emotional problems results in relapse and sobriety after treatment and prior to relapse results in positive feelings. She found that risk factors include the availability of drugs within the community, peer pressure and the need for support to change the lifestyle of the adolescent.

Etherington (2006) presents a single case study utilising the life story approach. She focuses on the impact of the cultural story on the addict's sense of self and identity. Her line of narrative enquiry reveals how early childhood experiences are understood by addicts. It

explores precursors to drug misuse and assesses the forces that enable people to transform their habits and lives. Her findings suggest that cultural stories impact on the individual's sense of self and identity. She thus emphasises the need to educate those who deal with drug users by challenging the idea that one's identity is fixed. Her analysis suggests that listening for stories that carry the potential for pathology, and paying attention to and building upon stories of resistance and resilience, should be incorporated in treatment. This unique study focuses on how societal narratives tend to underscore the negative aspects of users' personal and psychological characteristics without accounting for their life experience, their social, political and economic influences, and their relationship to drug use, all of which affect the sense of self and identity.

Bennet (2004) and Hanninen and Koski-Jannes (1999) further explore narratives of recovering addicts. Their analyses explore how addicts create meaning of and experience addiction. They further revealed particular types of stories of recovery from substance use. Their findings highlight the shifting perceptions of users' experience over time. It further suggests that the issue of agency plays a major role, as individuals themselves decide to stop using the drug. Interestingly, agency shifts throughout the narratives, as it is first placed on the drugs, before it then shifts back to the individual once the decision to stop using drugs has been taken. Stories highlight the progression of experience from a sense of enjoyment when individuals initially start using the drug to becoming increasingly powerless and having no control over their drug use. Retrospection thus allows recovering users to make sense of their experience and to understand the reasons for the initial use of the drug.

A study undertaken by Ajodah (2008) resonates with the current study. This study focused on the experience of *CM* addiction for both recovered addicts and those who are still using the drug. She found that identity is shaped by the use of *CM* and that it evolves with its use. In keeping with this line of enquiry, this study aims to contribute to the understanding of the experience of recovery from *CM* addiction. It acts as an extension of Ajodah (2008), as it explores the experience of addiction within a particular context.

These studies indicate that the experience of addiction is not a static one, but rather shifting and evolving according to the unique context of individuals. They highlight the fact that there are many ways of interpreting the experience of addiction. There are furthermore many ways

of constructing these experiences so that they provide meaning to individuals' lives. Their findings highlight the progressive nature of addiction. The current study will thus add to the existing literature in the field of *CM* addiction by providing detailed information on the cultural and social resources (specifically religion) drawn upon during the journey of recovery and addiction.

2.7 Chapter summary

Based on this assessment of the current literature in the field of methamphetamine and addiction, it is apparent that this study will contribute to the paucity of research on the subjective nature of addiction. In conducting the literature review, it is evident that the proportion of studies concerned with the experience of the drug user is quite limited. Biased assumptions continue to dominate most of the research on drug users, as they focus on quantifying human experiences within the framework of the 'disease' model. Users are not merely statistics or entities to be measured. Instead, users are acknowledged as individuals with unique experiences. By ignoring processes and personal experiences, scholars fail to take the opportunity to contribute to new understanding of drug use. In an attempt to address the above needs, the proposed study will focus on the experiences of drug users. By encouraging people to describe their worlds in their own terms, we can gain an insider perspective into these unique experiences. With this study, I would thus like to expand our understanding of this socially relevant phenomenon. The following chapter will focus on the specific methodology employed in this study in order to answer the research primary research question:

> How do recovering drug users involved in a community-based support organisation create meaning of their stories of addiction and recovery?

CHAPTER 3: METHODOLOGY, ANALYSIS AND ETHICS

3.1 Introduction

This chapter describes the research design employed in conducting this study. In addition, this chapter outlines the approach used to conduct this study, specifically ethnography. The characteristics of participants of this study and the method of data collection are considered. This is followed by a detailed reflexive account of my experiences of collecting data for this study. A discussion of the particular method of data analysis used in conducting this study and the motivation for choosing this particular method of analysis is then presented. This chapter concludes with a detailed account of the ethical implications of this study and offers a brief evaluation of the research design.

3.2 Design

Research design is referred to as the plan or protocol for a particular research piece. It is a plan that is constructed in order to maximize the validity of its findings (Terre Blanche, Durrheim & Painter, 2006). To maximize the validity of the findings consideration is given to the type of study being conducted. In order to gain insight into these subjective accounts, a particular qualitative methodology is employed.

Qualitative approaches study people in their natural settings, utilising their world as the primary source of data to gain an insider's perspective of complex phenomena (Cresswell, 1998; Marshall & Rossman, 1989; Willig, 2001). As a result, the inner realm (the individual) is given a greater authority and is privileged as the research focus. It is thus evident that the focus shifts from the identification of cause and effect to the interpretation of social phenomena (Smith, 2008; Willig, 2001). By shifting the focus from the identification of cause and effect to the subjective experiences one is enabled to gain a socially and culturally informed account of human experiences.

This study follows the qualitative approach specifically ethnography. According to Banister, Burman, Parker, Taylor and Tindall (1994), ethnography is a basic form of social research that involves observing specific phenomena, gathering information from particular

informants and constructing a hypothesis that is based on this information. It focuses on a particular group or culture (Fetterman, 1998). As a result, the researcher offers an insider's perspective and furthermore portrays the routine activities of the particular group under investigation.

Ethnography is deeply rooted in anthropology, from which it has borrowed certain concepts, methods and techniques. Techniques and data collection methods used include ethnographic fieldwork and participant observation (Fetterman, 1998; Kutsche, 1998). *Fieldwork* is a form of data collection that requires the researcher to gain access to a particular group, recruit participants', and gain an emic (insider) perspective of the particular group under investigation. Usually, the researcher negotiates entry into a particular group with the gatekeepers of the group under investigation (Fetterman, 1998; O'Reilly, 2009). In gaining an emic perspective, the researcher observes the norms, language, culture and patterns of the group in the hope of gaining a deeper understanding of said group. Fieldwork, as the name indicates, requires the researcher to be in the field, at the time that they are making observations, in the particular field under investigation (O'Reilly, 2009). In addition, *participant observation* requires the researcher to participate in the group, by both sharing in the experiences of the group and contributing to the group. At the same time, the researcher also has to act as an observer who is able to stand back, make objective observations and critically reflect on the experiences he or she has shared with the group. As a result, the researcher alternates between the emic perspective of an insider and the etic perspective of an external researcher. In recording and making sense of these conflicting perspectives, the researcher presents a reflexive account of his or her actions and decisions (O'Reilly, 2009).

Since ethnography's roots were found in anthropology, they share common concepts related to research design that will be broadly outlined as revealed by Fetterman (1998). Firstly, this design is *contextual* as information was gathered in the natural setting by observing natural everyday patterns of behaviour. Secondly, this design may be described as *holistic*, as it considered the history and religion of the group and the social situation in which the group existed (Fetterman, 1998). Thirdly, this study is *exploratory*, as it provides new insight into the experience of addiction (Marshall & Rossman, 1989). Fourthly, this study is *inductive* in nature, since it required immersion into the details and specifics of the data in order to discover the important dimensions (O' Reilly, 2009). It began with exploring open questions

rather than testing a deductive hypothesis (Terre Blanche, et al., 2006). Fifthly, the researcher sought to understand the *intercultural* (difference between cultures) and *intra-cultural* (difference between sub-cultures in a culture) differences of the group. Lastly, the researcher considered the *social* structure and function of the group (Kutsche, 1998).

Ethnography adheres to the social constructionist paradigm in accepting that representations of reality are merely constructions or interpretations thereof. As a result, the researcher accepts the existence of multiple realities and acknowledges that there is no one objective truth or reality (Fetterman, 1998; Kutsche, 1998). Truth is thus dependent on the meaning that a particular interpretation of reality holds for the teller. There are many methodological concerns related to the use of this approach. These are addressed later in this chapter.

3.3 Selection of participants

In order to gain insight into the subjective experiences of *CM* users the researcher had to recruit participants who personally experienced recovery from *CM* addiction.

3.3.1 Sampling plan

The researcher had personal contacts that were willing to participate in this study. As a result the snowball sampling method was used to recruit participants. In pursuing this method of recruiting participants for this study, I enlisted the involvement of three participants. This method proved viable and resulted in an invite, that was extended to the researcher, to participate in a support networking, community-based organisation located on the Cape Flats. Participation in this group would allow the recruitment of further participants by means of snowball sampling. Upon accepting this invitation, the study evolved into an ethnographic study. Hence, two of the participants who were part of the study did not belong to the group of participants from this organisation, while the majority did. A total of 11 participants were interviewed for this study.

3.3.2 Selection criteria

For participants to participate in this study they had to be over the age of 18 to avoid ethical

implications of conducting research involving minors. In addition the participants had to have been addicted to the use of *CM* for longer than one year. Furthermore they had to have stopped using *CM* for at least six months. This would ensure greater credibility and trustworthiness of their stories of addiction.

3.3.3 Characteristics of respondents

The sample for this study included five male participants and six female participants. Of the female participants, five were also mothers. The age of the participants ranged from 20-35. The average age of the participants was 25. At the date of the interview, only one male participant had completed a tertiary qualification. In addition, another male participant had enrolled at a tertiary institution to further his academic development and three participants expressed a desire to further their education. Furthermore, six participants maintained employment (four males and two females) throughout the study, and during the course of participation in the community-based organisation, three further participants acquired employment (two females and one male).

All of the participants resided in the surrounding areas of Lansdowne, Ottery, Hanover Park, Grassy Park, Belgravia and Southfield. The co-ordinator and creator of the community-based organisation was contacted (although he was not part of the sample), as he supplied useful background information on the establishment of the organisation.

3.4 Data collection

Upon accepting an invitation to attend a support networking, community-based organisation from one of the initial participants, this study evolved into an ethnographic study. The researcher participated in this group for the purpose of recruiting further participants. The researcher recorded field notes of her experiences as participant-observer within the group. These field notes added greater credibility to the findings of this study and analyses of the interview material. However, as a result of the researcher's participation in the group a number of methodological concerns were raised, as discussed below. In addition data for this study was collected by conducting unstructured interviews with the participants. These were recorded using a dictaphone.

3.4.1 The support group

The main aim of the group was to provide a platform for those recovering from addiction to mutually support each other during the process of recovery. The group had been created by a young man, Brian, who was in his late twenties. He created the group two years before this study was conducted in response to his own personal journey with addiction. I informed him of my interest to participate in the group as a recovering drug user and also as a researcher studying recovering drug users. I informed him of the topic and nature of the research study and negotiated entry into the group and exit from the group with him.

Participation in this group consisted of the weekly attendance at gatherings of recovering drug addicts that were held every Wednesday evening. The group consisted of an average of 100 attendees each week. These gatherings would take place in the church hall, which the majority of the participants attended. The church played an important role within this impoverished community. The weekly gatherings would open with a welcome to new members and those who previously attended the group.

The larger group consisting of over 100 people were then divided into smaller groups of approximately ten people per group. These were divided according to age and gender and members were seated on white plastic chairs in a circle. The attendees would then share their experiences and the challenges they faced during the previous week. Meanwhile other members of the group would offer encouragement and support. Thereafter, the larger group would reconvene and share the testimony of one of the members or watch a video that was presented by Brian. The testimony entailed stories of addiction and recovery and paid tribute to the role that God played in the lives of addicts during their process of recovery. At the end of the meeting, the group leader would call upon members who were ready to accept Christ into their lives and who were eager to convert to Christianity.

Five of the smaller groups shared the church hall. Sharing this space allowed members (including myself) to observe the actions and discussion of the other groups. One group was seated on the centre stage and four of the other groups were seated in each corner of the hall. The remaining groups were seated in separate rooms attached to the hall. These rooms were regularly used by the church for Sunday school held each Sunday. The group I participated in

originally shared the church hall with the other groups and was seated in the bottom, right hand corner, close to the entrance of the church hall. Later on this group moved to the upper left-hand corner and eventually it moved to one of the rooms used for Sunday school. These rooms were made of metal shipping containers that were transformed into classrooms. They were therefore extremely cold during the evening meetings. However, they provided users with a private and safe space to share their stories.

3.4.2 Multiple identities of the researcher

The researcher is part of the research process and interacts with the group under investigation and influence how stories are told (Murray, 2003). Therefore the researcher has to remain aware of their role within the research process. Following this, in conducting an ethnographic study the researcher exists within multiple identities. The researcher acts not only as researcher, but also as a participant, as observer and as an individual who has particular beliefs and values. These may differ from that of the group under investigation. In taking account for my role within the research process I explore the multiple identities I assumed. These include the identity as a recovering drug user, as a researcher and as a Christian.

As a recovering user of *CM,* I have remained abstinent for over two and a half years. When I took on this research topic, I was well aware of the conflicting and difficult position in which I was placing myself. Since the participants and I shared the same experiences I feared the influence that I would have on the stories they told. I therefore took cognisance of the information that I shared with the participants. I allowed them to tell their stories without influencing them with my own story. In addition I felt that this journey would challenge me to relive and make peace with my past as an addict. I was indeed able to make peace with my past by conducting the interviews and sharing in weekly meetings with participants.

As a female researcher, I have lived in Cape Town my entire life and I am of similar age to the participants. As a recovering drug user and researcher I had a responsibility towards the participants of this study to remain aware of how my past experiences could influence my interaction with them and the overall research process. However, the fact that I shared a mutual experience with the participants created a sense of closeness. These shared experiences allowed the participants to communicate their experiences more freely, openly

and without fear of judgement. Despite this, I felt that as a researcher I had a responsibility towards the participants and research community to produce work that was of high quality. As a result I took accountability for my actions by keeping a detailed reflexive account of the decisions I had taken throughout the research process. This furthermore ensured that I produced credible interpretations of the stories of addiction and recovery.

I am not a rigidly religious person but do believe that there is a God. I also do not come from a religious family, and my cynical nature prevented me from surrendering to the idea of conversion. In addition, the type of religion practised by the individuals in this group required those group members who believe in God to live by certain rules (in this case, the Ten Commandments). Although I do not live my life according to these commandments or rules, I did gain a more respectful understanding for those who have chosen this path. From my point of view there are two perspectives from which to view these narratives. From a Christian point of view religion offers long term healing from addiction in which the individual is cleansed from their past as an addict. In choosing long term healing conversion to Christianity is assumed. However, from an academic point of view this may be seen as replacing one addiction with another-albeit a more positive one-of living life according to God's commandments. By converting to the Christian faith indicated the attendance of endless meetings, church services and involvement in community projects.

3.4.3 Methodological Concerns

It is stated that, the longer the time spent in a particular context under investigation, the more accurate the results (May, 1993). As a result, participation in the group studied herein occurred over a six month period. In choosing to remain in the group for that length of time, I did experience the fear common among ethnographers of 'going native'. According to O'Reilly (2009, p.87), this is a "derogatory term associated with the rhetoric of colonialism". Within the context of this study, however, it refers to the loss of objectivity and the loss of distance from the topic under investigation. Consequently, boundaries may become blurred and the researcher may be unable to distinguish themselves from the topic under investigation. Since participating in the group as both researcher and participant this became an important issue. I feared the effects of sharing too much of myself with the members of the group. As a result I only revealed information that was relevant to the group and to the

naturally occurring discussion. In addition I carefully observed my reactions to the group, my participation in the group and my involvement in the group by keeping a detailed reflexive account of my experiences and decisions taken.

In line with the above observation it was an interesting, if challenging experience, to conduct research that evolved into ethnography and into participation in a community-based organisation. I noticed, for instance, that I was fearful and wary of this new experience. When I attended my first meeting there, I realised that the power of this group was quite overwhelming, especially for someone who had recently recovered from addiction. The powerful spirit of these people and their positive outlook on life offered those who had been addicts in the past the promise – and the opportunity – to become cleansed, to receive forgiveness, and to gain love and hope of a renewed identity. All of these are common needs of individuals living with addiction. As a result, it was difficult for me as a researcher, to remain objective and to keep some distance from the powerful energy of the group; I had to remind myself frequently of my reasons for attending these meetings, as it was easy to become caught up in the rituals of the group, especially with regard to religious conversion.

O'Reilly (2009) contends that barriers such as age, gender and race may distort findings. However, in this study as previously revealed, in-depth sharing only occurred within the smaller groups, which were made up of females of similar age. As a result, these barriers were not a relevant concern. However, since the members of the smaller groups remained constant from one meeting to the next, I feared that I was only gaining a limited view of the role of the smaller group discussions. I therefore participated in another group of females who were of a similar age and race to me. This enabled me to gain a more holistic view of the role of this organisation in assisting those living with addiction. However, I do admit that my view was still limited in that it only considered the role of the group within the lives of young women. However a general understanding of the role that smaller group discussions played were gained. For the older women of the group the weekly discussion focused on drawing support for mothers living with children who were drug addicts. This was similarly found with the older male group. In addition members also spoke about how they gained support from this group in dealing with other addictions.

When I found myself becoming too involved, and when members of the group were beginning to have certain expectations from me, which I could not meet, I attempted to negotiate my exit from the group. However, in attempting to negotiate my exit I found myself experiencing guilty feelings relating to my exit. These feelings were a result of the close bond that I had formed with particular members of the group. I felt as though I was deserting the group members and failing to live up to their expectations from me. I struggled to negotiate my exit from the group. As a result I took a decision to inform the leader of the group and members that I was close with (especially the members of the smaller group I participated in), that I was leaving as my data collection had come to an end.

3.4.4 The interview

Data collection took place in the form of semi-structured interviews that were tape recorded. The interviews were conducted using a narrative approach, with particular reference to stories of addiction and recovery. This enabled the chaotic nature of addiction to emerge through storytelling without imposing too much structure. Nonetheless, to maintain overall structure, the participants were asked five questions that were structured before the interview (see Appendix A). Additional questions were asked during the interviews for the purpose of clarification.

Willig (2001) contends that the research relationship is the cornerstone of the research process, and that it ultimately determines the type of information that is produced. Following this, I felt that it was important that the participants were comfortable in my presence. To address this issue, my years of experience at the University of South Africa (Unisa), Directorate for Student Counselling and Career Development (DCCAD) assisted me in establishing trusting relationships with and eliciting required information from participants. In addition, it taught me ways of probing without pushing, what information to listen for, and how to establish healthy boundaries with the participants. Furthermore, I learnt how to interact in a non-judgemental and ethical manner, thereby ensuring the safety of both the interviewees and myself.

Participants were invited to decide where they wanted the interview to take place. They could choose whether the interview was conducted at my residence or at theirs. I did not know the

participants well, and felt that my security was paramount. As a result, when the interview was conducted at a participant's home, I ensured that my boyfriend accompanied me and waited in the car at all of the interviews. At times, the interview would take place in the bedroom of the interviewee. When an interviewee allowed me into his or her personal space, I remained careful and maintained respectful boundaries, both for the sake of the participants and for myself. In addition, I left my cellular phone on at all times for security purposes when in the home of the interviewees.

Each interview would start with a detailed discussion related to the consent forms and issues surrounding confidentiality. This would be followed by a general discussion in order to ensure that participants felt comfortable, both in the new environment (my home) (where relevant) and with me. The interview would last between 30 minutes to one hour. Participants were invited to use the language of their choice (English or Afrikaans).

Towards the end of the interview, the participants completed a debriefing form (found in Appendix B). This allowed them to comment on whether they were comfortable with the issues that had been discussed, and whether they felt I was competent in dealing with the issues that had been discussed. It furthermore allowed me to assess whether there were any related topics that the participants felt were not discussed or that should have been discussed. Before the end of the interview, I gave each participant a R50.00 voucher inside of a card, by way of thanking them for their participation in this study and for sharing their stories. Since the majority of the participants were from a lower income bracket, this was highly appreciated.

At the end of each interview, I invited participants to ask me questions, as I felt that it would make them feel more comfortable if I shared my experiences with them too. It also served to break down the barriers I perceived between myself and the other participants. I was concerned that, if they perceived me to be the expert researcher, it would hamper the interview process. In addition, I wanted them to understand that I knew what the experience of addiction was like and I wanted them feel more comfortable about sharing their experiences with me. At the same time, I also had to be careful not to compare my experiences with theirs. I therefore attempted to limit my discussions with the participants, and only provided answers relevant to their questions without raising any new topics or using

them to deal with my own unresolved issues.

Once the interview was completed, detailed field notes were captured on the experience of the interview to ensure the credibility of the findings. The interviews were then transcribed verbatim. Pauses and intonations were not noted, as they were not seen as necessary for the type of analysis used in the study.

3.5 Method of analysis

Popular literature in the field of addiction aims to *quantify* addiction and thus fails to account for the *experience* of the user (Plüddemann et al., 2009). The user of the drug becomes a number that reveals the statistical implications for addiction in South Africa. This gives us a one-sided view of addiction, and we remain detached from the human being whom we aim to measure and observe. In contrast to studies that seek to quantify human experience, this study returns to the use of narrative. A narrative approach reveals how stories are used to shape lives and create identities. As a result, the focus then turns to the *meaning* of experiences and to how these meanings are created within a particular context.

3.5.1 Narrative analysis

Narratives are born out of experience and are inseparable from the self (Ochs & Capps, 1996). Human beings are social creatures who create their experiences by interacting with each other. We interact by means of stories that we share with each other. The construction of the narrative enables the individual to make sense of and attach meaning to experiences. In this way, the individual therefore becomes the theorist of their own life, arriving at an understanding of his or her experiences in accordance with their overarching conception of the world in which they live (Hanninen & Koski-Jannes, 1999). Furthermore, the narrative serves a particular function, as it places the experience of addiction within a human-centred frame and thus provides a way of understanding and creating meaning of experiences at a specific point in time.

Narratives are constructions of past events in personal stories that are relevant to claiming identity and constructing lives (Lieblich, Tuval-Maschiach & Zilber, 1998; Murray, 2003;

Riessman, 1993). Individuals constantly reconsider and reconstruct their identity. Neither the stories, nor the identity created through these stories, are stagnant. Instead, they are constantly evolving, changing and shifting with time and context. Narrative analysis therefore permits a view into these subjectively shifting perceptions and understandings.

Narratives are conveyed by heuristic devices embedded in language (Coffrey & Atikinson, 1996). Language provides pertinent information regarding the patterns of talk inherent within a particular social group. In addition, language has many functions within a social group, as it distinguishes one social group from the next and also increases group cohesion. Language is viewed as the medium through which we gain access to an individual's experiences, and it is the mechanism through which social reality is created. The narrative analyses therefore aim to discover meaning within the broader context, specifically how language conveys certain cultural norms and worldviews that inform stories (Esterberg, 2002; Riessman, 1993).

Stories may not always follow a logical sequence of events. Instead, they may appear to be rather chaotic. During the sharing of stories, dramatic events or turning points are revealed. Turning points in the story reveal the causal sequence of events. Narrative is a means for exploring such causal links to locate turning points within the individual's life. In making sense of twists and turns, the narrative provides coherence, structure and order to a sequence of events whose unanticipated links are revealed as they are narrated (Coffrey & Atkinson, 1996; Riessman, 1993). In addition, they may provide new visions for the future (Hanninen & Koski-Jannes, 1999; Lieblich et al., 1998).

In terms of the narrative approach to research, the interviewer is part of the interview process and of the narrative that is produced. The interviewer (or listener) plays an active role in the reconstruction of stories, which means that it is impossible to remove the influence of the listener from the teller. Narratives are thus created in an exchange between the narrator and the audience, in that the story told is continually re-written and reconstructed so that it is congruent to the present frame of reference (Hollway & Jefferson, 2000; Josselson, 1999).

The narrative framework follows a social constructionist paradigm. This paradigm is concerned with reality as socially constructed and with experiences as subjective. In accepting the subjective nature of reality, it assumes the relativist view that there are multiple

realities and that all descriptions are merely accounts and constructions of reality.

3.5.2 Narrative analysis within this study

The narrative approach used by the researcher to analyse interview material follows from the approach advocated by Ginsburg, which emphasises the concepts discussed above (Riessman, 1993). The researcher took the *story* as the object of study. In creating meaning of these stories the researcher noticed the language participants used and how this conveyed cultural and social meaning within the interview and community-based organisation. In addition the researcher had to remain aware that the identities of participants, who belonged to the community-based organisation, were formed within this group. These were continually changing according to the particular context in which they existed at a particular point in time. Furthermore, in conducting a narrative analysis the researcher considered the stories holistically by focusing on key turning points that were common across the eleven interviews. This provided the sequence and coherence to the disorderly stories of addiction.

The researcher transcribed and coded the interview material. According to Coffrey and Atkinson (1996) coding is a part of the analytic process by creating categories of data that share common elements. It aims to link the raw data to theoretical concepts. The researcher began with open coding by writing down phrases that labelled phenomena (Fetterman, 1998). Later during the research process focused coding was conducted thus allowing these labels to be explored in depth and enabling links to be established between them with a specific story in mind. As a result key themes were identified by constructing theoretical concepts that served to identify common experiences. These were then grouped together depending on the similarity of the experiences. Furthermore, in analysing these stories commonalities, differences, paradoxes and exceptions were identified and compared across interview material.

In creating meaning of the stories, the researcher offers an interpretation of the stories by using a mixture of direct quotes and a summary of the content of the speech produced by the participants. Direct quotes were used to provide evidence of interpretation. The ethnographic field notes were then used to contextualise the interview material and offers greater understanding into the lives and experiences of the participants.

3.6 Ethical Implications

The methodology employed in this study included conducting narrative interviews and negotiating entry into an organisation in order to recruit participants for this study. My participation in the group as both participant and observer meant that my role as an objective researcher was to some extent impaired. The ethical implications of this study must therefore be considered.

Research is governed by certain principles to ensure that participants are not harmed and that researchers do not abuse certain powers with which they are entrusted (Terre Blanche et al., 2006). The principles of informed consent, confidentiality, no harm (referred to below as nonmaleficence), conflict of interest, respect and responsibility are thus discussed.

3.6.1 Informed consent

Informed consent refers to the fact that the researcher must ensure that participants are given the necessary information to make informed choices. It includes educating participants about their rights, should they decide to participate in the study and building an empowering relationship with them (Corey, 2005).

Informed consent was obtained from each participant before each interview. The consent form made available the necessary details, such as the nature of the study, the number of participants, the funders, and issues related to confidentiality and the limits of confidentiality (Appendix C).

It furthermore explained the benefits, the risks and the voluntary nature of participation in this study. One signed copy of the consent form remained with the participant whereas the other signed copy remained in the possession of the researcher. These consent forms were read to and with the participants. Further consent was obtained to record the interviews by means of a dictaphone. Furthermore, the participants were assured of the anonymity of the recordings and that they were kept and stored safely, where no one else had access to them.

3.6.2 Confidentiality

Confidentiality is central to developing a trusting and productive relationship. It refers to the fact that the researcher must keep all the information provided by the participants anonymous and that such information is not shared with anyone without the consent of the participant.

Due to the sensitive nature of the topic and the nature of the stories that were revealed, confidentiality was discussed with the participants. The participants were assured that all the information that they shared would remain anonymous, and that no identifying information would be revealed or shared. The identities of participants are concealed by the use of pseudonyms. Participants were furthermore informed that information would only be shared, for the purpose of this study, with their written consent. Additionally, the limits of confidentiality were discussed with the participants. They were informed, for instance, that if the information they shared provided proof that they were intending to harm themselves or others, this information would be shared with the relevant persons and necessary action would be taken as a result.

3.6.3 Nonmaleficence

We have already considered the role of informed consent and confidentiality. We will now consider the role of nonmaleficence in the research process. This refers to that fact that the researcher must ensure that no harm comes to the participants in the research process and that they remain comfortable throughout this.

Firstly, participants were informed that their participation was voluntary and that they were free to leave at any point during the research process. Secondly, they were invited to contact the researcher at any stage, if they felt that they needed to discuss a sensitive issue. Thirdly, the language that was used was mindful of any stereotypes surrounding the perceptions of users of *CM*. Lastly, a detailed reflexive account was kept throughout the process. It detailed decisions made and the ethical implications thereof.

To ensure adherence to good practice, further measures were taken to deal with any distress experienced by participants during the interviews. After each interview, the participants and

interviewer engaged in a debriefing session related to their experience of the interview process. Each participant was given a referral guide, including the contact details of professional drug counselling centres and help lines (Appendix D). In this way, participants were assisted in dealing with any unexpected anxiety, discomfort or unresolved issues requiring professional assistance.

3.6.4 Conflict of interest

My role as participant (in other words, as a recovering user of *CM*) and the specific topic of this study made me aware of the particular conflict of interest that would arise. Since the topic was of a sensitive nature for the researcher, as well as for the participants, further steps needed to be taken to ensure the psychological wellbeing and safety of both parties.

Debriefing sessions were thus arranged with the Head of the Student Counselling Department (HOD) at the University of South Africa (Unisa), as deemed necessary. The HOD furthermore invited me to conduct a pilot interview, so that I could share my story and experience what it was like to be questioned. This enabled me to face my own barriers, to become aware of unresolved issues and to use these insights to ensure that the interviews with the participants would not be hampered by my own unresolved issues. Subsequent to the pilot interview, the HOD suggested a referral for consultation with a private psychologist, which was accepted. Debriefing and consultation with a private psychologist on my part therefore ensured that participants would not be harmed by my own unresolved issues.

3.6.5 Respect and responsibility

Due to the nature of the topic and my role within the group as participant observer, I had to fulfil particular ethical responsibilities towards the group and the participants. I had to respect the human dignity of the participants and the community-based organisation. As a result, I did not share any of the stories shared at the weekly meetings with those outside of the group. In addition, I had to fulfil particular responsibilities towards participants by keeping the promises that I had made to them.

As a researcher with years of experience in career counselling, I furthermore had an ethical responsibility towards the support networking, community-based organisation. The group had a department that assisted recovering users in obtaining and maintaining employment. Due to my years of experience in the field of career counselling, I was called upon to offer assistance in this regard. In maintaining respectful interaction and being aware of my responsibility towards the group, I supplied all the information that members of the group requested of me.

3.7 Research evaluation

Utilising the narrative analytic method will ultimately result in the interpretation of stories. As a result, steps need to be taken to ensure adherence to good research practice.

Since interpretation in itself is a subjective process, it potentially calls into question the credibility of the findings of this study. *Quantitative* research designs emphasise terms such as reliability and validity. Reliability refers to the dependability of a measurement instrument, in other words, "the extent to which the instrument yields the same results on repeated trials" (Terre Blanche et al., 2006, p.152). Similarly, validity refers to "the degree to which a measure does what it is intended to do" (Terre Blanche et al., 2006, p.147). However, in the case of *qualitative* studies, more naturalistic equivalents must be applied. These include terms such as credibility, transferability and dependability (Josselson, 1999; Willig, 2001).

Accordingly, credibility is comparable to internal validity, in that it refers to the fact that the conclusions of a study follow from the methods used. However, in working with narratives, the 'truth' or credibility of the stories told is frequently called into question. In narratives there is no 'truth' *per se*; rather, 'truth' is regarded as a "multifaceted reality which is the construction of subjective processes" (Lieblich, 1994, p.ix). Therefore, to ensure the credibility of the findings and of the stories, I employ various frames of verification (validity). Firstly, I conducted *negative case analyses*, whereby all cases were checked for disconfirming information. Secondly, the trustworthiness of the stories was determined by comparing the participants' stories for similarities and differences. Thirdly, I utilised various methods such as participant observation, interviews and field notes to enhance the credibility of my findings.

In addition to credibility, I also have to ensure the transferability of the findings. Transferability is analogous to external validity and refers to the fact that it is possible to generalise the findings of one study to other situations or that the findings are representative of broader populations (Terre Blanche et al., 2006). In this regard, I further provide 'thick descriptions' of the participants' narratives to ensure that the interview data was situated within a particular context.

Since qualitative approaches involve the interpretation of information, it raises questions about the dependability of such interpretations. Reflexivity allows me to trace my own influence and role within the research process. This creates greater accountability on my own part, as it allows me to identify my biases, values and beliefs, which may hamper the research process (Lieblich, 1994; Willig, 2001). It further ensures the dependability of findings (in other words, results that are not subject to change and instability). Additionally, reflexivity ensures the requisite level of trustworthiness on the part of the researcher and further ensures the authenticity of the narrative interpretation.

3.8 Chapter summary

This chapter looked at the particular qualitative design that guided this research study. An ethnographic approach is used in creating meaning of the participants' accounts of how they recovered from their addiction to *CM*. In addition this chapter focused on how participants were chosen and how data was collected. Furthermore this chapter looked at the method of data analysis used, namely narrative analyses. Lastly, the ethical implications of this study were broadly outlined. Chapters Four, Five and Six focus more specifically on the findings of this study. Chapter Four looks at how the addiction with *CM* began. Chapter Five examines the particular effects for the user who is addicted to *CM* and the identity acquired through the prolonged use of the drug. The final chapter of the results, Chapter Six, explores the process of recovery and change.

CHAPTER FOUR: NARRATIVES OF RECOVERING DRUG USERS: BEGINNING THE CM JOURNEY

4.1 Introduction

This chapter is the first of three chapters outlining key results. It reveals that addiction follows a particular pattern, which begins with the initial drug use. Following this, Chapter Five outlines the progression of addiction and the characteristic dependent states. Chapter Six concludes the progression of addiction by portraying the process of change and recovery. This chapter will therefore focus on relevant themes that include the initial reasons for *CM* use, the feelings aroused by *CM* use and the precipitating factors for addiction. Occasionally, some excerpts abstracted from the interviews conducted are repeated, since they have multiple meanings as ascribed by the *CM* users. Furthermore, I have provided English translations for particular Afrikaans quotations.

4.2 The journey for CM users begin

In creating meaning within stories, participants constructed their experiences of addiction and recovery as a journey. Within these narratives, participants spoke of various paths along which they travelled. The metaphor of addiction as a journey, which participants drew upon, was therefore employed in depicting their experiences. These journeys all began with the initial reasons for *CM* use.

4.3 Reasons for initial CM use

This study critically examines the reasons for initial drug use, particularly as it relates to the specific risk factors, which made those who experiment with drugs vulnerable to addiction. During the active conscious process of constructing their stories, participants began to understand what had initially influenced them to use *CM*. Among the reasons cited were: curiosity, the urge to experiment, boredom, dissatisfaction with familial relationships, peer pressure, stress and the experience of trauma.

4.3.1 Curiosity, experimentation and boredom

We have already considered that the experience of addiction was described as a journey beginning with the initial reasons for *CM* use. As participants constructed their initial experience, they emphasised the importance of curiosity, boredom and the desire to experiment with something new. The new experience offered a thrill and excitement not normally experienced. Bianca, for instance, revealed why she used *CM*:

> *...my sister found a straw of tik in our bathroom... and um... we didn't know what it was at the time... and then obviously we weren't into drugs and things like that /.../ and for a while we were really inquisitive, we wanted to know what it was and then eventually my sister found out what it was and it was tik of course /.../ and then um, one day out of curiosity we just decided to experiment and we did /.../ I think a lot of us did it like out of maybe boredom ...*

In other words, Bianca admitted that her curiosity was aroused when her sister accidentally found a straw of *CM* in their bathroom and had shown it to her. According to Bianca, the two of them together gathered information about the effects of *CM* use from others, before deciding – out of a mixture of curiosity and boredom – to experiment with *CM*. Previous research has clearly identified curiosity and boredom as common reasons for drug use (Cancrini, 1994; Imlah, 1970; Levinthal, 1996; Schlaadt & Shannon, 1994). In addition to Bianca, two other participants described their initial drug use as beginning with the urge to experiment and curiosity surrounding *CM*.

In addition to curiosity, the narratives of participants also indicated that they began to experiment with drugs out of boredom. Schlaadt and Shannon (1994) eloquently described the rebellious nature and sense of alienation experienced by some people that result in the need to make a statement about oneself. In the case of many participants, then, they spoke of how they tried to relieve their sense of boredom by doing something exciting or dangerous.

4.3.2 Dissatisfaction with familial relationships

Family issues, especially problematic relationships with parents, were identified as another important reason for beginning to use *CM*. In telling the stories of their addiction and recovery, participants constructed family members, and particularly parents, as significant individuals who played pivotal roles in contributing to their drug use, as well as during the subsequent stages of the journey via addiction to recovery. Claude, for example, revealed that he began using drugs because of the lack of love from his parents, and the absence of a strong and healthy relationship with them. Since he had not received the love he needed from his parents, he relied on external relationships:

> *I started hanging out with the wrong friends and started doing the wrong things... um... so I think by the fact of the divorce and the lack of love and the lack of a relationship with my mother and father, I found that love and what I thought was love and that relationship with other friends ...*

As participants told their stories and identified the role played by their families in initiating their drug use, they manifested physical tension in their bodies and a tone of sadness in their voices. In other instances, the lack of a parent or the neglect experienced from one or both parents was expressed as a negative experience.

These findings echo those of previous studies, which have found that the family serves as a risk factor in that it can make an individual vulnerable to addiction (Calafat et al., 2007; Sullivan & Farrel, 1999). Families contribute to creating identities and ensuring that basic needs, including needs of love and acceptance, are met. However, the participants spoke about dysfunction in their families as a result of parental divorce, a lack of love and a lack of healthy relationships with their parents. Indeed, Hirschman (1992) found that most consumers, of any product or substance, who have an addictive-compulsive personality subtype, tend to come from dysfunctional families. Children growing up in environments characterised by violence, patterns of alcohol or drug abuse and divorce often feel anxious. If these children learn that substance use is able to alleviate negative feelings, they are at risk for compulsive consumption. Four of the participants in this study, for example, constructed their family backgrounds as negative and attributed their initial drug use to them. They had

thus sought fulfilment of their needs from people outside the family, which meant that they were vulnerable to addiction.

In addition, this study found that the absence of one parent meant that children lacked acceptable parental role models within the family; this was exacerbated further if the remaining parent neglected their obligations towards the child (Bahr & Hoffman, 2008; Hirschman, 1992; Schlaadt & Shannon, 1994). Two participants, for instance, described living in a household with one parent, with whom they had maintained a relationship, while they felt neglected by the other parent. Without appropriate and positive parental role models and, in some cases, even being abandoned and forced to take care of themselves, participants were more likely to become vulnerable to the negative influence of others. In addition, Cattapan and Grimwade (2008) contend that a history of parental substance use results in subsequent illicit substance use among their offspring too. In that regard, Carla, one of the participants of this study, revealed that a history of parental substance abuse had led, to some extent, to her subsequent substance use.

4.3.3 Peer pressure

In addition to the above mentioned reasons for *CM* use, some participants spoke of peer pressure as a contributing factor. Family members are the primary caregivers and they are responsible for rearing positive young members of society. This was not the case in the lives of many of the participants. The negative circumstances of their family life thus propelled them outwards, turning to friends and peer groups as a means of escape. Anderson and Mott (1998) revealed that friends give individuals the means with which to cope with internal pain and a sense of marginalisation brought on by a variety of factors, including those previously mentioned. Narratives commonly revealed the influential role played by friends (in the form of peer pressure) in the initial use of *CM*. This was revealed by Marvin:

> *I basically started... where it went wrong is like I had... I chosen the wrong crowd of friends that I was hanging out with, the people that I was hanging out with... it started with smoking weed and then I just started drinking*
>
> *alcohol and then it went all downhill from there... that's how I believe I*

started hanging out with the wrong friends and started doing the wrong things ...

In constructing his experience of initial *CM* use in the quotation above, Marvin constantly referred to himself ("I"). This indicates that, although he was aware of the role played by his peers in initiating his drug use, he does also take responsibility for his own actions. This was a common occurrence amongst many of the participants. In accepting accountability for their actions, participants took responsibility for their drug use, although they did not completely discount the role of the peer group in exposing them to drugs in the first place.

Participants were not only shaped by their social networking group but also played an active role in shaping this group. They helped to shape the behavioural expectations of the social group by choosing to associate with people who used *CM* (Doweiko, 1993).The influential role of peer pressure was revealed by Sheridan et al. (2009). Participants who initially experimented with drugs learnt how to use drugs from their more experienced peers (Doweiko, 1993; Gifford & Humphreys, 2007; Hirschman, 1992; Levinthal, 1996; Schlaadt & Shannon, 1994). The peer group moreover served to validate the initial drug using behaviour and to reinforce future drug using behaviour (Bahr & Hoffman, 2008; Hirschman, 1992).

In addition to the influential role of the peer group, the use of drugs and alcohol is normalised in many cultures. We live in a culture that, to a certain extent, does condone the use and sale of drugs and alcohol. In particular societies, the use of alcohol is condoned and even forms part of rituals (McNeece & DiNitto, 1994). Within the South African context alcohol is used in churches and for the acknowledgement of traditional celebrations such as weddings, birthdays and religious celebrations. Prescription pills and medications are legal. It is my contention that the social acceptability of alcohol use, coupled with the accepted recreational use of particular drugs such as marijuana, meant that participants were more vulnerable to addiction (Allen, 2007; Schlaadt & Shannon, 1994).

4.3.4 Stress

In the previous sections, we have considered the role of curiosity, experimentation, boredom, dissatisfaction with familial relationships and peer pressure in initiating drug use and addiction. Another well-documented risk factor that increases one's susceptibility to developing an addiction is stress (Imlah, 1970; Lemonick & Park, 2007). Stress may emanate from various sources of life pressures. Within this study, particularly in the case of those who were single mothers among the participants, the experience of stress was understood to motivate the use of *CM*. Carla, a single mother, discussed the stress she had experienced when she first began using *CM*:

> *Somtyds jy weet jy't so baie probleme en goetis. Nou dink jy okay jy ga't... but as jy rook is it, is jy nou klaar gerook is die problems... is dan weer daar, is maar daai tyd, is jou mind nou af van it maar is... but isie maklik om af van it... isie maklik om a enkel ouer te isie... te weesie, jy weet daar'sie a pa nie, jy moet alles... moet jy self doen, geld is miskien te min, jy raak frustrated, almal daai dinge man en jy weet... doen jy al die verkeerde dinge.*
> *(Sometimes you know you have so many problems and things. Now you think okay you going to... but if you smoke is it, now you finished smoking is the problems... is then again there, it is that time, your mind is now off of it but it... but it is not easy to come off it, it is not easy to be a single parent... to be, you know there's no father, you must everything... you must do yourself, money is maybe too little, you get frustrated, all of those things man and you know... you do all the wrong things.)*

All five single female mothers who participated in this study said that they began taking drugs because they were experiencing stress in their lives and unable to cope with it. Lemonick and Park (2007) contend that the experience of stress impairs the decision-making process, and that it awakes the desire to avoid such negative feelings of anxiety. In the case of the five single mothers, all of them experienced the journey to motherhood, especially since it was taken alone, as stressful. Not having a husband or a male partner on whom they could depend, and who could share with them the responsibility of raising the child (in some instances it was more than one child), was constructed as a negative experience. In addition,

some of them were unemployed and thus unable or struggling to provide food, clothing and housing for themselves and their children. These young mothers commonly revealed that they had learnt to avoid negative feelings by using *CM*. However, they had soon realised that using *CM* could not take away their problems, although it did relieve the experience of stress at least for a short while. In this regard, McNeece and DiNitto (1994) revealed that the user learns that negative psychological states can be avoided and a pleasurable psychological state can be achieved by using *CM*.

4.3.5 Trauma

Two of the participants started using drugs, especially *CM*, for a different reason to those described above, namely, because they had experienced trauma. Trauma, for the purpose of this study, refers to the experience of physical and sexual abuse. Adrian's story, for instance, gradually intensified, as he revealed his traumatic experiences:

> *...but when I was like four um, uh, something hectic happened. It was my mom's step-brother, he sexually molested me okay /.../ I remember one case... one day actually sodomised me um, and it was like a traumatic experience... but I do remember once my mom catching him you know but I don't know if it was because of educator... of education that she didn't do anything while hid it away from my father /.../ so my neighbour's husband molesting me /.../ and not knowing I was seduced and I was manipulated you know... so there was a constant blaming yourself all the years, what am I doing wrong what is wrong with me, why ain't I good enough okay ...*

From Adrian's words, it is clear that the experience of being molested and sodomised was traumatic. It added to the trauma that his mother knew of this but chose to hide it from his father. In hiding the sexual abuse, which carried on for years, Adrian became vulnerable to similar occurrences perpetrated by men outside of his family. In fact, the molestation continued for many years, until past the age of 21; by that time, having been exposed to sexual abuse and manipulation for such a long time, he thought that it was normal. He was also not aware of the impact it had on him. He resorted to blaming himself for these occurrences and therefore turned to drugs in order to reduce the pain and hurt associated with

these memories. Anderson and Mott (1998) found that vulnerability to drug use is, to some extent, caused by the desire to avoid negative feelings of marginalisation related to early childhood experiences. The findings of this study are also in line with past research about the impact of childhood trauma on the onset of addictions (Cattapan & Grimwade, 2008; Duncan et al., 2008; Etherington, 2006; Perez, 2000; Waters, Albert & Margen, 1997; Whitfield, 1998).

In retrospect participants constructed their experiences of addiction in a manner that appears to relinquish them of taking responsibility for using the drug. However, in some instances participants did acknowledge their role in the process of addiction .In telling stories of addiction emphasis was placed on curiosity, the need to experiment and boredom. Such themes highlight the fact that participants were ultimately unaware of the seriousness and severity of their actions. The remaining participants articulated the role of other external motivating factors such as the dissatisfaction with familial relationships, peer pressure, stress and trauma. These were constructed in a negative light and left participants feeling unfulfilled thus resulting in the use of *CM*. For this reason participants gave *CM* use a functional quality and this assisted them in creating meaning of their stories.

Unlike traditional theories that aim to identify causes, subjective experiences focus on determining the meaning of the experience of addiction (Bahr & Hoffman, 2008; Cancrini, 1994; Feltenstein & See, 2008; Hart et al., 2008). Within these constructions, risk factors were indicated as meaningful. In this study, no one risk factor was responsible for making participants vulnerable to developing an addiction. Instead, it was a combination of risk factors, which were constructed as contributing to their addiction. Once a user understands their unique causes of drug using behaviour, they gain a better insight and deeper understanding of their addiction. In this study, though, it proved more meaningful to understand the complex process along which the addiction had developed.

4.4 The emotional aspects of CM use

In the preceding sections, we have discussed the risk factors that made individuals particularly vulnerable to addiction. These risk factors furthermore made participants, who were taking drugs to deal with negative psychological states, vulnerable to the negative

influences of others. The meaning of *CM* use, for each particular user, depends on the meaning that is attached to it. Initial *CM* use is accompanied by a particular effect that has an emotional impact on the user. In the course of their addiction, certain feelings became prominent. Most of the participants constructed their initial drug use as being accompanied by positive feelings of fun and enjoyment and an increased sense of self. These positive feelings played a prominent role in whether they continued to use drugs. It would later be revealed that within these feelings existed the lure of *CM*. However participants later revealed that with prolonged *CM* use these initial feelings transformed into negative feelings that would later play a prominent role in motivating them to stop using *CM*.

4.4.1 Fun, enjoyment and feeling good

Experienced drug-using peers told participants of the initial feelings of pleasure, including a sense of fun, enjoyment and pleasure. Ryan and Shawn were clearly excited, as they vividly recalled their initial experiences with *CM*:

> *For me it was... firstly before I knew I was an addict it was fun /.../ it was fun (repeated thrice) I mean you get together with as friends ...*
>
> *...when you high it feels, it feels good to be high, it's just, any drug user will tell you it feels good to be high ...*

Lemonick and Park (2007) contend that *CM* is able to exploit the user's emotions. Depending on the dosage, the perceived meaning for the individual drug user, the mental state of the user, the potency of the drug and the manner of its use, the effect of *CM* use for each individual was unique (Doweiko, 1993; McNeece & DiNitto, 1994). Ryan and Shawn vividly recalled their initial use of *CM* as being associated with heightened feelings of pleasure. These experiences were echoed by a number of other participants in this study. Past research, similarly, has identified the initial use of *CM* as producing a sense of euphoria and as amplifying the experience of pleasure in particular activities (Doweiko, 1993; McNeece & DiNitto, 1994; Schlaadt & Shannon, 1994).

4.4.2 Increased sense of self

In addition to the experience of fun and enjoyment, the use of *CM* furthermore resulted in an improved sense of self and a stronger sense of identity. Four participants admitted that the use of *CM* had appeared to increase their self-worth and self-esteem. Claude emphasised the impact of *CM* on his sense of self:

> *...it just made me feel... superior, it made me feel... stronger, it made me feel... like I was someone, it made me feel... happy and you know, it just made me feel... it made me feel, secure in it you know, it made me feel like you know, like I was wanted, yeah (speaking in louder tone of voice as if he just made this revelation) tik made me feel like I was wanted, tik made me feel like it wanted to be in me, it wanted to be with me ...*

It is clear from these words – and the narratives of other participants, that *CM* use aroused unaccustomed and intense emotions that could be overwhelming. They tended to have an increased sense of self and a heightened experience of pleasure (previously revealed). These feelings had attracted them to using *CM*, and it created an irresistible emotional connection with the drug. Drug addicts who wanted to stop using the drug were fearful of the strong emotional connection the drug use aroused, and fearful that its pull would be too strong to resist.

It was commonly revealed by all the participants in this study that *CM* elevated their mood and that it made them feel good about themselves, thereby resulting in increased self-confidence, self-esteem and a sense of grandeur. These findings are in line with past research (McNeece & DiNitto, 1994; Watanabe-Galloway et al. 2009). While they were using the drug, they felt good, but once the drug was withheld, they were overwhelmed by all the negative feelings they had ignored, repressed or avoided by taking the drugs in the first place. These negative feelings thus presented themselves in the form of depressive symptoms, paranoia and even suicidal ideation (Darke, Kaye, McKetin & Duflou, 2008).

The emotional aspects of *CM* use provide insight into the subjective experiences of *CM* use. This serves to inform our understanding of the complex phenomenon of addiction.

Participants recalled the initial use of the drug as having a positive psychological effect on them. This initially enabled them to avoid negative feelings surrounding particular life experiences. Once reliant on the pleasurable feelings associated with *CM* use, they then continued using the drug. In reconstructing these experiences they came to understand the purpose the drug served in their lives and how they became addicted to the drug. They were also able to relay this as a story about their addiction to the interviewer.

The value of this research lies in its focus on the immense difficulties facing addicts. In supporting theories that regard addictive behaviour as pathological, we cannot come closer to understanding the meaning of the experience of addiction. By gaining a glimpse into the world of addiction, however, we can begin to understand the complexities involved. And that is the aim of this study.

4.5 Precipitating factors

Risk factors, by definition, only place the user *at risk* for *CM* use. The emotional impact of *CM* use serves to maintain future drug using behaviour. However, prior to and once *CM* exposure has occurred, a number of factors – known as 'precipitating factors' – facilitate, exacerbate and hasten the addiction to *CM*. The participants' narratives suggest that the three main factors to facilitate the pathway of addiction to *CM* include the pattern of drug use, the use of multiple substances and the availability of *CM*.

4.5.1 Pattern of drug use

For some of the participants, the journey to addiction was progressive. In other words, they used other illicit substances over a prolonged period before developing an addiction to *CM*. For others, however, addiction to *CM* was instantaneous, occurring shortly after the initial experience with *CM*. The main reason for this was the initial pleasurable effect of using *CM*. Adrian revealed how he had gradually progressed to *CM* addiction:

> *...that's where the cigarettes started and then it went to a joint because my parents weren't there and obviously the pain I was dealing with that time um... and being always to hide, always keeping secrets... and it started to eat on me*

and um... from joints it went onto um... yeah I think "chales", green pipes and the more the guilt started the more... and then by this time I was drinking when I was fourteen. I had my first beer and um... by this time the more the guilt consumed me the more I consumed myself with alcohol and at the time the green pipe /.../ as the years went on sixteen, I started doing "E's" (ecstasy), 17, "E's", mandrax, crack... LSD I was introduced to um... what's it called acid at the time, liquid acid also, that time tik was called slate, it started ...

Adrian had experienced gradual addiction to *CM* that was preceded by the use of many other illicit substances including marijuana, ecstasy, mandrax, crack and LSD. He revealed that he started using drugs in order to avoid negative feelings regarding his life experiences. He then revealed that, the more drugs he used, the more the negative feelings started to consume him, which only served to exacerbate his addiction.

The pattern of addiction for each individual participant was unique. Degenhardt et al. (2009) contend that a progressive pattern of addiction is indicated by the use of alcohol and marijuana prior to *CM* use. It was commonly revealed by the participants in the study that they had used other illicit substances, including alcohol and marijuana, prior to using *CM*, thus indicating a progressive pattern of addiction. Findings of this study are furthermore in line with past research revealing that users of *CM* who follow a progressive pattern of addiction are experienced users of other drugs before using *CM*, which only starts at a later stage of the addiction process (Brecht et al., 2007; Sheridan et al., 2009). In contrast, four participants reported that they realised immediately that they had become instantaneously addicted to *CM* after the first time they had used it, most likely because of the initial positive qualities and emotional experiences of *CM* use. These participants had not used other illicit substances before or after using *CM*.

4.5.2 The use of multiple substances

In addition to describing the pattern of addiction, participants spoke about the use of multiple substances. With prolonged use of one drug, a level of tolerance was reached, resulting in the need to increase the dosage in order to produce the desired pleasurable effect (Barlow &

Durand, 2005; Doweiko, 1993). With increased consumption of a particular drug, tolerance reached a point where the user was no longer satisfied with the effect produced by that drug. Therefore, participants who followed a progressive pattern of addiction used other substances prior to *CM*, in order to produce the desired effect not achieved from using one drug alone. In most instances, the use of multiple drugs had more detrimental effects than the use of *CM* alone (Schlaadt & Shannon, 1994).

It is clear from the participants' narratives, that there are many factors influencing initial use of *CM* and leading to progressive addiction. Precipitating factors revealed that a pattern of drug use (whether addiction occurred the first time *CM* had been used, or whether the addiction developed progressively) together with the use of other illicit substances prior to *CM*, facilitated the addiction to *CM*. In other words, the narratives revealed that a progressive pattern of drug use and the use of multiple substances exacerbated the development of addiction to *CM*.

4.5.3 Availability

We have already seen the role of precipitating factors, including the pattern of addiction and the use of multiple substances, in facilitating *CM* addiction. Another factor was the easy access to drugs. Local "merchants" were in charge of the sale and distribution of *CM* in local communities. This was the conventional means of obtaining the drug. However, peers also became suppliers of drugs. In this regard, Bianca and Paula shockingly reveal how easy it was to obtain *CM*:

> *Very easy, extremely easy yes like there's a merchant around every corner.*

> *Kyk orals is it een en dieselfde, jy kan mos nou nie sè is net hier nie... want orals waar ek gegart ko kry ek dan jy hier (referring to CM)... is it net so famous orals waar ek gegart, dan lyks my ek loop inie goetes orals (referring to CM), by elke een van my vriende waar ek gegart... dan lyk my hulle wag my af metie goed (referring to CM).*
> *(Look everywhere it's one and the same, you can't now say it's just here... because everywhere I went I found you there (referring to CM)... it is just so*

famous everywhere where I went, then it looks to me like I am walking into the things everywhere (referring to CM), by every one of my friends where I went... then it looks to me like they wait for me with the things (referring to CM)).

All of the participants expressed shock at the realisation that their friends had supplied them with *CM*. The participants at times found this hard to come to terms with, as they felt that friends were supposed to be trustworthy and dependable. However, when it came to *CM* use, it appeared that friends soon became ways of obtaining the drug. In particular instances, this easy access to the drug was appreciated – especially during the early stages of the addiction. During recovery, however, this easy access was a significant source of unhappiness and frustration. Peers not only played a pivotal role in the initial journey but throughout the journey with addiction – and even through to recovery.

Sheridan et al. (2009) contend that the easy availability of *CM* is a precipitating as well as perpetuating factor that exacerbates addiction. The participants' narratives commonly revealed that *CM* was easy to obtain and that local 'merchants' could easily be accessed as suppliers of *CM*. In addition, narratives revealed that drug use was usually initiated within a social context and that individuals had been introduced to the drug by friends, who subsequently became a source of drugs. The social acceptability of *CM*, by the peer group, effectively resulted in the normalisation of the drug-using behaviour, thereby further reinforcing the addiction (Allen, 2007; Schlaadt & Shannon, 1994).

Within the stories of addiction it was shown that vulnerabilities for addiction are complex. Participants' recollections of addiction with the focus on risk factors and precipitating factors indicate that the users did, to some extent acknowledge the role they played in their addiction and ultimately claimed responsibility for using the drug. Despite this, their reflections also indicated the presence of social and cultural processes that played a critical role in increasing the likelihood that they would become addicted to *CM*.

4.6. Summary of chapter

This chapter sought to establish the meaning of the narratives of addiction. The common experiences of *CM* use, including the reasons for *CM* use, the emotional aspects of *CM* use

and the precipitating factors were presented. This chapter exposed the fact that the pathways to addiction are complex, and that many factors and influences make individuals vulnerable to developing an addiction. The following chapter outlines the progression of such addiction. Such progression reveals the formation of particular identities for the user. It further aims to identify the effects of prolonged *CM* use for the user and how the addiction is maintained.

CHAPTER FIVE: NARRATIVES OF RECOVERING DRUG USERS: THE JOURNEY TO DEPENDENCY

5.1 Introduction

Following the participants' initial experimentation with *CM*, their journey with addiction intensified. This chapter analyses how users become addicted to *CM*, a process that involves characteristic dependent states. These include the progression of *CM* addiction and the identity acquired through prolonged *CM* use. Additionally, this study focuses on the unpleasant symptoms and effects of *CM* dependence. Furthermore, it examines how some users support their addiction and how they avoid their obligations as employees and mothers.

5.2 Progression of addiction to CM

From the participants' narratives, it emerged that each of them had gone through a process of addiction to *CM*, which was unique to them. Chapter Four revealed that precipitating factors facilitating the use of *CM* included the pattern of drug use and the use of multiple substances, prior to initiating CM use, and the availability of *CM*. The progression to *CM* addiction was expressed by the shift from a casual use of *CM* to a more frequent use of the drug together with an increased need to use *CM* and the unconscious dependence on the drug.

5.2.1 Frequency

Initially, it seems that the participants would use *CM* mainly on the weekend to escape negative feelings. Once they realised that *CM* use resulted in a positive psychological state, they began to use it more frequently. Shawn, for instance, admitted that he used *CM* every day:

> *...basically, all day... whole day, every day. It wasn't just when it... wasn't just something's wrong or something's right, it's basically just became a lifestyle. We were constantly high.*

According to the participants, their initial reason for using *CM* was the desire to escape from negative psychological states. Later on, however, the anticipation of future pleasurable feelings associated with *CM* use motivated the continued use of *CM*. This, combined with the easy availability of *CM*, resulted in the increased frequency of its use. Past research has also found this to be true (McNeece & DiNitto, 1994; Schlaadt & Shannon, 1994).

Furthermore, the participants' narratives revealed that, as they used *CM* more frequently, they became accustomed to a daily pattern of drug-seeking and drug-taking behaviour. Moreover, the accustomed dose would gradually prove insufficient and therefore larger doses were required in order to produce the desired effect (Emmett & Nice, 1996). *CM* users developed a tolerance to the drug, becoming physically accustomed to its effects.

5.2.2 Need

In addition to using *CM* more frequently, and thus shifting from the casual use of *CM* to an increasingly frequent use, addicts began to *need*– physically, emotionally and psychologically – to consume *CM*. Instead of experiencing positive psychological states, users of *CM* developed a compulsive need to consume the drug. Bianca revealed:

> *...I had to use... I had to /... / Anyways as I was saying I was working at Adidas, there... I was just at a place where I had to use ...*

The participants described their initial use of *CM* as involving a choice of when and why to use *CM*. As they used the drug more frequently, however, they developed a tolerance towards it with more frequent use of *CM* they had commonly realised that they had reached a state of tolerance for *CM*. After some time, then, they felt that they no longer had a choice as to whether to use it or not. They found that, the longer they had used the drug, the less autonomy they had with regard to using it or not. This echoes the findings in a number of studies, which identified an increasing compulsion to use *CM*, together with an increasing lack of control, with users finding it almost impossible to resist the drug (Edwards, Russel, Hawks & MacCafferty, 1976; Glatt, 1974; Keane, 2004; Levy, 2006). Furthermore Keane (2004) revealed that addiction is a way of acting on problematic desires. These desires are based on unhealthy feelings for a particular substance or object. In retrospect it appears that

the uncontrollable compulsion to use the drug was based on unhealthy feelings.

An alternate explanation was offered by participants who suggested that the compulsion to use was a result of the intimate relationship that was being formed between *CM* and the user. In addition to the chemical addiction, users developed an almost personal relationship with the drug. In describing this relationship between *CM* and the user, Claude provided unique insight:

> *...I, the first... that first hit I took I can still remember that day, I remember the time, I remember who was around me, I remember where we bought it, I remember how much I gave, I just... tik was like... my new love, it was my new... I really had a relationship with tik. We went through our ups... we went through our downs it was just like it was like this person I was close ...*

Such narratives pointed to the emotional connection that users developed with *CM*. According to Glatt (1974), this kind of emotional dependence on *CM* is a result of the search for satisfaction by means of a drug. Narratives commonly revealed that participants resorted to drug use because they felt dissatisfied and marginalised by their negative life experiences (Anderson & Mott, 1998; Keane, 2004). *CM* satisfied their emotional needs, and thus an intimate relationship was forged between *CM* and the user. This is evident from the fact that narrators attributed human qualities to *CM*. Indeed Keane (2004, p.189) revealed that "refiguring addiction as a kind of intimacy is one way of making sense of the intense relationship people can develop with substances and with activities."

The increased frequency of use and the increasing need to use *CM* created a state of psychological and physical dependence. This is reiterated by Edwards et al. (1976). However, participants appeared to be unaware of these processes, which had facilitated their progression to *CM* dependence.

5.2.3 The unconscious dependence

Besides the increase in frequency of *CM* use and the increasing need to use the drug, it became evident from the discussions with the participants, that they were unaware of the

progression from initial use of *CM* to outright addiction. Ryan revealed that he only realised he was addicted to the drug when it was already too late:

> *...before I knew I was an addict it was fun /.../ Not when I started because I was probably in denial about it but... well as um... as years went on I was using it for about three years plus minus and I realised that I'd become an addict. Even if I said I can only do it weekends or I can only do it... and I never used to steal for it but still I needed to do it and I was in denial ...*

Participants dealt with their addiction in many ways. Most commonly, they denied their addiction, while others were simply unaware that they had become addicted to *CM*. In an effort to deny their addiction, users would rationalise their behaviour (Glatt, 1974). In addition, they also minimised the harmful effects of the drug and justified their drug-using behaviour to others (Edward et al., 1976). For these reasons, the narratives commonly revealed that they were unaware of the process of addiction and that they found it difficult to admit that they were indeed addicted to *CM*.

Constructions of how the addiction developed revealed the nature of the relationship that was being created between the user and the drug. By acknowledging the intimate relationship that was formed with the drug, it became possible for the interviewer to gain a greater understanding of the process of addiction. With such stories the basic human need to feel connected to others surfaced. In addition, to the interviewer such reconstructions communicated the fact that users were attempting to locate further functional explanations and motives for using the drug. However, despite these early signs of addiction, participants remained unaware of the process of how they were becoming addicted to the drug and continued to use *CM* frequently. Denial was revealed to be a common coping mechanism drawn upon to assist users with facing the reality of their addiction and enabled them to avoid taking ownership of it.

5.3 Identity

We have already considered the fact that participants were generally unaware of the progression to *CM* addiction. Their narratives revealed how difficult it was for them to admit

that they were dependent on *CM*. To others and to some extent to themselves, they denied their dependence on *CM*, and rationalised and defended their *CM* use. Once they were willing to admit to themselves and to others that they were in fact dependent on *CM*, a struggle for identity began: they struggled to reconcile the identity of 'the other person' they had been before they started using *CM*, and the 'addict identity'.

5.3.1 The other person

It emerged from their narratives that the personality of the users had changed dramatically while they were using *CM*, and that they found it difficult to identify with this. Narratives emphasised that there were two separate identities, viz. the identity of the person they were before using *CM* and the identity of the person addicted to *CM*. Claude expressed this distinction as follows:

> *...so I think when people saw how I was... before I was on drugs... so they knew, you know that wasn't actually me that was on drugs, you know, so they knew the person before the drugs and that's what they wanted back ...*

The user's identity evolved and was continually reshaped depending on their particular context at the time (Keane, 2001; Larkin & Griffiths, 2002). Those who were dependent on *CM* furthermore experienced a sense of detachment. Their identity changed from that of a normal human who was able to function and contribute to society to that of someone with whom they could not identify. They constructed their sense of self before starting to use drug use as being a completely different person who would not have considered doing drugs. They appeared to find it difficult to reconcile their drug addiction with their self-concept. In initiating and maintaining their drug-using behaviour, it seemed that their lives now centred on the acquisition and use of *CM*. The new sense of self that developed was creating a sense of confusion.

5.3.2 Addict identity

As indicated previously, a very close, almost intimate relationship developed between the user and *CM* because of prolonged use of the drug. Effectively, this relationship was based on

unhealthy feelings of pleasure associated with the experience of *CM* use. The relationship that evolved with the prolonged use of *CM* furthermore created the 'addict identity'. Shawn revealed how this happened for him:

> *It was that time when, it was periods when... like you wake up and your first thought is not about eating, not about anything... drugs, so you wake up and like about drugs... and you go do... that, that's the first thing you look for, last thing you wanna do is be high so you can sleep, um. So it's, it, it just becomes who you are, it's not even a habit, it's just who you are, um, you associate yourself with it after a while because you like... when you go out and it's not there you don't wanna be there where that's not, um, so yeah /.../ You like yor that's a sad life (laugh). You can sit in a room for hours and not care what is going on around you, you fine in that room, and so it's like, yeah... that who you become, you become, drugs just become who you are.*

The identity acquired because of *CM* addiction was unique for each participant. Shawn revealed that the drug had consumed his existence. Participants admitted that their first and last thoughts of the day related to the acquisition and use of *CM*. This daily use of *CM* had consumed their lives to a point where it became a part of them and their identity. In accepting this new identity as an 'addict', participants struggled to accept a loss of their sense of self, as it had been before they started abusing *CM*.

According to Riessman (1993) stories of past experiences are selective constructions. Following this, participants excluded experiences that undermined their claimed identity. As recovering drug users reconstructed their stories they gave emphasis to the struggle to assimilate the addict identity into their self-concept. In accepting the addict identity a deeper issue, central to understanding the subjective experience of addiction emerged; the nature of the relationship being formed with the drug. Narratives revealed that users compromised themselves by making sacrifices to maintain their addiction. This would continue until a point where they were no longer recognisable to themselves and others.

Users gave an insightful portrayal of their subjective accounts of addiction that did not fit into the dominant discourse of the aetiology of drug abuse. Users were continually challenging

their own conceptions and understanding of their experiences. They tried to give accurate accounts of their experiences, so that we might understand the process of addiction. In accepting their newly acquired identity, users became accustomed to a particular way of life, including embracing the unpleasant symptoms of dependence and the effects of *CM* dependence.

5.4 Unpleasant symptoms of dependence

Besides the progression to *CM* addiction and the battle to merge dual identities, individuals also experienced unpleasant symptoms of dependence. These were an indication that a level of addiction had been reached that made it hard to stop using *CM*. In order to avoid these negative psychological states, the users had to continue using the drug.

5.4.1 The comedown

The use of *CM* induces wakefulness and increased energy levels (Plüddemann et al., 2008a; Watanabe- Galloway et al., 2009). Once *CM* use ceased however, users experienced a 'comedown'. This was commonly experienced as negative, and it could only be prevented by resuming *CM* use. Paula revealed how these experiences served to maintain her drug-using behaviour:

> *...daai drug maak vir die hele paar aande somer nie slaapie, net van daai een skyf wat jy trek /.../ Jy slaapie, jy slaapie vir... jy slaapie vir twee tot drie aande, nou voel jy weer nou miskien by die vierde aand is jy moeg /.../ maar laat daai drug nou net uittrek dan is jy lui soos mòre die hele dag. Jy wil net sit, jy lus vir niks, jy lusie vir praatie... jy lus vir niks to doenie, niemand kan my eers a vraag vra nie dan spring jy nou af hulle keel af /.../ Kyk daai drug maak... kyk as jy daai drug in het is jy bang vir niks, jy is bang vir niemandtie, die way daai drug maak, maar as daai drug uit jou system uitrek dan is jy die bangste persoon op aarde.*
> *(...that drug makes that for a whole couple of nights you actually don't sleep, just from that one puff that you pull /.../ You don't sleep, you don't sleep for... you don't sleep for two to three nights, now you feel again you maybe want to*

by the fourth night you tired /.../ but let that drug now pull out of your system then you are lazy like tomorrow the whole day. You just want to sit, you are not in the mood for anything, you not in the mood to talk... you in the mood to do nothing, no one could even ask me a question then I jump down their throat immediately /.../ Look that drug makes... look if you have that drug in you then you are not afraid of anything, you are not scared of anybody, the way that drug makes, but if that drug leaves your system then you are the most afraid person in the world.)

After ingesting *CM*, participants reported experiencing periods of wakefulness and increased energy. This 'high' lasted for hours, depending on the dosage and the individual characteristics of the user. Afterwards, however, participants experienced a 'comedown'. This was accompanied by fluctuations in mood, aggression, short temper, lethargy and tiredness (Glatt, 1974).

Similarly, their narratives revealed many other contrasts in comparing the initial *CM* use to the experience of the comedown. Initially, *CM* use resulted in increased self-confidence. During the comedown, this transformed into a sense of fear. Additionally, the initial sense of pleasure and elation was replaced by aggression and a negative effect on the user's mood. Particular physical experiences were commonly experienced too, e.g. tightness of the chest, which could only be relieved by further use of *CM*. At this point, narratives revealed that a state of psychological and physical dependence had been achieved.

5.4.2 Withdrawal

In addition to the experience of the comedown, dependence on *CM* was further characterised by a state of withdrawal. Constructions of this experience revealed that it occurred when the user withheld the use of *CM* for a lengthy period, in an attempt to control the use of the drug. However, the substance was then used again to avoid or relieve the withdrawal symptoms. Bianca eloquently described her experience of withdrawal:

...I had... I did suffer from withdrawal symptoms I know that I slept for about a week straight after, after I had the encounter I slept a week straight um, I

didn't know how to handle my withdrawals, I used to scream, I used to cry, I didn't know what to do. Every night I dreamt about drugs, and um yeah... and eventually it just faded away.

Narratives revealed that their initially pleasurable experiences motivated users to continue using *CM*. However, once they stopped using the drug, users experienced the physical and psychological effects of withdrawal. However, it is uncommon that withdrawal from *CM* be accompanied by extreme physical pain (Emmett & Nice, 1996). None of the participants in this study mentioned that they had experienced physical pain during their withdrawal. They did say, however, that they felt lethargic and tired when they stopped using *CM*. Additionally, dreams and other triggers reminded them constantly of *CM*, which further compounded their addiction. A number of studies have found that withdrawal from *CM* is characterised by an increased need for sleep, tiredness and vivid dreams (McGregor et al., 2005; Newton, Kalechstein, Duran, Vansluis & Ling, 2004).

Thus far, we have considered the state of dependence as one that is characterised by the progression of addiction and the formation of a particular sense of identity through prolonged use of *CM*. As the journey to addiction intensified, users mentioned a state of dependence that was characterised by particular unpleasant symptoms such as the comedown and withdrawal. Contrary to popular belief, we cannot assume that users are aware of *CM* dependence and that their journey of addiction was filled with choice and control. Rather, it is clear from their narratives that users were bound by physical and psychological processes of tolerance (indicated by the frequency of *CM* use) and withdrawal. These experiences were unique for each participant. In addition to unpleasant symptoms of dependence, users also learnt to embrace the 'addict identity' in an unhealthy manner by managing the detrimental effects of their addiction.

5.5 Physical effects of CM use

After consistent and prolonged use of *CM*, a state of dependence developed that was characterised by physical and psychological effects. According to the participants' narratives, these effects began to manifest sequentially, beginning with the physical effects of *CM* addiction, before penetrating to the psychological level, the affective level and then finally

the social level.

5.5.1 Short-term physical effects

One of the physical effects experienced by users was weight loss. Rather than ceasing the drug use, however, *CM* dependent users learnt how to manage such changes to their physical appearance. Adrian revealed:

> *Always, always while doing the drugs because I had to maintain my image, I had to maintain my habit that is also why no one could see that I was into... yeah maybe my weight was a bit thinner but no one could see, I would always buy products for my face for you know always well groomed ...*

The main reason for the weight loss is the fact that *CM* acts as an appetite suppressant (Barlow & Durand, 2005; McNeece & DiNitto, 1994; Schlaadt & Shannon, 1994; Watanabe-Galloway et al., 2009). This also made it possible to reconstruct weight loss as a measure of the extent to which the addiction had developed; the more weight someone had lost, the more severe their addiction. This study found that, despite changes to their physical appearance, users did not stop using *CM*. Rather they hid the effects of prolonged drug use in order to avoid calling attention to this and to maintain their drug use. They wanted to avoid being challenged and confronted directly about their drug use. Most of the participants could indeed hide their addiction, until the time when they became physically ill. Ryan, speaking about using the drug within his social network, witnessed his friends coughing up blood.

Weight loss was a short-term effect of prolonged *CM* use. It would be resolved once the *CM* use ceased and normal eating patterns were resumed.

5.5.2 Long-term physical effects

Prolonged *CM* use also had particular long-term physical effects. The participants in this study said that they had experienced heightened sexual arousal when using *CM*. It was found that *CM* users tended to engage in risky sexual behaviours, which sometimes resulted in unplanned pregnancies, among other things. Carla shyly described how *CM* use increased her

sexual urges:

> *Wat dink ek van drugs... wat dink ek van tik, ooh yete daai's gevaarlik... so ko die babies gou (she laughs) ooh, ja ne. Van, van ja... as ek terug moet dink so't hy gekom. /.../ Van saam tik dan you know. Hoe kan ek nou sè, obviously as jy enie boyfriend nou saam tik dan agterna, dan gaan it naar sexual activities toe /.../ I... vir my, vir my'rt baie gebeur you know meerste vanie tyd is hy en ek nou saam.*
> *(What do I think of drugs... what do I think of tik, ooh it is dangerous... that is how the babies come quickly ooh, yes. Because, because yes, if I must think back that is how he came /.../ Of using tik together you know. How can I say now, obviously if you and the boyfriend now use tik then afterwards, then it goes to sexual activity /.../ I... for me, for me it happened a lot you know most of the time then he and I are together).*

On this score, there were marked differences in the stories of the men and women who participated in this study. The men were not likely to speak openly about their sexual experiences while using *CM*, with one male participant commenting that he could not identify himself with the "myth" of sexual activity. Female participants, in contrast, appeared more aware of and willing to speak about the impact of *CM* on their sexual behaviour. There were two reasons for these differences: Firstly, as five of the six women who participated in this study had children, it could potentially have been easier for them to speak about their sexual activity. Secondly, since I was a female researcher and thus most likely easier to relate to, they possibly felt more comfortable discussing such a personal topic.

CM use thus appeared to increase women's vulnerability to engage in sexual risky behaviour. These findings are in line with past research conducted in this area (Broman, 2007; Fergusson et al., 2008; Shoptaw & Reback, 2007; Waters et al., 1997; Wong et al., 2007). The mothers who participated in this study did not explicitly make this connection. However, they did reveal that their children had been conceived while they were using *CM* and that they had continued to use *CM* throughout their pregnancies. Carla in particular admitted that her two children were conceived because of risky sexual behaviour while using *CM*. Furthermore, they revealed that all of the pregnancies had been unplanned. For these reasons, it is possible

to conclude that the consumption of *CM* had impaired their decision-making processes and judgement, thus making them more likely to engage in risky sexual activity (Barlow & Durand, 2005; Bechara, 2005).

A study by Simbayi et al. (2006) (as cited in Harker et al., 2008) found that *CM* users were more likely to have exchanged sex for drugs, more likely to have multiple sexual partners and more likely to have unsafe sex. A female participant revealed that, in her area, it was common for young females openly to exchange drugs for sex and to have multiple partners. The babies were then used as objects in exploiting the social system, in that babies were used to gain access to social grants. The money obtained from these grants was used to pay for the young mother's drug habits.

Unplanned pregnancies can thus be regarded as one of the long-term physical effects of prolonged *CM* use. With regard to the short-term physical effects *CM* users distinguished very clearly between their bodies (physical appearance) and their minds (psychological state) (Keane, 2001). Such constructions indicate that the body had to be understood as separate from the mind for the user. This allowed him or her to contain and control the body, despite being dependent on *CM*. In addition, narratives of female users who were also mothers revealed the influence of social and cultural processes on addiction. Their constructions bring to light the existence of apparent taboos that evaded their respective communities. These carried specific negative connotations suggesting that females who use drugs were sexually promiscuous, neglectful of their children (in the case of mothers) and lacking self-respect and dignity. However, in an attempt to escape such taboos they consciously reconstructed their stories by not explicitly making the connection between their drug use and their sexual behaviour.

5.6 Psychological effects of CM use

After experiencing the initial impact of *CM* on a physical level, users experienced the impact of prolonged *CM* use on their psychological functioning. The mind/body distinction, made by participants in their narratives revealed that they found it easier to conceal changes in their physical appearance than the harsh psychological effects of *CM* use, which was far more challenging. Carla explained:

Is, is mos alles is jou mind... you know is a mind thing /.../ Is waar so jou mind sè ook hè jy't geld koop pakkie man, jy weet, so... of jy's nou boring en jy het geld, nee ga't dan toe of you know so /.../ you know jy dinkie daai nie, jy dink net aan as jy geld het tik koop, jy weet dis al wat op jou mind is... you know, jy dinkie nog aan jou kindersie ...
(It is, is actually all in your mind... you know is a mind thing /.../ It is true so your mind tells you also you have money buy a packet man, you know, so... or you now boring and you have money, no go there or you know like that /.../ you know you don't think that, you just think about if you have money to buy tik, you know that is all that is on your mind... you know, you don't still think about your children ...)

It is evident from their narratives that participants generally remembered the pleasurable effects of *CM* (Barlow & Durand, 2005; McCusker, 2001). In the statement above, however, Carla revealed that her addiction to *CM* was a battle that she endured within her own mind. She found it difficult, even frightening, to abstain from drug use, to control her addictive behaviour and to maintain control over her own thoughts, especially with regard to the memories of the pleasurable effects of *CM*. Nonetheless, she did realise that, if she lost the battle for control inside her mind, she would not be able to overcome her addiction to *CM*.

Users, who constructed their addiction as residing within their minds, did so in the hope of differentiating between the individual and the mind. They also implied that automatic processes beyond their conscious control were taking place in the mind (McCusker, 2001). Paradoxically, this also implied that the user could not be held personally accountable for their behaviour. These automatic processes had particular implications on the affective state of the users.

5.7 Effect of CM on affective states

Besides changing users' physical appearance and reducing their ability to control their thoughts, prolonged use of *CM* also had mood-altering effects. As such, it indicated a loss of control over one's emotions. According to the participants, this manifested as depression, suicidal thoughts and tendencies, and an increase in aggressive behaviour. These were

especially experienced during the comedown and withdrawal phases.

5.7.1 Suicide and depression

CM had mood-altering affects on participants. In extreme instances, the unpleasant experience of withdrawal resulted in suicidal thoughts. Natasha revealed:

> *Like suicide I won't, wooh... I don't wanna do that like for instance /.../ my sister, she live with her boyfriend, he also... she also had a abusive life but like him... he can do anything if he gets cross he cuts his pols (slits his wrist) then she must run, Why must she run? 'cos he's doing it you see, so for me I've been there but not anymore, I also had two problems almost like that... two overdoses so I won't do it again, never.*

Initial *CM* use resulted in a sense of euphoria for the user. Prolonged use of *CM*, however, had a negative effect on the emotional capacity of the participants. Their narratives compared the experience of using the drug with immersion into another state of being that was characterised by negative feelings. The mood-altering effect of *CM* use manifested itself in depression and to some extent accounted for users' suicide attempts. These findings are in line with past research, which reveals that the prolonged use of *CM* may result in suicidal ideation and depression (Doweiko, 1993; McNeece & DiNitto, 1994; Watanabe-Galloway et al., 2009).

5.7.2 Aggression

In addition to creating a higher likelihood of depression and suicide, prolonged *CM* use also increased the likelihood of aggressive behaviour. This aggression was expressed either physically or verbally. Claude explained:

> *I think it comes in different stages, I think the first stage you on the honeymoon. The second stage where you see the effects and you see the things happening but you still okay, then the third stage that would be the stage where you just start losing it and um, my, my family couldn't be around me, I*

just used to blow out on them; I used to fight with my mother, my father if things went wrong /.../ worst point was, where it came to a point where I almost tried to kill my mother um, I was, I just woke up one day and I just lost it and I wanted to push her down the stairs and I wanted to stab her, and then everything just went wrong, I just ran out of the house ...

Previous research conducted in this field found that aggressive behaviour is not an inevitable consequence of *CM* use (Imlah, 1970; Sommers & Baskin, 2006). However, long-term *CM* use does result in displays of violent or aggressive behaviour, which can be attributed to the mood-altering affects of prolonged use (Plüddemann et al., 2008a). Claude, for instance, revealed that, because of his drug use, he reached a point where he no longer could control his aggressive behaviour. It resulted in an attempt to kill his mother after numerous aggressive interactions with his family. While they were intoxicated by the drug, users commonly revealed that they were happy; but when the drug was withheld, it easily triggered violent or aggressive outbursts.

Narratives that gave emphasis to suicide and extreme aggressive tendencies (that nearly drove users to kill) revealed that users experienced, to some extent, a sense of powerlessness. To the interviewer users were constructed as being at the mercy of the drug thereby indicating the destruction behind its use. On a deeper level narratives bear witness to the impact of the drug on the attitude of the user who, as a result of prolonged *CM* use, looses respect and value towards human life.

These unpleasant symptoms of dependence and associated physical, psychological and affective states revealed that users had become psychologically and physically dependent on *CM*. In addition, users also described themselves as being bound by particular social processes.

5.8 Social impact of prolonged CM use

In addition to the physical, psychological and affective effects of prolonged *CM* use, it further increased the likelihood for social impairment for the user. Users surrounded themselves with other users of *CM*, which meant that their identity now revolved almost exclusively around

the acquisition and use of *CM*. This impaired their ability to maintain long-lasting caring relationships. Some of the participants discussed the negative effects their *CM* use had on significant relationships. Users who were dependent on *CM* tended to spend a large amount of time on activities related to the acquisition and use of their drug. As Marvin explained, this prioritisation on drug use was part of the reason why he broke his ties to his parents and others:

> *...it's almost like they didn't trust me anymore man, and I mean that is... that is hard to describe how to feel at that moment, people like, people they always need to tip toe around you man especially with their valuables they need to... okay you come in now to their house and they think now they need to, they need to hide their stuff and things like that man and it... I think I didn't realise at the time that it was impacting me more than I, more than... it was impacting me so much man and the hurt that I felt, that's why I think I just carried on going the route that I did man ...*

Users frequently complained that others treated them harshly. Drug users were commonly stereotyped as thieves who stole to support their addiction, even though this was not true for all addicts. It was particularly challenging to eliminate this stigma.

Glatt (1974) and Keane (2004) found that individuals who are dependent on *CM* might present disturbed priorities. Users tended to focus on the external reality (as affected by *CM* use) in order to compensate for any internal pain (Anderson & Mott, 1998; Keane, 2004). In exploring the effects of *CM*, narratives revealed that as the focus was exerted on the pursuit of pleasure, caring relations with others became a secondary priority, if not completely absent. When users prioritised drugs above relationships, families were forced to take a decision to protect them from the user. In some cases, it meant hiding valuable possessions from users who might steal from family or friends to support their drug using behaviour. In other cases, families had even forced users to vacate the home. Julia described that her family had to choose between her (their daughter) and protecting themselves. This meant risking the loss of their child to addiction, or living with her addiction. In desperation, her family forced her to leave their home.

Larkin and Griffiths (2002) further revealed that *CM* users tended to isolate themselves from caring and protecting relationships, which was reinforced by the fact that the drug itself was reconstructed as creating a distance between the users and those who did not use. For the users the only relationship that mattered was their relationship with *CM*. The more users distanced themselves from caring relationships, the stronger their relationship with *CM* grew. This was interpreted, by the interviewer, as a profound sense of isolation that was not only experienced on a relational level but also as physical isolation, as they used *CM* for most of the day behind closed doors and as they did not allow anyone who did not use *CM* into their world.

5.9 Supporting CM dependence

According to the Diagnostic and Statistical Manual, a state of dependence is characterised by the amount of time spent on drug-related activities, such as acquiring a substance (American Psychiatric Association, 2000). Participants used various approaches to obtain the drug and to continue using it. For instance, they would identify themselves with a particular drug subculture, some would work to support their habit, others would sell their possessions, and yet others would become involved in illegal activities.

5.9.1 Drug subculture

In order to support their drug habit, users tended to form close relationships with other users. This provided them with a reciprocal support structure. Janice revealed how her social network formed a particular subculture of *CM* users:

> *...in the beginning friends didn't contribute to me becoming addicted, and... but afterwards they were always there because we were always like to... together making a way for this tik and maybe I don't have... and my friend have, and they know that I do it... and they will come to me now... or maybe they "soek", they look for a, for a, for a, how do you say now /.../ the lolly or so and I always... I always had a lolly because I knew one day will come then I don't have tik, but at least I will have this... and you need it to take a hit.*

Various methods were employed in order to maintain the costly addiction. Given that users quickly develop tolerance to the drug, and that they need to use it frequently at stronger doses, it is worrying that the drug is becoming cheaper. The most common means of supporting *CM* dependence was to belong to a drug subculture. The narratives commonly revealed that users were not only dependent on *CM*, but also needed the support of their subculture to maintain their addiction.

It was discussed earlier that the addict identity was a label that society attaches to an individual with an addiction. In addition to adopting this identity, the user also forms part of a particular subculture (Hirschman, 1992). Within this, users tended to establish reciprocal relationships in which they provided for each other in times of need, e.g. when one user had a supply of the drug but lacked the appropriate paraphernalia, another user would provide this. The subculture was only maintained as long as the user had something to offer the group. When a user no longer had anything to offer the group, however, they were expelled from the group and had to support their own addiction.

5.9.2 Work for your habit

Users explained how they managed to control their addiction and to support it financially by maintaining employment. Janice, for instance, chose to work to support her habit:

> *...but when you do the drugs everything you do is just to, how do I say now, you just work for your habit man. Any money you get... or so you work so that you can keep your money for your addiction /.../ for me it was not like, I never sold any of my stuff for my addiction. I worked for what I wanted... mostly my friends and so, but I never, I never sold any of my possessions /.../ If I like felt today I want to tik nothings gonna keep me. I would take my phone and like they say go "pan"(pawn) (exchange possessions for money or drugs with those who sell the drugs) it 'cos I know the next day I will make a way so that I can go fetch my phone again like that I was just like that ...*

Remaining in employment was thus the most valuable means of supporting one's *CM* dependence. A user's ability to remain employed was associated with a degree of control

over their life, as well as over their drug use. If users did work, but did not have cash money available, they would search for alternative means to support their habit. Rather than selling their possessions, they would offer them to local merchants in exchange for money or drugs. Once they had earned enough money to pay their debt, they would retrieve their possession from these local merchants.

It emerged from the narratives that users' willingness to work for their addiction further indicated a particular level of addiction. The level of addiction was measured by the extent to which they would go to support their habit, for instance, whether they would sell their personal possessions. Over time, however, as the addiction progressed, these strategies would become ineffective and users increasingly risked legal consequences in maintaining their addiction.

5.9.3 Financial deception

In addition to the strategies explained above (i.e. belonging to a drug culture and working for money), users' strategies to support their drug habit also included the sale of drugs and the theft of goods. Users commonly revealed that, when they desperately needed a fix, they would deceive themselves into believing that they could still control their addiction. They even did this while committing risky or illegal acts. Julia, a young mother, revealed the length she went to, to support her addiction:

> *...and I end up in prison (she giggles slowly), in Pollsmoor okay, I was there for three months, three and a half months and they caught me with tik, five grams of tik on me, and yeah I was in prison for three and a half months and it's not lekker (nice) in prison... because of the tik ...*

In one particular instance, the user needed to find alternative work in order to support their addiction. Adrian revealed that friends had pushed him into prostitution:

> *...my friends, I started doing, going to... encouragement to do prostitution /.../ so by this time I felt wow um... you guys are living your life and you making money so I can also do it, deceiving myself... but I couldn't charge money but... I couldn't charge*

money, I couldn't get myself to charge money for it you know um, and they told me that I was stupid and this and that and... that but that was the lowest blow and that was the most degrading thing that I had to go through.

According to the Diagnostic and Statistical Manual, substance abuse is characterised by a maladaptive pattern of recurrent substance-related legal problems (American Psychiatric Association, 2000). The term legal in this instance refers to any form of socially unacceptable behaviour that is punishable by law. Due to the harmful effects of *CM* use, the production and sale of this drug is illegal in South Africa and in most other countries. There are therefore risks involved in using drugs, including encounters with the government system, which attempts to control the sale and use of drugs. Despite the known risks, those who were dependent on *CM* admitted that they continued to use it. *CM* users revealed that they would risk everything and do anything to support their drug habit. The desperation and distress of their experiences is evident from the aforementioned quotations.

It has been documented that prolonged use of *CM* results in the display of antisocial behavioural patterns on the part of the user (Barlow & Durand, 2005; Glatt, 1974). In exploring strategies for supporting *CM* dependence, users often spoke – without regret – about behaviours that were in direct violation of social norms. Their arrests were constructed as a result of being caught purchasing *CM*, selling *CM* or committing a crime such as car theft in order to support their addiction. Allen (2007) revealed the link between the increase in crime and drug use. In the most severe instances, users engaged in self-generated employment, such as prostitution, which was reflected upon as a quick way to earn a large amount of money. In the case of Adrian, he felt that it was the only means of sustaining his drug habit. As a result, however, he also experienced extreme feelings of shame, guilt, disgust and embarrassment. In order to avoid dealing with these negative feelings, he continued to use drugs.

From the participants' narratives, it is evident that their strategies for supporting *CM* dependence were driven by the uncontrollable compulsion to use *CM*, revealing the extent of their addiction. Their strategies included belonging to a subculture, working to earn money to pay for the addiction and in the most severe instances engaging in illegal activities. Constructions offering a view of the user, who supported their addiction without having to

become involved in illegal activities, indicated to the interviewer that they were not as immersed in the addiction as others and that they still possessed a degree of personal agency. However, alternative constructions of engaging in illegal activities reveal that users were completely immersed in the addiction to a point where they lost their sense of self and ultimately lost their sense of personal agency. In their efforts to maintain their new identity as a drug addict by embracing the effects of *CM* use and taking risks to support their addiction, users experienced conflict with their role obligations.

5.10 Avoidance of role obligations

We have considered many states of dependence, including the progression of addiction, changes to their identity, the unpleasant symptoms and effects of dependence, and the strategies employed to maintain their addiction. One of the strategies involved joining a subculture, which meant connecting to individuals outside of the family circle. This also meant that, as users developed a closer relationship with others in their drug subculture, they were moving further away from their roles and obligations within the family. Users furthermore had to manage life pressures, such as the birth of children and remaining employed. Ultimately, users had to choose whether to continue using the drug, or whether they were willing to sacrifice their drug habit in order to fulfil their occupational and parental roles.

5.10.1 Failure to fulfil role obligations as parents

This study found that, in the case of female participants who were also mothers, the use of *CM* resulted in a failure to fulfil their obligations towards their children. Carla revealed the impact of *CM* addiction on her role as a mother and the impact on her two children:

> *...you know jy dinkie daai nie... jy dink net aan as jy geld het tik koop, jy weet dis al wat op jou mind is, you know... jy dinkie nog aan jou kindersie, jy dinkie nog aan hulle education nie, jy dinkie aan wat ga't hulle aantrek, sulke dinge man, en kinders wil name goed hè en ek meen as ek nou nog op tik gewees it waar ga't my kinders... ek sal tien keer gedinges al, ek sal aire my a gram of wat ga't koop it as of vir hulle, you know... ek meen daai is... maar net die*

waarheid, ek meen jy sleep jouself af.
(...you know you don't think that... you only think about if you have money buy tik, you know that is all that is on your mind, you know... you don't still think about your children, you don't think about their education, you don't think about what they going to wear, that type of things man, and children want name things and I mean if I was now still on tik where would my children... I would have thought ten times, I would rather buy a gram or something than for them, you know... I mean that is... just the truth, I mean you degrade yourself).

Such comments made it clear that, since all thoughts and actions revolved around the use and acquisition of *CM*, mothers neglected their duties towards their children (Watanabe-Galloway et al., 2009). Thereafter, once the child had been born, they failed to care for, nurture and provide for their children's needs, which meant that children were often neglected and had to fend for themselves. The juggling of dual roles as mother and drug user was commonly constructed as particularly demanding. These experiences pressurised the user into considering whether they would continue using the drug or not.

Past research indicates that drug use not only affects the user but also results in the intergenerational transmission of substance use (Cattapan & Grimwade, 2008; Messina et al., 2008; Waters et al., 1997). Paula revealed that her drug use had, to some extent, impacted on her children, as her son started using drugs too. Furthermore, participants also spoke about losing a child. Julia described how she had nearly lost her child at birth to social services, because of her drug use. As a result she had realised the extent of drug use and she pleaded for them not to remove her child from her custody. Similarly, Paula described how a relative had taken her child away because of her continual drug use.

5.10.2 Failure to fulfil occupational role

As indicated previously, users tried to earn money in order to maintain their drug habit. Ultimately, though, they would become unable to fulfil their occupational roles, and users were faced with the choice of either relinquishing their occupational role or stop using the drug. If a user lost his or her job, however, they would lack the necessary financial support to

sustain their addiction. Bianca revealed how prioritising *CM* use above her occupational role placed her continued employment at risk:

> *...obviously this drug takes a lot out of you as well 'cos it brings you to a place where it just... you become lazy, you don't feel like doing anything really and... and I left my job, I didn't wanna work anymore I just wanted a break, I was tired as well ...*

Participants who were not parents constructed their experience of dependence on *CM* as the failure to fulfil occupational role obligations. Although their drug use initially increased their energy levels, later in the addiction they began to feel lethargic and to lack energy. Four participants told of how their increasing laziness resulted in them losing their jobs. Two participants described how they could not cope with having several jobs, which they could not maintain due to their drug habit. If they were no longer employed, they had more time to spend on activities related to their drug use. For some the loss of employment resulted in losing their place of residence and having to return to live with their parents, thereby risking their parents finding out about the addiction. This was revealed to have compounded the drug use, as well as to increase their risk of exposure.

Narratives were reconstructed to reveal that addiction had reached a point where users compromised their most valued roles for the use of the drug. This theme was reiterated throughout the descriptions of dependent states. In these instances users who were also mothers sacrificed their relationship with their children and those who were employed sacrificed the source of income supporting their addiction. This theme brought to light the ability of the drug to persuade the user to take decisions that they would not take if they did not use the drug.

The participants' journeys of addiction and the symptomatic behavioural consequences of their dependent states were constructed to have resulted in long-term consequences. For users, who had overcome their addiction the journey with addiction resulted in enduring memories of the journey and the lessons they had learnt. For the mothers who used the drug, the consequences of this journey were experienced a long time after they had overcome their addiction. The pressure of having to merge dual identities and juggle dual roles was

constructed as daunting for the user. Their subjective experiences were unique for each user, and no one story was able to account for the entire experience of addiction. In addition, the addiction was continually evolving and influencing the user in ways they could not control.

5.11 Chapter summary

This chapter looked at the meanings of participants' narratives by examining the progressive journey of addiction. Participants revealed their difficulties of merging dual identities as 'the addict' and 'the other person' they had been before the addiction. In embracing the 'addict identity', users would become accustomed to the unpleasant symptoms and effects of *CM* dependence. Narratives revealed that different methods were employed to support the addiction, and that prolonged *CM* use resulted in the avoidance of role obligations. Chapter 6 focuses on the journey to recovery, which highlights attempts to control the addictive behaviour and to examine how change is achieved.

CHAPTER SIX: NARRATIVES OF RECOVERING DRUG USERS: THE JOURNEY TO RECOVERY

6.1 Introduction

This chapter investigates the process of change and recovery undergone by the participants in this study. It looks at how the addict transforms their identity from the user of the drug to living without the drug. It outlines this process by looking at the urge experienced by the users to stop using the drug, motivations to stop using the drug and the changes that the user has to make to maintain a successful recovery. Following this, the role of support structures and the renewed identity of the user who has stopped using the drug are considered. In considering the impact of the experience of addiction, the narratives reveal individuals' reflections on the experiences of addiction and their future aspirations.

6.2 Urges to stop using the drug

At some stage during their addiction, often at a time when they were failing to fulfil major role obligations, participants were faced with the choice either to stop using the drug, or to continue suffering the effects of using the drug. On realising the detrimental effects of the prolonged use of the drug, participants experienced an urge to stop using the drug. In an attempt to stop using the drug users commonly mentioned that they would lock themselves in their rooms. In addition, they attempted to decrease the frequency of using the drug by only using it over weekends. Ultimately, however, these attempts to stop using the drug were unsuccessful. Claude, for instance, described his attempts to stop using the drug:

> *...I just didn't know how to stop, I had had enough of drugs, I had enough of not speaking to my family, I had enough of being this... what's the word, enough of being this mess up, enough of not making the right choices in life, enough of not succeeding, enough of just going down and down into the gutter /.../ So I had enough of the drug thing, but I couldn't stop, I tried my best but it just wasn't working /.../ I would lock me in my room because I wasn't working at the time, I had no money, I had no friends, I had no clothes so I just sat in the house... just locked me in the room just stayed there... watch TV, whatever ...*

It is clear from such comments that some participants had an overwhelming urge to stop using the drug, and yet they did not know how to do so. As participants spoke about their attempts to stop using the drug, they expressed feelings of worthlessness, hopelessness and despair. In addition, many had realised that they had not achieved any of the dreams they had set for themselves, before starting to use drugs.

In realising the effect that their addiction had on them and those they loved, they were faced with the truth of what they had become. The participants described this realisation of who they had become, because of their addiction, as an emotionally raw experience. It was accompanied by negative emotions that were related to various aspects of their addiction. For some participants, the methods they had used to support their addiction were experienced as shameful; for others it was the factors that had led to their addiction that were experienced as shameful. Past research found that these negative experiences result in a "spoiled identity" (McIntosh & McKeganey; 2000, p. 181; McIntosh & McKeganey, 2001, p.49). Consequently, participants realised that they needed to create a new identity.

6.3 Motivations to stop using CM

From the participants' narratives, it emerged that each of them had gone through a process of change, which was unique to them. As they shared their stories of recovery, it also emerged that their initial attempts to stop using the drug were largely unsuccessful, especially when they were not sufficiently motivated to change. In exploring their stories, participants spoke about their decision to stop using the drug. This decision was reconstructed as being motivated by particular reasons, which played a pivotal role in the process of recovery. The two main reasons were: children and spiritual encounters.

6.3.1 Children as motivating change

This study found that, in the case of the female participants, who were also single mothers, children played an important role in motivating them to stop using the drug. Three mothers described how they gradually, as their children grew older, started to realise the impact their addiction was having on their children. For instance, Julia, in sharing her story, described how nearly losing her child during pregnancy motivated her to stop using the drug:

...and then they told me we have to like go fetch her 'cos the child is gonna die now in your tummy, we have to go fetch her... and from there they like recovered she's like full of tik in her... not in her mind so much but it was like tik affected her a lot of places man but not so much in the mind you see... and they were like draining all the tik out of her system, and I ask the doctor what are you doing with my child and they told me no it's all the drugs and from there I was like opening my eyes no man tik is not good ...

In contrast, for many of the female participants, who were also mothers, the fact that they were pregnant had no effect on their addiction. Many of them were unaware, that, while they were using the drug, they were pregnant. When they discovered that they were pregnant, it did not affect or limit their frequency of drug use. However, in the case of Julia, once her child was born, doctors had to remove the drugs from her child's system and this made her aware of the impact of her actions on her newborn child. As a result, she began to realise that her addiction was no longer an isolated experience, but that it had also seriously affected her child. A number of other female participants, who were also mothers, revealed that their addiction persisted after giving birth. In these instances, the awareness that their actions were affecting their children did not result in the immediate cessation of the addiction. Nonetheless, as they gradually began to realise how their actions were affecting their children, this influenced them to give up their addiction.

Past research identified the experience of 'hitting rock bottom' as a common experience among addicts, and as one that often leads to a rational decision to stop taking drugs; at this point, the consequences of continual drug use are too detrimental and the addict realises that change *has to* occur (McIntosh & McKeganey, 2001). For some participants, the experience of continual drug use was weighed against the detrimental effects that drug use had on their lives. In the case of single mothers, as their children grew older, these participants realised that they had to act as role models for their children. They furthermore feared the negative impact that their addiction would have on their children. Consequently, in retrospect ceasing the use of the drug was reconstructed as a rational decision to sacrifice their addiction.

For some participants ceasing the drug use was motivated by multiple life pressures that were constructed as stressful. Particularly in the case of the single mothers among the participants,

the stress of falling pregnant and becoming a mother had originally motivated them to use *CM*. The journey to motherhood was experienced as stressful, especially since it was taken alone, without the assistance of the father of their child/children. Sinha (2009) contends that stressful experiences serve to motivate or induce craving and compulsive drug-seeking. In this case, however, these stressful experiences served a dual purpose in that they not only motivated the users to *start* using the drug but also motivated them to *stop* using the drug.

6.3.2 Spiritual encounters as motivating change

The stories of recovery revealed that the participants, once they had decided to stop using, found the journey to recovery to be filled with uncertainty. They were uncertain of how long they would remain clean and if they would be able to sustain their recovery in the long-term. Galanter (2006) revealed that religion offers a way of avoiding uncertainty. In their stories of recovery, many participants revealed that they had no religious beliefs. However, a number of the participants described how they had been invited or tricked into attending either a church service or a support networking, community-based organisation, or how they had been coerced into attending out of a sense of guilt. There, a spiritual encounter motivated them to stop using the drug. Claude revealed how this happened in his case:

> *...until one day I sat in church /.../ and the pastor is preaching and I'm still struggling to get off drugs /.../ I hear where this I dunno it's different... just as the pastor is speaking I just feel this, all of a sudden it come in the meeting again and this heat just come over me but it's like... it's like, it's like fires all around me and now... and it just gets hotter and hotter and I can't get out of my seat /.../ and this fire just starts burning, burning, burning, burning all over me, burning inside of me I just start sweating and I go again through a whole fear, paranoid thing I dunno... I felt like if I don't change now, then it's like God is just going to take me now or the devil's gonna just kill me or something /.../ Wednesday before the meeting even started the guy in charge I told him look at here, I wanna accept Jesus in my life /.../ and we go through the whole prayer thing I accept him into my life and so I'm saved ...*

While attending the weekly meetings at the support-networking support group, I observed that some members of the group became easily enticed by the idea of surrendering their lives

to a higher power. Other members, however, resisted this idea, were not completely convinced of its value, or were of another religious faith. In addition, I noticed that participation in the organisation, despite no direct pressure being placed on group members, meant that one either had to be willing to convert to Christianity in order to gain unconditional acceptance into the group or remain an outsider. The unspoken implication was that one either chose to live with God or Jesus Christ and thus to be healed from one's drug addiction, or to live without God and to receive no healing. Those who were converted had to 'jump through hoops' in order to belong to the organisation. You had to at some point, be willing and open to the idea that God is there for you and can restore your sense of self. In addition, you had to be willing to surrender your life to God and attend ritual ceremonies including attending church services almost daily, you had to be willing to attend the weekly meetings and become involved in the functioning of the group by assisting in particular community projects. Furthermore by accepting God as your saviour and healer you had to live according to the principles put forth in the Bible.

The resistance to surrender to God was tantamount to refusing to be saved, and led to the continual prayer and encouragement to become saved. As part of this entire process of surrendering to God, group members were also encouraged to attend the church to which this organisation was affiliated. I did not attend the church, however, and felt that certain things were expected of me that I would not be able to fulfil. I therefore chose not to become too involved in the group's activities.

Past research has shown that recovery from addiction occurs according to particular stages (DiClemente, Schlundt & Gemmell, 2004; McIntosh & McKeganey, 2001). Usually, there is a particular turning point where the decision is taken to stop using the drug. Unlike some participants who constructed the process of change as taking a rational decision to stop using the drug, some of the other participants experienced a crisis or trigger event, where they realised what their future would be if they continued using the drug, and what it could be if they stopped. For some of the participants, this turning point was constructed as an out of the ordinary, spiritual encounter with God who was revealed to them. They described how God had shown them the choices that had led to their addiction. In addition, God also revealed to them the plans for their future without addiction. This encounter with God was experienced as emotionally overwhelming, and they were faced with that part of themselves that their

addiction had enabled them to deny and that they found difficult to accept. Through these spiritual encounters participants described what was experienced as the instant 'deliverance' from the experience of withdrawal and immediately stopped using the drug. Other participants contributed their recovery to participation in a community-based organisation where they found themselves forming a closer relationship with God.

This study found that religion did play an integral role in motivating participants to stop using the drug. Participants attributed their recovery to God and admitted that they had to depend on God for healing. Although attributing healing to God they did acknowledge the role that they played in taking responsibility for their healing. They took responsibility for their healing by avoiding the use of the drug and they turned to God for strength to not use the drug. This echoes the findings of a number of studies, which identified the role of religion in addiction (Van der Meer Sanchez, Garcia De Oliveira & Aparecida Nappo, 2008; Wills et al., 2003). These studies applaud religion for acting as a protective barrier against various forms of addiction. In other studies, however, religion is criticised for being rigid and involving rule-following (Vanderheyden, 1999). Religion was accordingly portrayed as forcing people to live their lives by adhering to particular rules. These included the attendance of prayer meetings, church services and the religious acts.

6.3.3 Taking the decision alone

Until this point, participants contributed their recovery to a number of factors. A few participants constructed their decision to stop using the drug as lacking any particular motivating factor. Ryan, for instance, revealed that the father of someone that he knew (at the time that he was using the drug) found out that he was using the drug and in an attempt to cover up his addiction, that individual blamed Ryan:

> *...one of my friends told his father that I'm using but I wasn't even friends with that guy at the time, but to save his back he brought my name into it... and his father and my father are good friends and his father came over, and when they asked me I actually just admitted 'cos I wasn't going to lie /.../ I wanted to stop but it was so hard to stop /.../ where I saw there was help offered, I grabbed it first time /.../ it wasn't as easy /.../ was the hardest because, that I have to face them and I have to wonder what*

they thinking of me, if they trust me ...

In other words, when Ryan's father confronted him and asked him directly, Ryan admitted to using the drug. At the time of the confrontation, he had already been struggling to stop using the drug and so, when the opportunity came to reveal the truth, he did so. Being faced with the truth of who he was, and seeing himself through the eyes of his parents, motivated him to change his behaviour. Another participant, Shawn, revealed how he had struggled through numerous attempts to stop using the drug after years of addiction. He finally took a serious decision to stop using the drug, and made a commitment to change his life. Drastic changes were necessary for his life, as this was the only way that he could ensure a successful recovery in the long term.

Factors motivating change were reconstructed in a manner that supports a particular version of the process of recovery. As they shared their stories users appeared to attribute recovery to a particular factor or event. However, in considering the descriptions of addiction it became evident that the process of recovery was more complex than users would like one to believe. Rather than any one particular factor existing at a particular point in time a combination of factors motivated the process of change. Consequently, these constructions do not offer a recipe for others struggling with addiction but rather highlight the unique journey and processes involved in recovery.

6.4 Changes in lifestyle

Participants spoke of how, after numerous unsuccessful attempts to stop abusing drugs, they took a conscious decision to stop; this decision was commonly motivated by external factors. In addition, and in order to ensure that their recovery from addiction was successful, participants realised that they needed to make particular changes in their lifestyle, including changing their friends and their social identity.

6.4.1 Change of friends

The decision to stop abusing drugs had immediate repercussions with regard to their circle of friends. As participants shared their stories they revealed that they had prioritised the drug

use above caring relationships, the only friends they had were those with whom they were using drugs. Once they chose to stop using the drug, however, participants found it difficult, if not impossible, to remain in the same group of friends - especially if these friends continued to use drugs. As a result, the decision to stop using effectively meant that they would have to leave their group of friends (or face rejection by them) and to find new friends. Shawn was shocked to realise that, by deciding to stop using drugs, he also had to change his friends:

> *...I think for the first like three months... because all my friends also did drugs, doing the same thing... so the first three months it was very, very lonely 'cos you try to stay away from where your temptations are... it's just like you don't know other people, you don't know where to go, what to do 'cos your life has been for such a long time, it's just been partying and drugs, so what do normal people actually do, you don't know ...*

Participants spoke of how they had realised that they had to *want* or *be willing* to change. In order to do so, they had to acknowledge the negative impact of drug use on their lives. They also had to be willing to acknowledge that, not only had taking drugs become part of their identity, but it was also affecting their relationships. It furthermore had an impact on the lives of their family and friends. In creating the non-addict identity, they were effectively distancing themselves from those friends with whom they had been using drugs. This meant that they had to reinvent their social identity and find a new social network of non-drug users (Hughes, 2007). This further complicated the process of recovery and change.

6.4.2 Change of social identity

As participants realised that they had to create an entirely new social identity, they also articulated the realisation that they would need to change their whole lifestyle. They would have to become involved in non drug-related activities. Shawn, for instance, revealed how this happened in his case:

> *One of the things about coming off is a lot a lot changes, not only like with drugs, like even your friends, they change drastically /.../ Definitely a lifestyle change, definitely,*

if I can put it that way 'cos like I said it was a lifestyle change... everything changed, not just, when you stop drugs, it's not, 'cos if you don't make a lifestyle change, I doubt much else will change, you probably end up going back somehow, so it definitely takes a whole lifestyle change, a whole change of mindset to get off.

Prolonged drug use, however, reduced the participants' ability to take rational decisions, and their ability to reflect critically on decisions (Spriggs, 2003). There is a belief that addiction kills autonomy and agency – and yet, participants did choose to change their behaviour and to stop using the drug (Levy, 2006). This may not irrevocably confirm the existence of their autonomy but does suggest that a particular level of autonomy does exist while under the influence of the drug. The narratives presented in Chapter Five revealed the impact of prolonged use of the drug on the participants' ability to fulfil their role obligations. By admitting and becoming aware of the effect that the drug was having on their lives, and by deciding to stop using it, participants effectively increased their autonomy (Spriggs, 2003).

Participants also spoke about how they had to change their lifestyle completely in order to change their social identity as drug addicts (Hughes, 2007). By changing their social identity, they became part of a non-addict social network. As a result, they spoke about how they became more involved in non-addict activities, including going to the movies, taking part in outdoor activities and becoming leaders within a community-based organisation that supports the process of change.

Recollections of the process of change focused on the process of re-inventing the social identity of the user that required personal agency. However, this process is more complex and multilayered than users would like one to believe. Rather than identifying change as occurring on any one level users viewed it from multiple levels especially change that occurred within the community-based organisation.

6.5 Support

Once the decision to stop using the drug was taken, participants described their difficulties in remaining abstinent. Users drew on the support of family to remain abstinent and thus recover from addiction. In addition participants in this study found solace by having faith in

God, and drew support from a community-based organisation that also facilitated the change in social identity. For these participants, this organisation served many roles, such as providing the user with a platform to share their experiences, providing support and encouragement, and strengthening their religious faith.

6.5.1 Family

From their stories of recovery, it emerged that the family was the main source of support for the participants. Participants spoke about how isolated they suddenly felt when they had decided to stop using drugs. They were rejected by their drug-using friends, and had to search for a new social identity, which was commonly found in the community-based organisation. Their biological family also provided a sense of belonging and a safe space into which participants could retreat when they felt isolated. Paula revealed the role of her family in her addiction and recovery:

> *Nee, ek bly al die jare hier, my ma hulle't geweet ek was opie drugs, hulle het... elke keer as ek daar gegaan't na my ma, my ma sê, kyk hoe lyk jy, kyk hoe wild is jou oë, sê ek, "Nee ma, jy's mal", sê sy weet, he, "Ek weet vir jou... ek weet vir jou, ek kenie vir jou so wildie". Maar ek het altyd vir haar gestry /.../ Ja dit... kyk ek is bly sy't by my so uit geko want as hulle nie genag it sal ek nooit vanie drug afgekor't ...*
> *(No, I stay here for years, my mother them knew I was on drugs, they... every time I went there to my mother, my mother say look how you look, look how wild is your eyes, I say "No mommy is mad", she say I know, hey, I know you, I know you... I don't know you so wild. But I always argued with her /.../ Yes it... look I am glad she came out to me like that because if she did not nag I would never have come off the drugs ...)*

Despite efforts to conceal their addiction, the participants' families did find out that they were using the drug, usually in the later stages of addiction. The out-of control behaviour and the physical effects of prolonged *CM* use were key indicators of their addiction. By the time that families made this discovery, however, it was already too late – and thus too difficult for addicts to quit, and thus families were left to fight against the addiction and for the lives of their children. Mothers especially took the prominent role in this battle and in some instances

resorted to finding organisations that could assist their addict children.

It has been documented that family support was the main source of support for recovering addicts (Bühringer & Wittchen, 2008; McIntosh & McKeganey, 2000). Participants stated that families were willing to be brutally honest, and even to use force, as they challenged them to face their addictive behaviour. Such challenges were, in most instances, met with denial and aggression. Furthermore, it emerged from the narratives that many parents were at their wits end, having run out of options and forced to harass and plead addicts to look at themselves and their behaviour, to stop using drugs and to seek help. For instance, Claude, who lived with his grandmother, remarked that at one stage she went so far as to watch his every move. When she saw him interacting with gangsters and drug sellers, she would scream at them.

6.5.2 Community-based organisations

In addition to receiving support from the family a number of the participants in this study found the support they needed in a community-based organisation. This organisation was revealed as a support-networking organisation that aimed to assist those in recovery and those living with addiction. Participants attended weekly meetings and received free counselling. Julia, for instance, revealed the role played by this organisation in her recovery:

> *...yeah I was clean before I got saved... how can I say, there was like still issues, man, I used to um... how can I say face /.../ but there is like drugs support group by our church /.../ when it's only for... how can I say drug addicts... they there to help even you when you are on drugs, even when you off the drugs or whatever... they are there to help you and that's how I how can I say, didn't have time for the drugs because I was like going a lot /.../ and like from there I was like clean /.../ I'm clean for a year now and I'm saved for a year ...*

Only one participant revealed that she had attended church and had a close affiliation with her church before becoming a drug addict. A few participants revealed that they had religious affiliations beforehand but however had no faith in the church and in God's ability to heal them. Claude spoke of how he would use the drug in church just to spite God. Similarly,

Bianca revealed that she would attend church, high on the drug, in order to make herself feel righteous. However, a change in attitude was commonly experienced after a religious encounter at either the church or after attending a community-based organisation. Upon being introduced to this organisation, participants decided to stop using drugs. And thereafter, the organisation was then drawn upon for continual support throughout their recovery.

Past research has revealed that the self and identity are integral to understanding addiction (Hughes, 2007; Larkin & Griffiths, 2002). More specifically, the focus is on understanding the addict's subjective experiences. Telling the story of their addiction and recovery is one of the techniques, which allows addicts to understand and make sense of their experiences (Gilbert & Beidler, 2001; Hughes, 2007). Accordingly, the participants in this study revealed that they too used narratives to share their experiences of addiction and to become enmeshed in a social process of storytelling at a relational level. Talking about their experiences allowed them to reconsider their identity and shift from addict to non-addict identity. This social network ultimately gave them a platform for the formation of a new identity and a new social network.

When comparing the narratives above it became apparent that support received at the community-based organisation was constructed differently to the support received from families. Family support, at times, was reconstructed as being dependent on whether the user used the drug or not. However, the support received at the organisation was interpreted as unconditional. Moreover, participation in this organisation revealed a crucial issue regarding the manner in which empowerment was cultivated and is thus central to understanding the process of change. Empowerment is defined as "an intentional, ongoing process centred in the local community, involving mutual respect, critical reflection, caring and group participation, through which people lacking an equal share of valued resources gain greater access to and control over those resources" Rappaport (1995, p. 802). Accordingly, resources were understood as personal and communal narratives. Following this, it is evident that within this group telling ones personal story and to have influence over collective stories were constructed as a powerful resources that contributed to and supported the process of change.

One participant in recovery had personally experienced rehabilitation as negative. The remaining participants developed their own perceptions of treatment based on what they had heard from family members and friends who had attended rehabilitation centres for the treatment of CM addiction. Conventional rehabilitation centres were commonly perceived by participants as not being able to provide effective treatment for addiction. They believed that rehabilitation provided short-term healing for the addiction, and only served to treat the *symptoms* of addiction and not the *cause*. Constructions were interpreted as offering information regarding the manner in which users understood what caused their addiction. Participants revealed that the causes of their addiction were unique and were related to coming to terms with their parents' divorce, accepting childhood abuse or admitting their role in creating their own problems. A common thread that emerged from participants' descriptions of the root causes of their addiction was problems with self-acceptance. In accepting themselves, they had to stop blaming themselves for situations that were beyond their control. At the same time, they had to accept responsibility for creating circumstances that perpetuated their addiction and to accept accountability for their actions. In addition the female participants who were also mothers described how difficult it had been for them to access treatment. They were all single mothers, and participation in formal treatment was costly. Furthermore they feared for the wellbeing of their children if treatment included relocating and being separated from their children. This finding echoes past research, which revealed that treatment for females does not provide for their unique needs (Cohen, Greenberg, Halpin & Zweben, 2007).

The fact that participants had a negative perception of formal treatment centres motivated them to use the community-based organisation as an alternative treatment option. Within the context of this study, alternative treatment refers to the treatment of addiction without the assistance of formal treatment and pharmacological assistance. Instead of treating addiction to a substance with another substance, religion is found to offer users healing and is believed by participants to result in the recovery from addiction.

6.6 Renewed identity

The community-based organisation that was drawn on for support offered users the opportunity to form and maintain a new identity. Their identity now related to religion and

how it related to the community-based organisation. Claude reveals:

> *Delivered, set free from addiction, from cravings, from withdrawals... from everything that comes with drugs, completely delivered. I think delivered like not even thinking about it... like the furthest thing on your mind.*

The identities of participants were continually reconstructed as they passed through time. Narratives revealed that participants now regarded themselves as "delivered addicts" or "recovered addicts". They used the term "delivered addict" to emphasise that God had delivered them, healed them and saved them from addiction. As previously revealed, for some participants, these identities were created within either a church or a community-based organisation that motivated the process of change.

According to Rappaport (1995) a communal narrative is created by a group of people who share a common story. He furthermore posits that within mutual help organisations narratives are formed as people offer one another new ways to think and talk about themselves. In this instance, the community-based organisation offered users alternative stories that centred upon the idea of overcoming addiction (through the grace of God) and thus the opportunity to reconstruct their personal narrative. It was also easier for users to maintain their individual story as it was supported by the dominant story within the community.

6.7 Relapse

A relapse occurs when, after a prolonged period of not using any drugs, a user starts using drugs again. Despite receiving support from various external agents, a few participants who were now in recovery explained that they had still experienced a relapse. Shawn revealed how this happened for him:

> *...how long have I been off... ' bout four years, yeah even... even now cravings still come once a while, and you like where did that come from... I mean like... I don't think I will consider myself fully recovered in the sense that I can just go wherever and it will be ok. Recovered in a sense that, ok I'm not doing it but I still fear very much for drugs /.../ I will admit I kind of relapsed twice. Not into not into tik though,*

into dagga, so I and when I done that I kinda realised there's always that danger, it... it's something that if you not gonna watch ...

Unlike the participants who were in recovery but who were fearful of relapsing, this was not an option for the remaining participants, especially those who declared themselves delivered from addiction and converted to Christianity. Regarding the latter group of users relapse was constructed as an occurrence that was highly unlikely and was frowned upon. From their narratives, it emerged that they nonetheless still had cravings for the drug, even years after ceasing its use. Participants who were in recovery described how, on claiming their non-addict identity, they still struggled to remain distanced from old friends. In struggling to come to terms with their new identity and coming to terms with the rejection of old friends, they would at times fall into the trap of sitting in the company of old friends with whom they used to use the drug. The social pressure and re-exposure to the drug resulted in their relapse (Stewart, 2003; Yen & Chang, 2005).

In another instance, Claude revealed that he did not experience any cravings. However, when he was shown pictures of the drug at a drug support meeting, prior to the one that provided support for the process of change, these pictures induced cravings. This finding is echoed by Stewart (2003) who revealed that drug-related cues increase the likelihood of relapse. In the case of other recovering drug addicts, the experience of life pressures and stress increased their probability of relapsing. Indeed, Sinha (2009) found that stress increases craving and the risk of relapse. As a result, some users' constructions of relapse emphasise how they turned to God for guidance, and how, through prayer and obedience to God they found alternative coping mechanisms. In addition, participants recovering from addiction described how the support of their family and of other participants in their social networking support group served as protective factors against cravings and relapse. This finding is supported by past research (Bühringer & Wittchen, 2008; Sullivan & Farrel, 1999; Van der Westhuizen, 2007).

6.8 Reflections on past experiences

Upon reflecting on their experiences of addiction, participants expressed a mixed sense of sadness, regret and happiness. This sense of sadness arose in response to the time they had lost and the regret they felt for the lives affected by their addiction. In addition, they wanted

their stories to be a lesson to those who are currently using drugs. For instance, Paula spoke about how she would like her story to be a lesson to others:

> *I'm still being healed but I've learnt that it is a process that I do not rush on the healing and I've... what also have helped me to overcome this is the Lord Jesus Christ. If it wasn't for him I do not know where I would have been today... I do believe that everything happens for a reason... I do believe if I hadn't to go through what I had been through I wouldn't have been sitting where I am sitting today and having this interview with you um... if it can help anyone what I've been through, then the experiences that I've been through, then it wasn't in vain, you know ...*

Participants were thus hopeful that their experiences would send a clear message to the youth. Their messages contained warnings to the youth, including an emphasis on the fact that had only become aware of their addiction when it was already too late. In addition, all of the participants agreed that the use of the drug had 'messed up their lives'. Their narratives furthermore revealed a sense of regret, guilt and shame, related to how easily they had been influenced by others, and how easily they in turn had influenced others to use the drug. Consequently, they were still coming to terms with those they had encouraged to take drugs, and who were now struggling with addiction, while they were already in recovery.

Participants emphasised in their narratives that their drug addiction had been a waste of money, time and life, and that they now understood the devastating consequences it had on their lives and on the lives of those close to them. Most commonly, this study revealed that recovering users had many regrets. Nonetheless, they also said that they would not change anything, since it had taught them many life lessons. Their ability to reflect on their lives thus brought them understanding and insight into why and how they had become addicted; it also made them realise that healing was a process that would take time. Overall, they expressed sincere thankfulness to the Lord for saving them and providing healing along the process of recovery.

6.9 Future aspirations

The participants' stories commonly revealed despair and desperation in attempting to fight

addiction. With these stories, however, hopes and future aspirations were revealed too. Adrian, for instance, shared his hopes for the future:

> *...love to go travel the world hey, to go share my testimony and also to do what God is calling me to go do. There is many souls you know... I've got a spiritual, physical and mental side so that's the spiritual side of my life. The mental side is I'd like to finish my matric, I would like to go study law, you know, one day the Lord provides you the opportunity. Physically, I would like to go to gym also /.../ be financially comfortable you know /.../ I would like to have my own house God willing, my own car that is nearly there, God willing um, I would like to have a wife and um, only two children you know, maybe a boy and a girl, whatever the Lord blesses me with.*

Larkin and Griffiths (2002) revealed how, in order to make a successful change, users needed to have a sense of purpose in life. They admitted that, in order to make the necessary changes, they needed to have a purpose in life and to identify goals towards which they wanted to work. Such goals included maintaining their new identity, obtaining employment, maintaining employment, pursuing tertiary education or becoming religious role models within the community-based organisation that provided support along the process of change.

Their narratives also revealed their realisation that, unlike the lack of control they experienced while they were addicted to the drug, they now understood that their future was in their control and ultimately controlled by God. As a result, they were excited, but also fearful of the power they had in controlling their own destiny. In addition, they were no longer blaming others for their actions, which was often the case while they were still using drugs. They had learnt to accept their own role in their addiction and to forgive those who had been instrumental in them becoming addicted to the drug in the first place. They understood that they were now free to live their lives without being restrained by the physical and psychological processes of addiction.

6.10 Chapter Summary

This chapter looked at the journey to recovery by examining participants' urges to change their drug using behaviour. Participants revealed that upon many failed attempts to stop using

the drug they had to take a conscious decision to stop using the drug. This was motivated by a multiple factors. In order to maintain a successful recovery users had to make a number of changes to their lifestyle. The journey to recovery was described as difficult and therefore various support structures were drawn upon. In making changes to their lifestyle and social identities, a shift occurred from the identity as addict to one of recovering user or 'delivered addict', especially in the case of those who had converted to Christianity. However, despite the support received, recovering users were still at risk of experiencing a relapse, and their journey to recovery was thus a long and difficult one. In looking back on their journey with addiction participants expressed a sense of mixed emotions. Ultimately users provide insight into their future aspirations that expresses a sense of control. Chapter Seven provides a synthesis of findings in Chapters Four, Five and Six. It furthermore outlines the strengths and limitations of the study. Following this it provides recommendations for future research.

CHAPTER SEVEN: CONCLUSION AND RECOMMENDATIONS

7.1 Introduction

This chapter contains a synthesis of the main findings presented in the preceding analysis. In particular, this study found that participants used narratives to find meaning in their stories of addiction and recovery. In addition, many of them found meaning in religion, and particularly those who had used drugs for a prolonged period were motivated to change their lives after having a spiritual encounter or attending a community-based organisation. For some, this resulted in a decision to convert to the Christian faith. This chapter also discusses the contributions and limits of this study, which is followed by a brief look at the recommendations for future research.

7.2 Findings

From the results of this study, several broad themes emerged that will be outlined below. The first theme was the start of the participants' journey towards *CM* abuse. In this regard, we looked at the reasons for their initial use of the drug, the emotional aspect of using the drug and the factors that precipitated the use of the drug. The second important theme was the progression of the addiction to *CM*; this was facilitated by a number of factors, mainly including the changes in personality and behaviour that resulted from prolonged use of the drug and the unpleasant symptoms of dependence. Aspects of this theme included the physical and psychological effects on the user of using the drug, the drug's impact on the affective state of the user, and the social impact of using drugs. The third theme revolved around the user's decision to stop using the drug. In this regard, we looked at the urge the user experiences to stop using the drug, the factors motivating this decision, the changes made by the user to overcome his or her addiction, and the support required during the recovery process. Further related aspects were the renewed identity of the user, user's experiences of relapse, the user's reflections on their experiences of using the drug, and their future aspirations.

7.2.1 Beginning the CM journey

This study found that initial *CM* use was often motivated by curiosity, experimentation and boredom. This study also found that some users were motivated by problematic relationships within their immediate family. Such relationships stem from a lack of love from either or both parents. Their experiences of being raised in a dysfunctional home led to an inability to gain the acceptance of their immediate family and a sense of belonging within it. This drove users to seek the emotional connection and fulfilment they needed outside their family home.

In line with past research the study also revealed that users learned how to use the drug within their social group, specifically from their more experienced peers (Doweiko, 1993; Gifford & Humphreys, 2007; Hirschman, 1992; Levinthal, 1996; Schlaadt & Shannon, 1994). Furthermore it was found that stress, and the difficulty of dealing with stress appropriately, was a crucial factor motivating participants to use the drug.

Sexual and physical abuse, particularly childhood sexual abuse, was also found to result in the use of the drug. These findings are validated by past research (Cattapan & Grimwade, 2008; Duncan et al., 2008; Etherington, 2006; Perez, 2000). Victims of physical abuse and molestation frequently resorted to blaming themselves for the sexual abuse. In an attempt to escape these negative feelings, they began to use the drug.

Unlike the negative feelings motivating the use of the drug this study further revealed the fact that the initial use of the drug results in a particular positive psychological state. The ability of the drug to distort users' emotions results in the user forming a strong emotional connection with the drug.

In creating meaning of their addiction, participants in this study mentioned a number of factors that exacerbate the addiction. They revealed a progressive pattern of addiction, as indicated by the use of other substances, including marijuana and combinations of multiple substances, which actually facilitated the use of CM. These findings confirm past research (Degenhardt et al., 2009).

Users' reconstructions of how they became addicted to the drug provide pertinent information

concerning their subjective experiences of the complex processes involved. It was shown that the abovementioned findings confirm current literature regarding the topic of addiction. In addition this study contributes to literature regarding the subjective experiences of factors motivating the initial use of the drug. In addition it makes information available that informs our understanding of the positive reinforcing effects of the drug on the user and the factors hastening the addiction to the drug.

7.2.2 The journey to dependency

A combination of factors influences how a user becomes addicted to the drug. The easy availability of the drug combined with the positive psychological effects of its use results in the increased frequency of its use. The user becomes accustomed to the daily pattern of acquiring and using the drug. He or she thus experiences a shift from casual user to frequent user of the drug.

With the daily use of the drug, a level of tolerance is achieved. At this point the user develops a physical, emotional and psychological *need* to consume the drug. The need to use the drug may be explained by the intimate relationship that the user forms with the drug. This relationship is driven by the user's dissatisfaction with his or her negative life experiences. Consequently, this added dimension contributes to the paucity of research in the field of addiction that takes into account the nature of the relationship that the user forms with the drug (Glatt, 1974; Keane, 2004).

This study obtained information regarding the physical effects of using the drug. These include short-term physical effects of weight loss as well as long-term physical effects related to the use of the drug and its association with risky sexual behaviour. In addition to the physical and psychological effects, the use of the drug also had a significant impact on the affective state of the user, even having mood-altering effects.

The social impact of prolonged CM use involves the disintegration of caring relationship and the role of risky sexual behaviour. In addition, it was common for females to use their unplanned pregnancies as a way to exploit the social system, because single mothers were able to gain access to social grants. This income was then used to maintain their addiction.

These findings reveal the unique role that females play in addiction and it adds to current literature information concerning the implications of gender roles in addiction.

Constructions of addiction give the impression that the processes involved are more complex than traditional (theoretical) representations currently dominating existing literature would like one to believe (Barlow & Durand, 2005; Cancrini, 1994; Hart et al., 2008). Conversely, this study contributes to existing literature on the subjective experiences of the user and brings to light the multilayered nature of addiction (Ajodah, 2008; Etherington, 2006; Hanninen & Koski Jannes, 1999; Van der Westhuizen, 2007). These experiences are conveyed as narratives and support a particular version of addiction. Users ultimately share their stories of addiction in a manner they find meaningful at a particular point in time.

7.2.3 The journey to recovery

According to the findings of this study, the process of change and recovery is preceded by an urge to stop using the drug and a decision to act upon this urge. The decision to stop using the drug is not immediate. Over time, however, users begin to consider the impact of their addiction.

Some users were motivated by a religious or spiritual encounter to stop using the drug. Many of the users who experienced this surrendered their life to God and converted to Christianity. From these narratives it became clear that the users attempted to attribute recovery to a single factor. However, it is clear that recovery was a result of a combination of such factors and that their narratives were reconstructed to support the version of addiction that supported their sense of self.

Once the decision to stop using had been taken, many changes in lifestyle had to be made. Support from external agents was needed in this regard. Common sources of support included the family and a support-networking community-based organisation. The latter provided the user with a platform to form new social networks and to create a new identity. Despite all the support they receive throughout the process of recovery, the user may still relapse and use the drug again.

This study revealed that the participants' reflections on their experiences of addiction are filled with a sense of sadness and loss. Users also felt a sense of regret at the impact their addiction had had, not only on their own lives, but also on the lives of others. However, reflecting on these experiences also assisted them in gaining insight into why and how they had become addicted in the first place. In this way, understanding, insight and meaning emerged from their stories of addiction. They furthermore developed a renewed sense of self and a new future, in which they hoped to meet certain goals they had set themselves.

The subjective experiences of addiction conveyed as narratives offer a unique look into the lives of eleven drug users who, within a particular religious context achieved recovery and found meaning in their stories of addiction. This added dimension regarding the role of religion, especially Christianity in addiction contributes to current literature (Van Der Meer Sanchez et al., 2008; Wills et al., 2003). It provides evidence of the role of religious faith in not only preventing the initial use of the substance but also in assisting recovering drug users along the process of recovery. Overall the findings of this study contribute to literature on the subjective experiences of addiction, in this case *CM* addiction.

7.3 Contributions of this study

This study makes valuable contributions in terms of the unique manner in which narratives were explored. The subjective experiences of those who use substances and those who recover from addiction have been explored. Although past studies have looked at such narratives, they have not incorporated the ethnographic approach into research (Ajodah, 2008; Etherington, 2006; Hanninen & Koski Jannes, 1999; Van der Westhuizen, 2007). By utilising the ethnographic approach, this study offers information that is contextually based, thereby lending greater credibility to the findings. It furthermore offers unique insight into the role of religion during the process of addiction and recovery.

7.4 Limitations of this study and future recommendations

This study was conducted within a particular community-based organisation, and it is thus able to offer a unique view into the role of religion in helping recovering drug addicts to create meaning from their experiences of addiction and recovery. Not all *CM* addicts undergo

this type of 'treatment', and the findings are thus limited to this specific context. I feel that conducting research with other alternative treatment programmes will provide further information on how other recovering drug addicts cope with the process of recovery without being admitted to formal treatment centres.

In addition, the sample group for this study was small (consisting of only eleven individuals) and therefore the ability to generalise the findings is limited. However, it was possible to generate particular themes that were in line with and contributed to the literature in the field of addiction. To spend a limited amount of time in the research field is not ideal. Usually ethnography involves lengthy time spent in the field that is under observation. In this study six months was spent in the research field. Furthermore, the focus of this study was only on the use of *CM* and therefore the findings cannot be generalised to other forms of addiction.

In view of the above, it is recommended that future studies should focus on drugs other than *CM*, and they should look at the unique cultural and social influences of recovering drug addicts in order to understand what treatments are most appropriate for those living with an addiction. In considering these unique influences, future studies should consider the perceptions of members of different faiths in order to ascertain their views on addiction and the role of their faith in recovery. In addition further research should focus on the role of self-help groups and other treatment programmes in local communities and how these may be accessed to assist those recovering from all types of addictions. Furthermore research should focus on how narratives, within these self-help groups, assist recovering drug users in creating a renewed identity.

7.4 My reflection on the impact that participation in this group had on me

Upon my first encounter with this group, I became aware that it would be a difficult task to distance myself from them. It is hard, as a recovering drug user, or as anyone who attends these meetings, not to be absorbed into the rituals of the group. By means of constant reflection, I remained aware of how my participation in this group was affecting me. When I left this group, the spirit and energy of the members remained with me. The language they used motivated me to aspire to greater things, to have faith that all is possible with the Lord, and to remain positive. Although I am not a converted Christian, I have gained or reclaimed

my trust and faith in the Lord. In addition, I admit that participation in such rituals, and being part of a community that espouses religious beliefs and that is motivated by stories of recovery is powerful, not only for those suffering from addiction but for anyone who does not believe in the healing power of God. Furthermore, during the course of participating in this group, I have become more confident about my own story of addiction. I am no longer afraid or ashamed to share my story. By reframing my story and by informing others of how God worked in my life, it is a testimony to others that anything is possible. Consequently, as a result of this study I am seriously considering a career in addictions counselling for myself.

7.5 Conclusion

The present study investigated the pattern of *CM* use from the perspective of the user. It served to generate qualitative knowledge on the trends of *CM* use. The severe physical, physiological and social impact of the prolonged use of the drug revealed the devastating impact it had on the user. Not only the youth are at risk but they are easily influenced due to the increased level of peer pressure that they experience.

The research findings add to the current literature and provide an added dimension to *CM* addiction by complementing the existing views. These include the processes involved in the initial use of the drug and its effects. In addition it provides pertinent information regarding the perception of treatment from the perspective of the user. This added dimension depicts the context in which the addict experiences the addiction. Narratives explored the impact of the drug use on the addicts' lives, and the common themes that emerged revealed their struggles in ceasing drug use.

This study found that formal treatment is viewed as not helpful; it appears that specialised treatment options need to be developed to assist different types of users. These should focus on both individuals and couples regardless of whether they have children. The focus should specifically be on single mothers who abuse the drug and who fear being separated from their children as a result of in-patient treatment centres. Treatment should not only focus on dealing with the addiction but also with the underlying issues that resulted in the addiction in the first place, especially the occurrence of traumatic experiences, such as childhood abuse. Formal treatment centres are not able to accommodate the large number of drug users in the

Western Cape. In addressing this issue, it would be ideal to establish alternative treatment options to assist those recovering from addiction. Such treatment should be given by trained individuals who are able to deal with the complex issues around addiction.

Religious organisations such as the one identified in this study should take the lead in assisting people with addictions. Such organisations offer addicts a cost-effective, efficient, long-term, easily accessible alternative treatment option.

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Appendix A

Interview schedule

- Describe the experience of addiction.
- What was your parent's reaction? What was the role of your parents?
- What the role of social pressures and friends?
- What was the change process like for you?
- What was the role of religion/ the religious group in bringing about change?

Appendix B

DEBRIEFING FORM

1. Did the interview cause you to feel any discomfort?

2. Are there any issues that you feel needs to be further discussed?

3. Are these issues within the scope of the investigator?

4. If not then was a referral made? And to which organisation was the referral made?

5. Did you receive a referral list detailing organisations that you could seek further counselling or care with?

Appendix C

University of Cape Town
Department of Psychology

Informed consent to participate in research and authorisation for collection, use, and disclosure of information regarding the narrative study and other personal data

You are being asked to take part in a research study. This form provides you with information about the study and seeks your authorisation for the collection, use and disclosure of your data, as well as other information necessary for the study. The Principal Investigator (the person in charge of this research) or a representative of the Principal Investigator will also describe this study to you and answer all of your questions. Your participation is entirely voluntary. Before you decide whether or not to take part, read the information below and ask questions about anything you do not understand. By participating in this study you will not be penalized or lose any benefits to which you would otherwise be entitled.

Name of Participant

Title of Research Study

A Narrative Account of Recovering Drug-Users

Principal Investigator and Telephone Number(s)

Chantal Lynn Adams (Masters candidate)
Student with the University of Cape Town
Department of Psychology
021 6922 112

Source of Funding or Other Material Support

Harry Crossley Foundation and the University of Cape Town Equity bursaries.

What is the purpose of this research study?

The purpose of this research is to collect information about how individuals make meaning of and experience the process of recovery and drug use.

What will be done if you take part in this research study?

In this study you will be requested to an interview in which you will be requested to share your addiction story. There may be follow-up interviews in which the investigator may want to explore any topics shared in the previous interview.

> After the interview is over, you will be informed in detail about the design of the study and the research questions we hope to answer with this study. You will also have the opportunity to ask questions and to thus learn more about psychological research.

If you have any questions now or at any time during the study, you may contact the Principal Investigator listed in #3 of this form.

If you choose to participate in this study, how long will you be expected to participate in the research?

The study consists of one interview or a number of interviews, which should not last longer than 30 minutes at a time. If at any time during the interview you find any of the questions or topic of discussion uncomfortable, you are free to discontinue your participation without penalty.

How many people are expected to participate in the research?

11

What are the possible discomforts and risks?

There are no known risks associated with participation in this study. One possible discomfort

you may experience is with the topic of discussion. In order not to cause you too much distress, you will have the power in deciding and guiding the topics for discussion and you will have the choice to continue with the study. If after the study you still feel distressed, the Principal Investigator will talk with you and give a referral for care if necessary.

If you wish to discuss the information above or any discomforts you may experience, you may ask questions now or call the Principal Investigator listed on the front of this form.

What are the possible benefits to you?

You may or may not personally benefit from participating in this study. Participation in this study may, however, will allow you to explore in conversation with the investigator issues related to your addiction story. Furthermore you may, as result of the interviews, explore how you make meaning of your experiences especially with reference to the addiction experience.

What are the possible benefits to others?

The information from this study may help improve our understanding of drug use, addiction and the recovery process. Additionally, this research will allow us to gather information about the implications of findings for informing culturally appropriate treatment for particular group. Furthermore this study may inform research in related fields.

If you choose to take part in this research study, will it cost you anything?

Participating in this study will not cost you anything.

Will you receive compensation for taking part in this research study?

You will receive no a gift voucher for taking part in this study.
Information already collected may be used.

Once personal and performance information is collected, how will it be kept secret (confidential) in order to protect your privacy?

Information collected will be stored in locked filing cabinets or in computers with security

passwords. Only certain people have the right to review these research records. These people include the researchers for this study and certain University of Cape Town officials. Your research records will not be released without your permission unless required by law or a court order.

What information about you may be collected, used and shared with others?

This information gathered from you will be demographic information. If you agree to be in this research study, it is possible that some of the information collected might be copied into a "limited data set" to be used for other research purposes. If so, the limited data set may only include information that does not directly identify you. For example, the limited data set cannot include your name, address, telephone number, ID number, or any other photographs, numbers, codes, or so forth that link you to the information in the limited data set.

How will the researcher(s) benefit from your being in the study?

In general, presenting research results helps the career of a scientist. Therefore, the Principal Investigator and others attached to this research project may benefit if the results of this study are presented at scientific meetings or in scientific journals.

Signatures

As a representative of this study, I have explained to the participant the purpose, the procedures, the possible benefits, and the risks of this research study; and how the participant's performance and other data will be collected, used, and shared with others:

_____ _____

Signature of Person Obtaining Consent and Authorisation Date

You have been informed about this study's purpose, procedures, possible benefits, and risks; and how your performance and other data will be collected, used and shared with others. You have received a copy of this form. You have been given the opportunity to ask questions before you sign, and you have been told that you can ask other questions at any time.

You voluntarily agree to participate in this study. You hereby authorize the collection, use and sharing of your performance and other data. By signing this form, you are not waving any of your legal rights.

_____ _____

Signature of Person Consenting and Authorising Date

Please indicate below if you would like to be notified of future research projects conducted by the abovementioned researcher:

_____ (initial) Yes, I would like to be added to your research participation pool and be notified of research projects in which I might participate in the future.

Method of contact:

Phone number: _____

E-mail address: _____

Mailing address:

_____

Appendix D

Referral Guide

EMERGENCY NUMBERS	
Police	10111
Ambulance	10177
Crime stop	08600 10111
Child Protection Unit	(021) 592-2601
LIFELINE (021) 461-1111	
24 Hour Counselling	
Rape Counselling	
Trauma Debriefing	
Face-to-face Counselling	
Training and Outreach Programmes	
Corporate Training	
ABUSED WOMEN/RAPE	
NICRO	(021) 422-1690
Lifeline	(021) 461-1111
FAMSA	(021) 461-4228
	(021) 461-7360
Rape Crisis	(021) 447-1467
Women's Helpline	0800 150150
WREP (Women's Recovery Empowerment Programme)	(021) 788 9217
Islamic Social Welfare Association	(021) 6963001/3
ADDICTION	
Alanon (alcohol abuse)	(021) 418-0021
Alcoholics Anonymous	(021) 592-5047
The Cape Town Drug Counselling Centre	(021) 447-8026
Mitchell's Plain	(021) 391-0216
Lifeline	(021) 461-1111
SANCA (SA National Council for Alcohol and Drug Dependence)	
Bellville	(021) 945-4080/1
Tygerberg	(021) 919-9557/8
Athlone	(021) 638-5116/5/8
Mitchell's Plain	(021) 397-2196
Khayelitsha	(021) 364-5510