

SUBSTANCE ABUSE AMONG MALE ADOLESCENTS

by

IRENE PATIENCE MOHASOA

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SUPERVISOR: DR EDUARD FOURIE

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DECLARATION

I, Irene Patience Mohasoa, declare that *Substance abuse among male adolescents* is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

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SIGNATURE

I.P. MOHASOA

.....

DATE

ABSTRACT

Adolescent substance abuse is a major problem facing the world today. In order to understand the reasons for adolescent substance abuse behaviour, various theoretical perspectives were utilised and strategies to curb substance use were also identified. The study was conducted in the rural areas of Zeerust, North West province of South Africa. The participants included 12 male adolescents, whose ages ranged from 12 to 15 years. A qualitative, explorative research design was employed. Data was gathered using semi-structured interviews, genograms and observations. Thematic analysis was used to analyse audio-taped data. The study found that substances abused by the participants include alcohol, nicotine, cannabis and heroin. Their reasons for using these substances include individual, family and environmental factors. However, peer group pressure was identified as the primary factor for adolescent substance use. This study emphasises the painful nature of substance abuse among adolescents, yet at the same time it succeeds in highlighting the strategies that can be employed to address substance abuse among adolescents. In addition, this study recommends a concerted effort by all the stakeholders in addressing the substance abuse problem.

KEY TERMS

addict; adolescence; adolescent; dependence; genograms; interviews; NUDIST program; qualitative research; substance abuse; thematic analysis; theoretical perspectives

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Dedication

*I dedicate this study to my mother, Emmah,
my husband, Joseph,
my children, Kelebogile and Boitumelo
and the Sindanes family*

ACRONYMS/ABBREVIATIONS

AIDS: Acquired Immune Deficiency Syndrome

ATS: Amphetamine – type stimulants

ETS: Environmental Tobacco Smoke

Govt: Government

HIV: Human Immuno Deficiency Virus

IDU: Injecting Drug Use

LSD: Lysergic acid diethylamid

NGO: Non-governmental organisation

NUDIST: Non numerical Unstructured Data Indexing Searching and Theorising

NWDC: North West Development Corporation

SACENDU: South African Community Network on Drug Use

SANAB: South African Narcotics Bureau

SAPS: South African Police Services

TADA: Teenagers Against Drug Abuse

UNODC: United Nations Office on Drug Control

USA: United States of America

WHO: World Health Organisation

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CHAPTER 1

ORIENTATION TO THE STUDY

INTRODUCTION

Drug abuse among adolescents continues to be a major problem worldwide, and in particular, South Africa (United Nations Office on Drugs and Crime, 2009). Most teenagers begin to experiment with substances at an early age (De Miranda, 1987; Jaffe, 1998). The most widely abused substances are alcohol, tobacco and cannabis because they are in excess (Alcohol and substance abuse information, n.d.; Madu & Matla, 2003). Most high schools encounter problems with males who smoke cigarettes and dagga on the school premises. Some of these males come to school under the influence of liquor.

Abuse of substances among adolescents is associated with a broad range of high-risk behaviour. This type of behaviour can have profound health, economic and social consequences, for example, some adolescents participate in deviant peer groups, unprotected sexual intercourse, interpersonal violence, destruction of property and perform poorly in their studies (De Miranda, 1987; Jaffe, 1998; Substance Abuse and HIV/AIDS, n.d.).

According to the United Nations Office on Drugs and Crime (2008), substance abuse is worsened by complex socio-economic challenges such as unemployment, poverty and crime in general. These social ills are devastating many families and communities. Substances from all over the world currently flood South Africa. Drug pushers are forcing young people into taking substances so that once they are hooked; they can manipulate their friends into taking substances (United Nations Office on Drugs and Crime, 2008). Too many youth seem to think of experimentation with substances as an acceptable part of transition into adulthood. Few take seriously the negative consequences of dependence on substances (Madu & Matla, 2003).

Various theories such as disease or biomedical theory, psychological theories, progression theories, economic theories, symbolic and interaction theory, social control theory, and availability theories explain the reasons for substance use (Cicchetti, 2007; Crain, 2004). These theories will be discussed further in chapter 2.

Substance abuse among adolescents costs a country a lot of money every year. This is evident in large sums of money that are used in prevention and treatment centres throughout South Africa (United Nations Office on Drugs and Crime, 2008). Eventually this affects the whole country because these funds could be used in other avenues such as poverty alleviation programmes, since poverty is one of the reasons that lead to substance abuse.

Various organisations control the flow of substances and discourage the youth from getting involved with substances. These organisations include, among others, the South African Narcotic Bureau, the South African Police Services, Alcoholic Anonymous, government departments as well as non-government departments (Department of Social Development, 2006). Despite their effort to control substance use among adolescents, recent national survey data indicate that the use of substances is still on the rise (Alcohol and Drug Abuse Module, n.d.; Substance Abuse and HIV/AIDS, n.d.).

The urgency of the problems associated with adolescents' substance abuse and misuse of substances impels lawmakers, educators, parents and communities to take actions. Thus, there is a need to develop more effective evidence based prevention methods.

BACKGROUND TO THE RESEARCH PROBLEM

The Zeerust district is one of the areas affected by substance abuse. The area is next to the borders of Botswana (NationMaster-Encyclopedia, n.d.), which makes drug trafficking into Zeerust easy as the border is permeable. Many adolescents in the Zeerust district tend to engage in risky behaviours such as drug abuse, sexual intercourse and crime.

There are no recreational facilities in the rural areas of Zeerust, as a result adolescents tend to engage in risky behaviours. Most of these adolescents stay on their own, or with single parents and extended families, where most adults are using drugs. The family background of these adolescents tends to be a risk factor for drug abuse. In addition, substance abuse in Zeerust is one of the leading causes of HIV/AIDS.

Most adolescents start using drugs as young as 12 years of age (Karen Lesly, 2008; Parrott, Morinan, Moss & Scholey, 2004). The problem of substance abuse usually starts with smoking

cigarettes at the toilets during school breaks. These adolescents would then proceed to use other drugs such as alcohol, cannabis and hard drugs (Berk, 2007; Donald, Lazarus, & Peliwe, 2007). Adolescents use substances for various reasons and contributing factors include their developmental stage, peer group pressure, family problems and stress relief (Jaffe, 1998; Liddle & Rowe 2006; Rice & Dolgin, 2008). These adolescents seem not to be considering the long-term effect of these drugs on their lives.

Once these adolescents are under the influence of drugs, they become aggressive and violent towards their parents, educators, other learners, and other members of the community. The use of drugs by adolescents also affects their academic performance. Adolescents in the Zeerust district perform below the expected National Standards (Department of Education, 2008). Some of these adolescents end up dropping out of school and adding to the rising rate of unemployment in South Africa. In addition, some male adolescents are arrested by the police because of their involvement in criminal offences such as robbery, house breaking, shop lifting, theft of stock, rape and murder (South African Police Service, 2007).

Parents, educators, social workers and the police have tried their best to discourage the adolescents to stop using substances through awareness campaigns, but their efforts seem to be ineffective. There is a need for intensive intersectoral intervention strategies to address the substance abuse problem before it escalates even further.

RATIONALE FOR THE STUDY

The study is conducted for the following reasons: The extent of substance abuse among adolescents is on the rise. There is a high death rate among adolescents due to substance abuse.

Parents and educators are trying their best to discourage adolescents from using substances, yet their efforts seem to be ineffective. Parents and adolescents need to be made aware of the extent of substance use and its effects. Parents and educators seem not to be able to assist and even cope with adolescents once they are dependent on substances. Secondary schools are facing a high rate of drug abuse, as a result this has a negative effect on teaching and learning. Some of the adolescents who abuse drugs do not perform well in their studies. Others drop-out of school. This adds to the number of illiterate and unemployed youth in the Zeerust district. Adolescents abusing substances tend to be aggressive and uncontrollable.

The study will help parents and adolescents to understand how it came about that adolescents abuse substances as well as their knowledge thereof. I found no existing research explaining substance abuse in Zeerust. It is therefore important to determine the reasons and nature of substance abuse by adolescents in Zeerust, in order to be able to suggest measures which could be applied to prevent and control the substance abuse problem in Zeerust.

SIGNIFICANCE OF THE STUDY

The findings of this study could be used to educate adolescents and their parents on substance abuse in Zeerust and other rural areas in South Africa. Furthermore, the findings of this study will help educators, health care professionals, and other professionals involved with adolescents to understand the prevalence of adolescent substance use and abuse, associated morbidities and most importantly, to develop effective evidence-based strategies and policies that could be used to control the substance abuse problem.

AIMS OF THE INVESTIGATION

The aims of this research are to: Investigate how it came about that male adolescents abuse substances. Investigate the complexities of substance abuse among a small group of adolescents in secondary schools in the Zeerust district, North West province of South Africa. Explore what adolescents know about substances and its effects. Identify the family structure and the social environment in which the adolescents live. Identify strategies to prevent substance abuse among male adolescents.

STATEMENT OF THE PROBLEM

In light of the above, the main research question for the study is: Why do adolescents use substances? The following are the sub-questions for the study: Which substances are used by male adolescents? What do they know about substances? Which socio-cultural factors contribute to substance abuse? Which strategies can be developed to prevent substance abuse among adolescents? These guiding questions are merely tools that were used to generate questions and to search for patterns. Guiding questions were not discarded when I entered the field and found other exciting patterns of phenomena (De Vos, 1998; Marshall & Rossman, 1995).

RESEARCH STRATEGY AND RESEARCH METHODS

A qualitative research strategy is employed in this study. Qualitative research is a multi-perspective approach to social orientation, aimed at describing, making sense of, interpreting or reconstructing this interaction that a subject attached to it (Denzin & Lincoln, 1994). Qualitative research is a many labelled tradition. The most commonly used label appeared to be 'field research, naturalism, ethnography, interpretive research and constructivist research' (De Vos, 1998: 240). To ensure that this study concentrates on qualities of human behaviour, qualitative research was employed to obtain information on substance abuse among adolescents.

Interviews and observations were conducted and genograms compiled with adolescents who abuse drugs until data were saturated (Hammel & Carpenter, 2004; Marshall & Rossman, 1995; McGoldrick, Gerson, & Shellenberger, 1999). Audio-taped interviews were transcribed verbatim. Thematic analysis was used to analyse data (Aronson, 1994; Attride-Stirling, 2001; Braun & Clarke, 2006). The Non-numerical, Unstructured data Indexing, Searching and Theorising (NUD*IST) computer program was used to analyse the data (Bryman & Burgess, 1999). This research design was pretested with two male adolescents who were not participants in the main study (Stachowiack, 2008).

Details of the research design will be discussed in chapter 3.

ETHICAL CONSIDERATIONS

The following ethical considerations were taken into account in this study. Permission to conduct the study was requested from the Zeerust Area Project Office, Department of Education, North West province, principals, parents, and the respondents. Participants were fully informed about the procedures of the study. Participation in this study was voluntary, as such no participant was forced to take part. Participants were informed that all records pertaining to the study will be confidential, and that numbers instead of names will be used to identify participants. As suggested by previous authors (Berg, 2001; Kerlinger & Lee, 2000; Newman, 2000; Patton, 2001; Seidman, 1998), participants in this study were also protected from any harm. Ethical considerations will be discussed further in chapter 3.

DEMARCATIION OF THE STUDY

The study was conducted in four secondary schools in Zeerust. Only male adolescents attending school were participants in this study, therefore, the findings cannot be generalised to females and to adolescents in other parts of South Africa as conditions may differ. However, the results may be used to develop policies and intervention strategies for adolescent substance abuse.

DEFINITION OF CONCEPTS

For the purpose of this study, the following key terms are used and defined below:

Adolescence

Adolescence is a Latin word *adolescere* which means to grow. Adolescence refers to a stage of physical and mental human development that occurs between childhood and adulthood (Berk, 2007; Louw, Van Ede, & Louw, 1998). The ages that are considered to be part of adolescence vary according to the culture and ranges from pre-teens to young adults of 19 years (Berk, 2007). According to the World Health Organisation (WHO), adolescence covers the period of life between 10 and 20 years of age. This transition involves biological (i.e., pubertal), psychological, and social changes (Shaffer & Kipp, 2007). In this study, adolescence refers to a transitional stage of development between childhood and adulthood, in which males between the ages 12 and 15 years experience physiological, psychological and social changes.

Adolescent

Adolescent refers to a boy or girl between the ages 10 and 20 (Berk, 2007; Louw et al., 1998).

Substance

A substance is a chemical used in the treatment, cure, prevention or diagnosis of disease or to enhance physical and mental well-being (De Miranda, 1987; Kring, Davison, Neale & Johnson, 2007; Pressly & McCormick, 2007; Rice & Dolgin, 2008). Furthermore, a drug also refers to chemical substances that affect the central nervous system, such as tobacco, alcohol, dagga, cocaine, and heroin. These drugs are used for perceived beneficial effects on perception, consciousness, personality and behaviour. These chemical substances, both medicinal and recreation can be administered in a number of ways; orally, inhaled, injected and rectally (Butcher, Mineka, Hooley, & Carson, 2004; Carson, Butcher, & Mineka, 2000; Craig & Baucum,

2001; Davison, Neale, & Kring, 2004; De Miranda, 1987; Kring et al., 2007). These substances can be legal or illegal. In this study, drugs refer to legal and illegal substances abused by male adolescents, which are not used for medicinal purposes and which have a negative effect on their mind, thinking, perception, and their behaviour, for example, alcohol, cannabis, cocaine and heroin.

Substance use

Substance abuse refers to chronic or habitual use of any chemical substance to alter states of body or mind, other than medically warranted purposes leading to effects that are detrimental to the individual's physical or mental health or the welfare of others (De Miranda, 1987; Kring et al., 2007; Rice & Dolgin, 2008; Drug Addiction and Drug Abuse, 2008). In this study, substance abuse refers to the misuse of legal products (prescription medications) and illegal products such as cocaine and cannabis, which are harmful to adolescents' well-being as well as the welfare of the society.

Substance dependence

Substance dependence refers to the uncontrollable craving and use of substances despite the potential or actual harm to the person and society that may result from it (De Miranda, 1987; Kring et al., 2007; Pressly & McCormick, 2007; Rice & Dolgin, 2008). It includes both legal and illegal substances. Those dependent on substances are often unable to quit on their own and need treatment to help them to stop using the substances (Alexander, 2001; Cicchetti, 2007; Jaffe, 1998; Kring et al., 2007). In this study substance dependence refers to continued use of a substance or substances by male adolescents, despite the physical and psychological harm that may result from it.

OUTLINE OF THE STUDY

Chapter 1 provides a brief background and overview of the study. Chapter 2 discusses the literature review undertaken for the study. Chapter 3 describes the research design and methodology. Chapter 4 covers data analysis and interpretation. Chapter 5 discusses the findings of the study. Chapter 6 concludes the study, discusses its limitations, makes recommendations, and makes suggestions for future research. My personal reflections are also discussed.

CHAPTER SUMMARY

This chapter provided an overview of the study, including the background to the research problem, rationale for the research, significance of the study, aims of the investigation, statement of the problem, research strategy and research methods, ethical considerations, demarcation of the study, definition of concepts, and outline of the study. Adolescents are in the most vulnerable stage of development. Substance abuse among adolescents creates a concern among parents, educators and other professionals, thus, effective evidence-based intervention strategies to address substance abuse among adolescents need to be implemented. The next chapter discusses the literature review.

CHAPTER 2

LITERATURE REVIEW OF ADOLESCENT SUBSTANCE USE

INTRODUCTION

In this chapter, literature relating to adolescent substance use will be discussed. The literature review will be used to identify a relevant theoretical and conceptual framework for defining the research problem, lay the foundation for this study, inspire new research ideas, and determine any gaps or inconsistencies in the body of research (Polit, Beck & Hungler, 2004). Many studies have investigated the reasons or risk factors involved in substance use among adolescents. Information gathered from previous studies will be used to provide an understanding of the factors that could contribute to substance abuse among adolescents. The literature review will focus on the following aspects; types of abused substances, prevalence of substance use and abuse among male adolescents, theoretical perspectives on the causes of substance use and the effects of substance abuse on health, economic and social aspects. The socio-economic status of the area where the study was conducted and a background of adolescents in that area are also discussed.

TYPES OF ABUSED SUBSTANCES

Adolescents abuse both legal and illegal substances. Legal substances are socially acceptable psychoactive substances (De Miranda, 1987; Parry, 1998), and include over the counter and prescription medicines, such as pain relievers, tranquilisers including benzodiazepines, cough mixtures containing codeine and slimming tablets (Craig & Baucum, 2001; Conger, 1991; Rice, 1992). In addition, there are other agents such as solvents in glue, alcoholic beverages, nicotine and inhalants, nail polish and petrol. Illegal substances are prohibited and the use, possession or trading of these substances constitute a criminal offence (De Miranda, 1987). These substances include cocaine powder, crack cocaine, heroin, ketamine, cannabis, ecstasy, fentanyl, morphine, methaqualone (Mandrax), opium, flunitrazipam (Rohypnol), methamphetamine and Wellconal (Craig & Baucum, 2001; De Miranda, 1987; Parry, 1998). These illegal substances will be discussed later in the chapter.

PREVALENCE OF SUBSTANCE USE AND ABUSE AMONG ADOLESCENTS

A number of institutions gather information about the prevalence and trends of alcohol and other

substance use. These include, among others, the Centre for Addiction and Mental Health, Canadian Medical Association in Europe, United Nations Office on Drugs and Crime (UNODC), and the South African Community Network on Drug Use (SACENDU).

Studies on the use of substances among adolescents have been conducted throughout the world. An estimated 13 million youths aged 12 to 17 become involved with alcohol, tobacco and other substances annually (Lennox & Cecchini, 2008). In general, tobacco and alcohol are the most frequently used substances by young people, with cannabis use accounting for 90% or more of illicit substance use in North America, Australia, and Europe (Alexander, 2001). Furthermore, the Canadian Centre on Substance Abuse (2002) has conducted a survey which indicated that the average age for first users of substances was 12 years. About 64.7% of the youth in grades 7 to 12 reported the lifetime use of alcohol, 29% cannabis, 43% cocaine powder and less than 4% other substances including heroin, ketamine and crystal methamphetamine (Canadian Centre for Substance Abuse, 2002).

Studies conducted in South Africa (see Alcohol and drug abuse module, n.d.; Madu & Matla, 2003) indicate that the average age of a first-time substance user is 12 years, which is similar to findings in European countries (Karen Lesly, 2008; Parrott, et al., 2004). In a study conducted by Fisher (2003), 45% of participants had tried drugs and 32% were still using them, while in a study conducted in treatment centres in the Free State, Northern Cape, and North West, alcohol was found to be the most common primary substance of abuse among patients (Plüddermann, Parry & Bhana, 2007). In addition to that, a survey conducted in Cape Town found that more than 10% of 11 to 17 year olds had been drunk more than 10 times (South African Community Network on Drug Use Report 11, n.d.).

There is also a considerable abuse of over the counter and prescription medicines such as slimming tablets, analgesics, tranquilisers and cough mixtures. Cannabis was found to be the second most common substance used among patients under 20 in treatment centres in the Free State and North West (Plüddermann et al., 2007).

Crack cocaine and cocaine powder use are also relatively common in the Northern Cape and Western Cape for patients under the age of 20 (Plüddermann et al., 2007). There has also been a

dramatic increase in the use of heroin and cocaine as secondary substances of abuse in Cape Town and Gauteng. Poly-substance abuse remains high in treatment centres (Parry, 1998; Plüddermann et al., 2007).

Many substance users in South Africa are poly-substance users, that is using various substances in combination with alcohol as well as other combinations, such as cocaine and heroin (Parry, 1998). There are also reports of increasing availability and use of synthetic substances such as ecstasy and 'CAT', which are sniffed or snorted. In a study by Plüddermann, Parry, Bhana, Dada and Fourie (2009), Alcohol, cannabis, and heroin were the most common primary substances of abuse for patients younger than 20 years.

According to Plüddermann et al. (2007) over 75% of patients younger than 20 years are black, a significant increase over previous periods; 88% are male and 12% are female. About 31% of patients reported swallowing their substances when alcohol is excluded. Almost 92% report smoking as their mode of use. Only 1% of patients reported that they injected drugs. Blacks constitute the majority of patients in treatment centres, followed by whites, coloureds, and Asians (Plüddermann et al., 2007). For many youths, substance abuse precedes academic and health problems including lower grades, higher truancy, drop out decisions, delayed or damaged physical, cognitive and emotional development or a variety of other costly consequences (Lennox & Cecchini, 2008).

Thus substance abuse occurs in various countries including South Africa and among various racial groups. Whites, blacks, coloureds and Indians are experiencing a problem of substance abuse among adolescents in their families. Substance abuse also occurs among adolescents from various socio-economic backgrounds. That is evident in studies conducted in urban and rural areas (Madu & Matla, 2003; Plüddermann et al., 2007), which shows that substance abuse does not only occur among the poor but also among wealthy families.

THEORETICAL PERSPECTIVES ON THE CAUSE OF SUBSTANCE USE AND ABUSE

The causes of substance use are complicated and differ among individuals. There are various theories explaining the etiology of substance use disorders. These include developmental theories, biological theories, psychological theories, learning theories, progression theory,

economic theories, symbolic interaction theory, social control theory, bonding theory and availability theory (Cicchetti, 2007; Crain, 2004). Developmental theories are the point of departure in this study as the study intended to investigate participants in a specific developmental stage, namely adolescence. Other theories were considered in order to contextualise the reasons for substance use and abuse among adolescents.

Developmental theories

Adolescence is a period of physical and sexual development, as well as development of adolescents' thinking, feelings, personal relationships, behaviour and identity (Berk, 2007; Conger, 1991; Louw et al., 1998; Rice & Dolgin, 2008). Adolescence is a period of transition, in which individuals seem to be more impulsive, reckless and non-conforming than during other developmental stages of their lives (Donald et al., 2007; Louw et al., 1998; Visser & Routledge, 2007).

Adolescence is a time of growth, exploration and increased risk taking. Many adolescents engage in substance use activities which they perceive as acceptable within their peer groups. As a result, risk behaviours including substance abuse during the adolescent years are of major concern because they are associated with the increased risk of injury, interpersonal violence, crime, high-risk sexual behaviour, suicide, academic difficulties and school drop-out. Consequently, substance abuse can have a major impact on the lives of adolescents (Berk, 2007; Nolen-Hoeksema, 1998; Pressly & McCormick, 2007; Rice, 1992).

Thom (1988) showed that black and white adolescents in South Africa experience adolescence as a difficult developmental stage. This experience of adolescence is not only an indication of the effect of physical, cognitive, social and psychological development during this transitional stage, but could also be an indication of the effect of the change-oriented society in which they are growing up. This society is not only characterised by rapid technological and social changes, but also by changes in roles, behavioural norms, ideologies and values.

Furthermore, Boulter's (1995) study suggests that South African adolescents also have to obtain a synthesis between indigenous traditional, cultural changes and modern Western culture. According to Boulter (1995), the dramatic changes that are being implemented in the school

system in South Africa, as well as the extensive family, social and personal changes, bring about vast adjustments. Boulter's research suggests that adolescents struggle with issues such as self confidence, self-esteem, emotional stability, health, family influences, personal freedom, group sociability and moral sense, and these cause them to end up engaging in substance abuse.

The development of identity

The establishment of identity is widely viewed as the key developmental task of adolescence, sometimes accompanied by emotional strain as adolescents grapple with the question of who they are and what they want to become (Donald et al., 2007; Louw et al., 1998; Rice & Dolgin, 2008). Identities can be based on roles, relationships, status in an organisation, or those related to character traits (psychological and behavioral attributes). Adolescents must navigate between traditional expectations and contemporary conditions (Louw et al., 1998; Rice & Dolgin, 2008).

According to Erikson (1968), in order to form an identity, all the psychological crises of the previous developmental stages need to be resolved. That means that adolescents must have acquired basic trust, autonomy, initiative and industry to successfully accomplish the tasks required for identity development. Identity development implies that adolescents need to define who they are, what is important to them, and what directions they want to take in life (Louw et al., 1998).

Erikson (1963) referred to this identity development as an identity crisis, a temporary period of confusion during which adolescents explore, question existing values, and experiment with alternative roles in order to develop their own set of values and goals.

According to Erikson (1963), this experimenting, exploring and questioning do not indicate negative development, but rather how the individual forms a personal and social identity. Furthermore, Erikson (1963) points out that society allows adolescents a certain period of time, called the psychosocial moratorium, to find themselves and their roles as adults. Experimentation takes place during this psychosocial moratorium, for instance 'trying out' various identities, by endless self-examining, investigating about careers and ideologies, fantasising about roles and identity with other people and hero-figures.

The following elements are important in forming an identity: gender, religion, politics, an own value system, independence from parents, social responsibility and work roles. According to Erikson (1974), adolescents have to accomplish the following: formation of a continuous, integrated, unified image of the self; sociocultural identity; gender role identity; career identity and their own value system identity. The successful completion of these tasks will promote adolescents' sense of identity and thus limit confusion (Erikson, 1974). Furthermore, the establishment of identity provides a sense of faithfulness or fidelity. Through self-examination, experimentation, and the formulation of an own value system and philosophy of life, adolescents get to know who they are and what they want in life. Adolescents can therefore be faithful to their own values and principles and this will establish self-confidence.

Identity confusion

Identity confusion occurs when adolescents are indecisive about themselves and their roles. They cannot integrate the various roles, and when they are confronted by contradictory value systems, they have neither the ability nor the self confidence to make decisions. This confusion causes anxiety, as well as apathy or hostility towards roles or values (Erikson, 1977). The identity confusion could also result in an identity foreclosure or negative identity. Identity foreclosure means that the identity crisis is resolved by making a series of premature decisions about one's identity, based on other's expectations of what one should be. This happens when external demands or role expectations pose a threat to adolescents' identity development. In their confusion, adolescents tend to fulfil roles simply to meet the expectations of others, without truly identifying with these roles. In addition to that, they develop a negative identity. Negative identity means that adolescents form an identity contrary to the cultural values and expectations of society, for example, adolescents who abuse drugs and juvenile delinquents (Burger, 2008; Donald et al., 2007; Louw et al., 1998; Sdorow & Rickabaugh, 2002; Visser & Routledge, 2007).

Theorists (Craig & Baucum, 2001; Liddle & Rowe, 2006; Sdorow & Rickabaugh, 2002) also confirm that substance abuse is one of the high-risk behaviours during adolescence and young adulthood. In addition, data from around the world suggest that substance abuse starts between the ages of 11 and 14 (Parrott et al., 2004; Richter et al., 2006 cited in Visser & Routledge, 2007). A large number of adolescents experiment with legal and illegal substances out of curiosity (Conger, 1991; Jaffe, 1998; Rice, 1992; Visser & Routledge, 2007). Many adolescents

consider smoking and drinking 'safe' habits that make them look more adultlike (Craig & Baucum, 2001). Other reasons for adolescents' abuse of substances include coping with stress, peer group pressure and following the example set by adults (Donald et al., 2007; Jaffe, 1998; Karen Lesly, 2008; Parrott et al., 2004).

This period of adolescence fosters egocentrism and a sense of being vulnerable, encouraging adolescents to take risks (Williams, 2004, cited in Visser & Routledge, 2007). Being a male adolescent surrounded by societal stereotypes and pressures can contribute to psychological difficulties and risk-taking behaviour (Visser & Routledge, 2007). The fact that adolescents take substances is a reflection of the element of sensation seeking prevalent in the years of adolescence (Baucum & Smith, 2004; Berk, 2007). Adolescents indulge in substance abuse as a way of trying to channel their heightened energy of this developmental stage (Rikhotso, 2002). Another reason for trying substances is to have fun or sensual pleasure. Users seek an exciting experience (De Miranda, 1987; Rice, 1992; Rice & Dolgin, 2008).

Adolescents seem to experiment with substances even though they have heard what the effects of different substances are. Adolescents also use substances to prove their boldness and express their sense of adventure and partly because they do not believe that anything disastrous can happen to them (Conger, 1991). If adolescents are more attracted by the promises of a substance than repelled by its potential harm, they may be led to experimenting. Some adolescents begin using substances as a means to rebel, protest, and expressing their dissatisfaction with traditional norms and values. This group includes activists and protestors whose life-style includes involvement in substances (Pedersen, 1990, cited in Rice, 1992).

Experimentation with alcohol, tobacco and cannabis is common among adolescents (Donald et al., 2007; Parrott et al., 2004). This occurs because of the developmental need to behave in a way that looks more 'grown up' as well as to challenge adult authority (Donald et al., 2007; Rice & Dolgin, 2008). Furthermore, Rice and Dolgin (2008) suggest that a convergence of developmental changes sparks teenage alcohol consumption. The physical changes associated with puberty cause a person's tolerance to alcohol to increase and so he or she can begin to drink without feeling ill. Adolescents, who no longer view themselves as children, want to look more mature and adult-like. They believe that having a drink in their hand will make them appear

grown up (Donald et al., 2007).

The cognitive skills that emerge post-puberty allow teenagers to view issues including whether or not to drink in relative rather than absolute terms. Adolescents move beyond thinking about alcohol consumption in terms of 'yes' or 'no' and begin to think about 'when' and 'how much'? Cognitive conceit makes youth more likely to question the wishes of authority figures. The personal fable makes adolescents feel invulnerable and so they perceive that there is little threat of harm to them. Increased inferential skills make teens more aware of adult hypocrisy. Teens may lose respect for adults who drink alcohol but then tell their children or students that drinking is risky (Donald et al., 2007).

The process of finding an identity involves trying new experiences. Adolescents have more freedom and independence than younger children and they are less closely supervised and monitored. Adolescents spend more time with their peers and less with their families. This serves to increase peer influence and decrease family influence on behaviour. Teenagers mistakenly believe that the drinking rate is higher than it really is. The perception that 'everyone drinks' encourages them to also drink (Kring et al., 2007; Louw et al., 1998). Adolescents are interested in romance and sex; this encourages them to frequent locations such as bars and party venues, where alcohol is served. Adolescents face many stresses and drinking is perceived as a means of relaxing. Thus, substance use is likely to start during adolescence (Alloy, Acocella & Richard, 1996; Kring et al., 2007; Louw et al., 1998).

Disease or biological theories

Disease or biological theories recognise substance abuse as a disease requiring medical treatment. As disease, substance abuse has symptoms and may be acute, chronic or progressive (Canadian Centre on Substance Abuse, 2007). These theories consider biological and genetic factors that contribute to substance use. According to these theorists, an individual's genetic make up predisposes him or her to substance abuse (Alloy et al., 1996; Berk, 2007; Butcher et al., 2004; Carson et al., 2000; Davison, et al., 2004; Meyer & Salmon, 1988; Oldman, Skodol & Bender, 2005; Papalia, Olds, & Feldman, 2004; Parrott et al., 2004; Pressley & McCormick, 2007; Santrock, 2000; Sue, Sue & Sue, 1994).

Furthermore, people with family members who abuse drugs are more likely to follow suit (Alcohol and drug abuse module, n.d.; Alloy et al., 1996; Nolen-Hoeksema, 1998) and it seems substance abuse runs in families (Baucum & Smith, 2004; Butcher et al., 2004; Carson et al., 2000; Liddle & Rowe, 2006; United Nations Office on Drugs and Crime, 2008; Zastrow, 2004). A family history of drug abuse and dependence substantially increases the risk of such problems among members (Conger, 1991; Davison et al., 2004; Liddle & Rowe, 2006; Santrock, 2000).

Research has shown that some people, such as the children of alcoholics, have a high risk of developing problems with alcohol because of an inherent motivation to drink or sensitivity to the drug (Conrod, 1998 cited in Butcher et al., 2004). Children who have parents who are extensive alcohol or drug abusers are vulnerable to developing substance abuse and related problems themselves (Carson et al., 2000; Liddle & Rowe, 2006; Papalia et al., 2004; Sue et al., 1994). Teenagers who drink alcohol are firstly exposed to parents who themselves drink and their peers who act as models for heavy consumption. The parents not only show inappropriate behaviour such as antisocial tendencies and the rejection of their children. When such children loosen their parental ties, they tend to be strongly influenced by peers who are also heavy drinkers (Papalia et al., 2004; Sue et al., 1994).

However, children who are exposed to drinking by their parents, do not necessarily grow up to be problem drinkers. Having a genetic predisposition or biological vulnerability to alcohol abuse, is of course not a sufficient cause of the disorder (Butcher et al., 2004). The person must be exposed to the substance to a sufficient degree for the addictive behaviour to appear (Butcher et al., 2004; Carson et al., 2000; Rice & Dolgin, 2008). It seems the family environment plays a role in both promoting and protecting children from substance abuse and dependence.

The ability to tolerate substances may be what is inherited as a diathesis for alcohol abuse or dependence (Goodwin, 1979 cited in Davison et al., 2004). To become an alcoholic, a person first has to be able to drink a lot; in other words, the person must be able to tolerate large quantities of alcohol (Davison et al., 2004). It is interesting to note that some ethnic groups, such as Asians, may have a low rate of alcohol abuse because of physiological intolerance, which is caused by an inherited deficiency in an enzyme that metabolizes alcohol (Davison et al., 2004). Noxious effects of the substance may also protect a person from alcohol abuse (Davison et al., 2004).

Psychological theories

Psychological theories consider the underlying psychological problems within an individual as causing substance abuse (Carson et al., 2000; Davison et al., 2004; Kring et al., 2007; Rice & Dolgin, 2007; Visser & Routledge, 2007). Risk behaviour such as substance abuse can therefore be related to individual psychological factors such as self-esteem, locus of control, need for acceptance, anxiety levels, sensation seeking and eagerness to act like adults (Butcher et al., 2004; Gladding, 2004; Oldman et al., 2005; Rice & Dolgin, 2008; Shiel, 1999 cited in Visser & Routledge, 2007).

The above mentioned theorists believe that individuals who use substances receive some form of psychological reward from alcohol or other substance abuse (Davison et al., 2004; Meyer & Salmon, 1988; Oldman et al., 2005). Substance use is therefore reinforcing, either by enhancing positive mood states or by diminishing negative ones (Davison et al., 2004). This is evident from some adolescents who reported that they used substances because they wanted to be sociable, to feel good or to relax, because they like the taste of alcohol or enjoy drinking (About the partnership - the partnership for a drug free America, n.d.).

In previous studies, adolescents also reported that they wanted to get high (About the partnership – the partnership for a drug free America, n.d.; Conger, 1991; Zastrow, 2004). Other adolescents reported that they abused substances because they believed that using substances will help them deal with anxiety, low self-esteem, a lack of comfort in social situations, and to take away pain (Karen Lesly, 2008; Rice, 1992; Rice & Dolgin, 2008; Zastrow, 2004). Some insomniacs drink in order to sleep, which often lead to them passing out (Zastrow, 2004). People often also drink to temporarily get rid of unwanted emotions such as loneliness, anxiety, depression, feelings of inadequacy, insecurity, guilt and resentment (Zastrow, 2004).

Thus, adolescents often use substances as a means of escaping tension, boredom and the pressures of life (Conger, 1991; Visser & Routledge, 2007; Zastrow, 2004). In addition to that, local research has shown that the most common reasons reported for substance use include habit, to alter mood states, to improve health, to cope with personal, social or interpersonal situations or for enjoyment or taste (Rice, 1992).

Learning theories

Learning theories holds that substance abuse is a learnt behaviour (Burger, 2008; Carson et al., 2000; Liddle & Rowe, 2006; Shaffer & Kipp, 2007). Social learning theories focus on the interaction between the individual and the environment in shaping patterns of substance use. According to these theories, adolescents abuse substances because they have seen their parents, peers, and other people abuse substances (Burger, 2008; Carson et al., 2000; Davison et al., 2004; Donald et al., 2007; Gladding, 2004; Jaffe, 1998; Meyer & Salmon, 1988; Pressley & McCormick, 2007; Rice, 1992; Rice & Dolgin, 2008).

The experiences and lessons that adolescents learn from important figures in society have a significant impact on them (Carson et al., 2000; Davison et al., 2004; Gladding, 2004; Visser & Routledge, 2007). Children who are exposed to negative role models early in their lives or experience other negative circumstances because the adults around them provide limited guidance often falter on the difficult steps they must take in life (Vega, 1993 cited in Carson et al., 2000). These formative experiences can have a direct influence on whether a youngster becomes involved in maladaptive behavior such as alcohol or substance abuse (Carson et al., 2000). Parents influence substance use through their attitudes, values, behaviour, and through the kinds of relationships they have with their children. Parents who believe that substance use is harmful, socially unacceptable or morally wrong and who convey these attitudes to their children, are less likely to have children who engage in substance use (Conger, 1991; Rice & Dolgin, 2008). However, parental use of alcohol, tobacco, cannabis and other illegal substances positively correlated to the illegal use of these substances by their children (Conger, 1991).

Another strong motive for experimenting with substances is the social pressure to be like friends or to be part of a social group (Conger, 1991; Liddle & Rowe, 2006; Rice, 1992; Rice & Dolgin, 2008), while other adolescents reported that their peers influenced them to use substances (About the partnership - the partnership for a drug free America, n.d.). Unconventional adolescents tend to select deviant peers who share characteristics similar to their own personality attributes (Davison et al., 2004; Liddle & Rowe, 2006).

If an adolescent uses substances, he or she is more likely to associate with substance-using peers, which in turn, increases the chance of the adolescent's maintaining or increasing his or her own

substance involvement (Liddle & Rowe, 2006; Rice & Dolgin, 2008). Deviant peers, in turn, influence deviant attitudes and behaviour via role modelling, which further increases the probability of adolescent substance use (Liddle & Rowe, 2006). This motive is strong among immature adolescents who are seeking to belong to a crowd or gang, and some adolescents become associated with deviant peer groups who are heavily involved with drugs (Rice, 1992).

Although peer influence is important in the decisions adolescents make about using substances, those who have a high sense of self-efficacy (Bandura, 1997, cited in Davison et al., 2004) are influenced less by their peers. Teenagers grow up in substance-dependent cultural contexts. They see adults using caffeine to wake up in the morning, cigarettes to cope with daily hassles, a drink to calm down in the evening, and other remedies to relieve stress, depression and physical illness (Berk, 2007; Rice & Dolgin, 2008). Furthermore, young people often live in poverty, which is linked to family and peer contexts that promote illegal substance use (Berk, 2007).

Some adolescents grow up in a fun oriented culture that emphasises the need and value of having a good time. If smoking cannabis is thought to be fun, this becomes a strong motive for its use (Rice, 1992). Another aspect of having fun is to experience sensual pleasure. This pleasure may be sexual and many adolescents feel that pot makes the exploration of sex less inhibited and more enjoyable. The pleasure may involve seeking an increased sensitivity of touch or taste (Rice, 1992). These findings support the idea that social networks influence an individual's substance use behaviour. The relationship between the adolescent's parents need to be considered when trying to understand his or her development (Liddle & Rowe, 2006). Family conflict and parents who are not emotionally supportive are associated with a higher risk for substance use. Marital conflict is likely to interfere with the development of mutual attachment between the parent and the child, reducing the opportunity for the parent to influence the child and for the child to internalise conventional rules (Liddle & Rowe, 2006).

Marital discord has also been found to affect the quality of parenting (Fincham, 1994 cited in Liddle & Rowe, 2006) and may result in an increased risk of drug use. Indeed, parental conflict may be a greater risk for adolescent drug use than parental absence (Liddle & Rowe, 2006). One can therefore see how being an adolescent, especially being a male surrounded by societal stereotypes and pressures, can contribute to psychological difficulties and risky behaviour. Being

part of certain communities where there is a higher exposure to substance use can also increase the likelihood of becoming involved in substance abuse. Visser and Routledge (2007) argues that all these contexts need to be taken into account to understand the nature and aetiology of adolescent substance abuse.

Progression theory

Adolescents move from substance use to abuse, taking drugs regularly, increasing amounts to achieve the same effect, and moving on to harder substances (Berk, 2007; Donald et al., 2007; Pressley & McCormick, 2007). Some theorists argue that adolescents often begin with the casual use of less serious substances, often referred to as ‘gateway drugs’, such as tobacco, alcohol, and dagga and then progress towards more frequent use of more dangerous drugs (Gateway drugs, 2008). The youth drug user begins with drugs that are legal for adults and for which social norms and meanings are less negative, such as tobacco and alcohol. Furthermore, teenagers who start with alcohol and cigarettes, move on to harder substances, and eventually become hooked (Berk, 2007). They then progress to the least socially objectionable illegal drugs such as cannabis (Department of Health, 2007; Kandel, 1982, cited in Jaffe, 1998; Madu & Matla, 2003).

Adolescents can also move on to use the rapid dependence producing substances such as heroin and crack cocaine (Craig & Baucum, 2001; Department of Health, 2007; Plüddermann et al., 2007). Contrary to popular belief, smoking cannabis need not be the phase between using alcohol and tobacco and experimenting with illegal substances such as cocaine and heroin (Srikameswaran, 2006). Research conducted at Pittsburgh’s School of Pharmacy found that nearly a quarter of the young men they studied used cannabis before they began drinking or smoking cigarettes (Srikameswaran, 2006). This is the reverse of what is known as the ‘gateway hypothesis’, in which substance use is thought to progress from alcohol and tobacco to cannabis to ‘addictive drugs’. Furthermore, people who abuse one substance often abuse other substances as well. Polysubstance abuse, the abuse of two or more substances simultaneously, is a growing phenomena (Gladding, 2004).

Economic theories

The decrease in local controls after apartheid lead to an increase in tourism, trade links, and economic and political migration to South Africa. This together with changes in global

production, distribution, and marketing of substances in general increased travel to South Africa (Parry, 1998). Additional factors supporting the increase in the use of substances in South Africa are likely to include the falling real price of many substances and poverty which is likely to have increased the street level trade in substances (Parry, 1998). The cost of substances such as alcohol, cigarettes and cannabis is less. As a result, adolescents abuse these substances because they are available and affordable (Kawaguchi, 2004; Liddle & Rowe, 2006). Adolescents tend to buy alcohol and other substances if they are easily available. This is evident in a large number of licensed bottle stores and taverns. However, there are laws that restrict bottle stores and taverns to sell alcoholic beverages to children under the age of 18 (Liquor Act no. 59 of 2003).

The increased use of substances such as crack cocaine, may well be ascribed to the increased marketing of cocaine because of this substances' decrease in the United States market as well as the related decrease in the quality of local Mandrax (Methaqualone). In addition, the increase in the use of amphetamine type substances is probably due to the increase in the global production of these substances and an increase in local marketing (Liddle & Rowe, 2006; Parry, 1998).

Symbolic interaction theory

Theorists who subscribe to the symbolic interaction theory focus on adverts of alcohol and cigarettes as the cause for adolescents to use those substances (Alloy et al., 1996; Davison et al., 2004; Parrott et al., 2004). Adolescents are brainwashed by the huge advertising industry from the early years of childhood (Rice, 1992). An increasing number of cigarette adverts is designed to appeal to teenagers. Over 90% of teenagers are aware of such adverts and most say the adverts influence their behaviour (Berk, 2007). Billboards equate cigarettes with excitement, relaxation, or being in style (Davison et al., 2004; Parliamentary Portfolio Committee on Health, 1998). Furthermore, cigarette smoking is identified with masculinity, independence, nature, beauty, youth, sex appeal, sociability, wealth, and the good life (Conger, 1991; Parrott et al., 2004; Rice, 1992). The sensory, cognitive, and psychomotor components of smoking can also be pleasurable; spending money, breaking open the new packet, lighting up, and the sensorimotor manipulations of fingers and lips. Movies also play an important role, in that smoking is generally portrayed as sexy and pleasurable, rather than addictive and problematic.

Smokers are thus bombarded by positive advertising images for smoking, which is why funding

for accurate health information is so important (Parrott et al., 2004). The appeal is always to the emotions and to the desire for acceptability, popularity and sexual allure. The presenter in the advertisement's sultry voice, the society setting, the back-to-nature promises, are all rewards teenagers seek (Rice, 1992). Evidence from previous studies indicates that advertising does influence smoking. In a longitudinal study of non-smoking adolescents who had a favourite cigarette advert were twice as likely to subsequently begin smoking or to be willing to do so (Davison et al., 2004). Studies conducted in South Africa also confirm that cigarette adverts do influence adolescent to smoke. A study by Yach (1989) found that by the age of 15 years, 40% of males became smokers because of tobacco adverts.

According to these theorists, adolescents who have the most difficulty figuring out 'who they are', are more susceptible to the effects of alcohol and cigarette adverts (Louw et al., 1998; Shadel, Taylor & Fryer, 2008). Adolescents are also bombarded with TV commercials in which beer is associated with athletic-looking males, bikini-clad women and good times. Thus, it seems adolescents use drugs because they succumb to the persuasive message targeted at them. Most adverts, especially those for beer, associate substance use with success and happiness (Alloy et al., 1996). Research by the National Cancer Institute of South Africa has shown that tobacco marketing has a greater influence in encouraging adolescents to take up smoking than peer pressure or exposure to parents who smoke (Parliament Portfolio Committee on Health, 1998).

Factors that contribute towards low smoking rates include higher tobacco taxes, enforcement of laws to reduce under-age purchase, and school-based anti-smoking programmes (Parrott et al., 2004). Presently, there is a law in South Africa to control the adverts of tobacco (Tobacco Products Amendment Bill B24, 2006). The bill restricts smoking in public places, prohibits indirect advertising including sponsorships of programmes, projects, bursaries and scholarships, prohibits the use of words such as *light* and *low tar*, increased the age of sale to minors from 16 to 18 years of age, and increased the penalties for transgressing certain laws from R500 to R50 000.

The bill also seeks to prohibit smoking in a car with a child under the age of 12 years (Statement by Minister of Health, 2007). The Tobacco Control Bill has resulted in a 50% reduction in tobacco use. It has also contributed to the health and educational welfare as well as the

international science of tobacco and substance use control (Parliamentary Portfolio Committee on Health, 1998; Statement by Minister of Health, 2007). Furthermore, the increased price of cigarettes has reduced consumption of tobacco. Through the enactment of the Tobacco Control Bill, a clean and healthy environment is maintained and the health of non-smokers is not impaired (Parliament Portfolio Committee on Health, 1998). Most South Africans have decided not to smoke; 70% of adults are non-smokers (Parliamentary Portfolio Committee on Health, 1998).

Furthermore, through tobacco control measures, smoking is not allowed in certain outdoor places such as schools, sport stadiums, cinemas, theatres, public transport, workplaces, et cetera (Department of Health, 2007). Surveys show that 70% of smokers and 90% of non-smokers support a ban on smoking in public places (Parliamentary Portfolio Committee on Health, 1998). South Africa has been successful in enforcing the Tobacco Control Product Legislation and this has contributed immensely to the reduction of smoking among the youth and adults (Department of Health, 2007).

Furthermore, the 2002 Global Youth Tobacco Survey showed that the smoking prevalence among adults decreased from 23,0% in 1999 to 18,3% in 2002. The 2004 South African Demographic Health Survey recorded that 31% of males and 11% of women are smokers (Department of Health, 2007). Thus, there is progress in reducing the level of tobacco use. Even though the Tobacco Control Act has a positive impact on the welfare of the society, it has economic implications. This include possible job losses in industries within and peripheral to the tobacco industry (Parliamentary Portfolio Committee on Health, 1998).

Social control theory

According to social control theory adolescents abuse drugs because there are insufficient social controls to restrict them from using drugs. Most of the adolescents in one study reported that most of the time they are left alone at home because their parents are always busy or away because of their demanding jobs (About the partnership – the partnership for a drug free America, n.d.). Thus these adolescents have more freedom to use drugs (About the partnership – the partnership for a drug free America, n.d.). Lack of parental monitoring leads to increased association with drug abusing peers and subsequently to higher drug abuse (Davison et al., 2004;

Pressley & McCormick, 2007; Rice & Dolgin, 2008). In addition to that, adolescents who are not well nurtured and have poor relationship with their parents are more likely to use drugs (Liddle & Rowe, 2006; Rice, 1992; Rice & Dolgin, 2008). The lack of emotional support by parents is linked to an increase in the use of tobacco, alcohol, and marijuana (Davison et al., 2004; Rice & Dolgin, 2008).

Parenting skills or parental behaviour is also associated with substance use among adolescents (Carson et al., 2000). Alcoholic parents are less likely to keep track of what their children are doing and this lack of monitoring often leads to adolescents' affiliation with substance abusing peers (Carson et al., 2000). In addition, Chassin and colleagues (1996, cited in Carson et al., 2000), found that stress and its negative effect are more prevalent in families with an alcoholic parent, and were associated with alcohol use in adolescents. These authors reported that 'parental alcoholism was associated with increases in negative uncontrollable life events which in turn, were linked to negative affect, to associations with drug-using peers and to substance use'.

Parental control patterns that involve setting clear requirements for mature and responsible behaviour, in contrast to power-assertive or authoritarian techniques of discipline, resulted in less substance use (Liddle & Rowe, 2006; Louw, 1998; Rice, 1992). Furthermore, appropriate parental monitoring, has been found to be effective in reducing delinquency and substance use (Liddle & Rowe, 2006). Studies of family structure around the world have found that young people who live with both biological parents are significantly less likely to use substances, or to report problems with their use, than those who do not live with both parents (Rice & Dolgin, 2008). However, family structure alone does not appear to explain substance abuse. Disruptions in the family life cycle seem to characterise these single-parent households.

An unstable family environment, that is father absence, one or both parents who had immigrated, or death of parents are associated with substance abuse (Rice & Dolgin, 2008). Thus, family structure along with characteristics of these families seems to account for substance abuse. Although they may place members at risk of substance abuse, family factors may also be protective. As noted above, two-parent households appear protective. High levels of perceived support from family members seems to protect youth from alcohol use. Researchers have found that effective family relationships, for example family involvement and communication,

proactive family management, or attachment to family serve to protect youth against substance abuse across racial and cultural groups (Liddle & Rowe, 2006). Furthermore, the positive effects of family support during adolescence seem long lasting. Greater family support and bonding during adolescence has predicted less problem alcohol use in adulthood (Rice & Dolgin, 2008). These factors interact with each other to promote appropriate use of substances (Flisher, 2006).

Availability theory

According to the availability theory, adolescents use substances because all kinds of substances are readily available (Carson et al., 2000; Conger, 1991; De Miranda, 1987; Liddle & Rowe, 2006). Furthermore, availability theorists points to the fact that the degree to which alcoholic beverages are accessible to people affects the amount and pattern of alcohol use. Alcohol is present in many social settings such as cultural ceremonies and parties. There are currently almost 23 000 licensed liquor outlets with an estimated 150 000 to 200 000 unlicensed outlets, yielding approximately one liquor outlet for every 190 persons in South Africa (Parry, 1998). Adolescents tend to buy alcohol, tobacco, and other substances if they are available in stores. Research has shown that school-going youth find it easy to buy alcohol from bottle stores, supermarkets, bars, and shebeens (Parry, 1998).

With regard to smoking, if cigarettes are perceived as being easy to get and affordable, the rate of smoking increases (Davison et al., 2004). In addition, chemicals for manufacturing methamphetamine are readily available, although recent laws such as the Methamphetamine Control Act of 1996, have been passed to try to cut off the supply (Davison et al., 2004). Availability has increased because the trafficking of substances such as cocaine and heroin through South Africa has increased. This may be ascribed to factors such as the decrease in local controls following the collapse of apartheid, increased travel to South Africa as a result of more tourism and trade links, and increased economic and political migration to South Africa (Parry, 1998). Illicit substances are more dominant in peripherals of urban regions as well as in localities where the level of poverty is high (Lakhanpal & Agnihotri, 2007). Thus, the easy availability and low prices of substances have greatly contributed to adolescent use (Jaffe, 1998; Kawaguchi, 2004).

EFFECTS OF SUBSTANCE ABUSE

Substance abuse has profound health, economic, and social consequences. The negative consequences of substance abuse affect not only individuals who abuse substances but also their families and friends, various businesses and government resources. Substance abuse and dependence have grave consequences for existing social systems, affecting crime rates, hospitalisations, child abuse and neglect, and rapidly consuming public funds (Hoffman & Goldfrank, 1990). The exact effect of a substance will depend on the substance used, how much is taken, in what way, and on each individual's reaction. Substances can be extremely harmful and it is relatively easy to become dependent on them.

Health effects of substances

There is an array of health related harms associated with substance use and abuse (Berk, 2007; Donald et al., 2007; Drug abuse and substance abuse information/Partnership for a drug free America, n.d; Jaffe, 1998; Kring et al., 2007; Parrott et al, 2004; Rice & Dolgin, 2008). For the purpose of this study, only the effects of substances known to be abused in South Africa will be discussed.

Substance dependence

The continued use of substances leads to dependence (De Miranda, 1987; Kring et al., 2007; Pressly & McCormick, 2007; Rice & Doglin, 2008). The user will continue using the substance despite the physical and psychological harm that may result from it. The physiological or biochemical component of substance dependence usually, but not always, consists of the development of tolerance to the substance, that is increasing amounts are needed to have the required effect and withdrawal symptoms can occur for a number of reasons. The process of substance dependence is a complex one, involving an interaction of biogenetic, neurochemical and psychological factors. For these reasons its onset is unpredictable and therefore no one who uses and at times abuses psychoactive substances, including alcohol, is ever able to say, 'this cannot happen to me' (De Miranda, 1987).

The process of dependence entails an uncontrollable urge to satisfy a need and can be said to exist if, as a result of the repetitive use of a substance, there is impairment of functioning, that is physical, emotional and social of the affected individual (De Miranda, 1987; Kring et al., 2007;

Rice & Dolgin, 2008). The physiological or biochemical component of substance dependence usually, but not always, consists of the development of tolerance for the substance. That is, larger volumes are required to experience the required effect and withdrawal, for example signs of shock and physiological deprivation, occurs when the substance of dependence is withheld (Davison et al., 2004; De Miranda, 1987; Kring et al., 2007; Rice & Dolgin, 2008). The pattern of substance dependence commonly observed in adolescent substance dependents include the following: experimentation and first time use, occasional or social use, regular use and dependence (Davison et al., 2004; De Miranda, 1987; Rice & Dolgin, 2008). Experimentation and first-time use usually occur between the ages of 12 and 16. Adolescents often believe that experimentation with substances is safe and even normal (Davison et al., 2004; Madu & Matla, 2003).

Occasional or social use occurs when the person does not actively seek out the substance, but passively accepts it when offered by friends as being part of 'acceptable peer group behaviour' (De Miranda, 1987; Donald et al., 2007). Regular use occurs when a substance abuser actively seeks out his substance and makes sure he can maintain ready supplies. Use is typically regularly once or twice weekly (De Miranda, 1987). Dependence: At this stage, the substance or substances will constitute the primary part of the person's life and any effort to separate the person from the substance or substances will be met with substantial resistance (De Miranda, 1987). During this stage adolescents who use substances, not only suffers progressive physical and psychological deterioration, but also loses the psychological, social, and even economic ability to break out of the cycle (Donald et al., 2007).

Substance dependence, unless treated, is a fatal, progressive illness (De Miranda, 1987). Persons dependent on substances often cannot quit by themselves and must receive treatment to help them stop using substances (Alexander, 2001; Cicchetti, 2007; Drug abuse and substance abuse information/Partnership for a drug free America, n.d; Jaffe, 1998; Kring et al., 2007; Rice & Dolgin, 2008).

The next section presents a brief description of various substances and their effects. Substances that are discussed include alcohol, cigarettes, cannabis, cocaine, heroin, ketamine and crystal amphetamine. These are the drugs that are known to be abused in South Africa:

Alcohol is a central nervous system depressant with effects similar to those of sleeping pills or tranquilisers (Craig & Baucum, 2001; Meyer & Salmon, 1988). Larger doses of alcohol distort vision, impair motor coordination and slur speech (Butcher et al., 2004; Carson et al., 2000; De Miranda, 1987). Other common physiological changes include damage to the endocrine glands and pancreas, heart failure, erectile dysfunction, hypertension, stroke and catapillary haemorrhages, which are responsible for the swelling and redness in the face, and especially the nose, of chronic alcohol abusers (Davison et al., 2004; Kring et al., 2007). Short term abuse of alcohol may affect cognitive performance of alcohol abusing students (Carson et al., 2000; Davison et al., 2004; Rice & Dolgin, 2008).

Furthermore, there is an increased probability of engaging in high-risk sexual behaviours, placing the user at risk for both unwanted pregnancies and sexually transmitted diseases, including HIV/AIDS (Davison et al., 2004; Odejide, 2006; Parry & Pithey, 2006; Rice & Dolgin, 2008). This is because of the addictive and intoxicating effects of many substances, which can alter judgement and inhibition and lead people to engage in impulsive and unsafe behaviours (Carson et al., 2000; Donald et al., 2007). While intravenous drug use (IDU) is well known in this regard, less recognised is the role that substance abuse plays more generally in the spread of HIV, the virus that causes AIDS by increasing the likelihood of high-risk sex with infected partners. Substance abuse and dependence can also worsen the progression of HIV and its consequences, especially in the brain. Injecting drug users are at great risk of contracting HIV/AIDS, anyone under the influence of a substance, including alcohol is at heightened risk. This includes IDU's who share contaminated syringes or injection paraphernalia, as well as anyone who engages in unsafe sex, for example, with multiple partners, unprotected sex or 'transactional' sex.

The latter refers to trading sex for substances or money that could expose them to infection (Nolen-Hoeksema, 1998). Young people are at risk for HIV/AIDS. Long term habitual use of alcohol increases tolerance but eventually causes damage to the brain (Butcher et al., 2004; Carson et al., 2000; Craig & Baucum, 2001; Davison et al., 2004; Kring et al., 2007; Meyer & Salmon, 1988; Rice & Dolgin, 2008).

Adolescents abusing alcohol are more likely to think of taking their lives. Thus, adolescents who abuse alcohol are more likely to do things that they might later regret. They might end up dying

because of alcohol (Davison et al., 2004; Drug abuse and substance abuse information/ Partnership for a drug free America, n.d; Jaffe, 1998). About one-third of these deaths occur as a result of respiratory paralysis, usually as a result of a final large dose of alcohol in people who are already intoxicated (Nolen-Hoeksema, 1998).

Furthermore, excessive use of alcohol leads to loss of consciousness, disability and death induced by alcohol related traffic accidents (Craig & Baucum, 2001; De Miranda, 1987; Jaffe, 1998; Kasirye, 2006; Nolen-Hoeksema, 1998; Rice & Dolgin, 2008). Alcohol users may gradually build up tolerance for the substance so that ever-increasing amounts may be needed to produce the desired effects (Carson et al., 2000). Excessive use of alcohol is linked to the use of other substances. Thus, the average life span of the average alcoholic is 12 years shorter than that of an average citizen (Carson et al., 2000).

Tobacco is smoked, chewed or ground into small pieces and inhaled as snuff. Nicotine is the addicting agent of tobacco. The most probable harmful components in the smoke from burning tobacco are nicotine, carbon monoxide and tar (Davison et al., 2004). Cigarettes discolour teeth, affect skin colour and makes breath, body and clothes smell unpleasant. In addition to that, smoking increases heart rate, constricts blood vessels, irritates the throat and deposits foreign matter in sensitive lung tissues, thus limiting lung capacity (Cicchetti, 2007; De Miranda, 1987). Years of smoking can lead to premature heart attacks, lung and throat cancer, emphysema, and other respiratory diseases. Even moderate smoking shortens a person's life by an average of 7 years (Eddy, 1991, cited in Craig & Baucum, 2001).

Withdrawal of nicotine produces nervousness, anxiety, lightheadedness, headaches, fatigue, constipation or diarrhoea, dizziness, sweating, cramps, tremors, and palpitations. Smokers also become tolerant of nicotine. When the supply of tobacco is curtailed, smokers show unreasonable, antisocial behaviour similar to that of heroin dependents (Rice & Dolgin, 2008). Cigarettes are one of the leading causes of premature death (Davison et al., 2004). The National Council on Smoking estimates that about 25 000 smoking-related deaths occur annually (Department of Social Development, 2006). The health hazard of smoking are not restricted to those who smoke. The smoke coming from the burning of a cigarette, so-called second hand smoke, or environmental tobacco smoke (ETS), contains higher concentrations of ammonia,

carbon monoxide, nicotine and tar than does the smoke actually inhaled by the smoker.

Environmental tobacco is blamed for more than 50 000 deaths each year (Davison et al., 2004). Non-smokers are also at great risk of developing cardiovascular disease and lung cancer (Davison et al., 2004; Kring et al., 2007; Nolen-Hoeksema, 1998; Parrott et al., 2004). Cigarettes remain an alluring symbol of maturity to some adolescents despite overwhelming evidence that cigarette smoking is a serious health hazard and the increasingly negative image associated with smoking in the minds of many young adults (Craig & Baucum, 2001). Cigarette smoking is a highly addictive habit that is difficult to break. Once started, it is not a habit that the majority of smokers can break by an effort of will (Nolen-Hoeksema, 1998; Rice & Golgin, 2008).

Cannabis is made from the dried and crushed leaves and flowering tops of the hemp plants *Cannabis sativa*. It is most often smoked, but it may be chewed, prepared as tea, or eaten in baked goods (Butcher et al., 2004; Carson et al., 2000; Davison et al., 2004; De Miranda, 1987; Kring et al., 2007; Rice, 1992). The intoxicating effects of cannabis, like those of most substances, depend in part on its potency and the size of the dose (Butcher et al., 2004; Davison et al., 2004). Smokers of cannabis find it makes them feel relaxed and sociable. The short term somatic effects include blood shot and itchy eyes, dry mouth and throat, increased appetite, reduced pressure within the eye and somewhat raised blood pressure (Davison et al., 2004; Kring et al., 2007; Rice, 1992).

The substance apparently poses a danger to people with already abnormal heart functioning, for it elevates heart rate, sometimes dramatically (Kring et al., 2007). Short term effects of cannabis also include problems with memory and learning, distorted perception of sight, sound, time, and touch, trouble with thinking and problem solving. Long term use of cannabis causes lung cancer (Drug abuse and substance abuse information/Partnership for a drug free America, n.d; Jaffe, 1998). Large doses have been found to bring rapid shifts in emotion, to dull attention, to fragment thoughts and to impair memory (Butcher et al., 2004; Davison, 2004; De Miranda, 1987; Kring et al., 2007; Nolen-Hoeksema, 1998). Scientific evidence indicates that cannabis interferes with a wide range of cognitive functions (Davison et al., 2004; Nolen-Hoeksema, 1998; Rice, 1992). These studies revealed intellectual impairment in those under the influence of cannabis. Because cannabis is intoxicant, it impairs memory and concentration. It also interferes with a range of

intellectual tasks in a manner that impairs classroom learning among student users (Rice, 1992).

Adolescents with good to excellent academic records who become heavy cannabis users begin to have difficulty in paying attention or remembering what they read or hear in class (Rice, 1992). Some find it difficult to read aloud or speak in class and generally stop participating in the learning process. When not being disruptive, they are often inattentive, lost in daydreams or mindless staring and frequently 'nod off'. They cut classes regularly, with very little regard for the consequences of their actions (Alloy et al., 1996; Rice, 1992).

Extremely heavy doses have sometimes been found to induce hallucinations, extreme panic, sometimes arising from the belief that the frightening experience will never end (Butcher et al., 2004; Carson et al., 2000; Davison et al., 2004; De Miranda, 1987; Nolen-Hoeksema, 1998). Withdrawal symptoms can occur following discontinuation of high-dose chronic administration of cannabis (Rice, 1992). These symptoms include irritability, decreased appetite, sleep disturbance, sweating, tremor, vomiting and diarrhoea (Rice, 1992). Several studies have demonstrated that being high on cannabis impairs complex psychomotor skills necessary for driving. Highway fatality and driver-arrests figures indicate that cannabis plays a significant proportion in accidents and arrests (Davison et al., 2004; Rice, 1992). Cannabis can lead to psychological dependence, in which a person experiences a strong need for the substance whenever he or she feels anxious and tense (Carson et al., 2000). Smoking cannabis is highly correlated with adolescent use of other dangerous substances such as heroin (Alloy et al., 1996; Craig, 2001; Davison et al., 2004).

Heroin referred to as 'H', 'Horse', or 'Hary' is produced from morphine by a simple chemical process. It is a white, odourless powder (De Miranda, 1987; Rice, 1992). It is usually injected for a maximum effect, although it can also be sniffed, smoked or taken orally (Carson et al., 2000; Craig & Baucum, 2001; Davison et al., 2004). Heroin affects the central nervous system, causes respiratory depression, nausea and vomiting (Carson et al., 2000; Drug abuse and substance abuse information/Partnership for a drug free America, n.d). In addition to the effects of the substance itself, street heroin may have additives that do not dissolve and result in clogging the blood vessels that lead to the lungs, liver, kidney or brain. This can cause infection or even death of small patches of cells in vital organs (Carson et al., 2000; Drug abuse and substance abuse

information/Partnership for a drug free America, n.d).

With regular use, tolerance develops (De Miranda, 1987; Rice, 1992). This means that the abuser must use more heroin to achieve the same intensity or effect. Addicts usually lose their appetite for food, which leads to malnutrition. They neglect their health, suffer chronic fatigue and are in a general devitalized state (Rice, 1992). Heroin produces euphoria, drowsiness, reverie, and sometimes a lack of coordination (Davison et al., 2004). An additional problem now associated with intravenous drug use is exposure through sharing needles to HIV/AIDS (Alloy et al, 1996; Carson et al., 2000; Davison et al., 2004; Nolen-Hoeksema, 1998; Rice, 1992). Use of heroin can lead to death from homicide, suicide or accidents and from overdosing of the substance (Carson et al., 2000; Davison et al., 2004; Rice, 1992).

Cocaine ('coke', or 'snow') is extracted from the leaves of the coca plant (Davison et al., 2004; Rice, 1992). It is available as an odourless, fluffy, white powder (De Miranda, 1987; Rice, 1992). Cocaine can be swallowed, sniffed (snorted) or injected (Alloy et al., 1996; Butcher et al., 2004; Davison et al., 2004; De Miranda, 1987; Rice, 1992). It is highly addictive in any form (De Miranda, 1987). The main undesirable effects are nervousness, irritability and restlessness, mild paranoia, physical exhaustion, mental confusion, loss of weight; fatigue or depression when 'coming down' and various afflictions of the nasal mucous membranes and cartilage (De Miranda, 1987; Rice, 1992). Cocaine affects the brain. Users of cocaine become confused, anxious and depressed. Frequent users of cocaine might experience a 'cocaine psychosis' consisting of hallucinations and delusions among others of insects crawling under their skin (Drug abuse and substance abuse information/Partnership for a drug free America, n.d). Other known risks of cocaine use include death from stroke, heart attack, or respiratory failure (Craig & Baucum, 2001).

Cocaine increases sexual desire and produces feelings of self-confidence, well-being and fatigability. Ceasing cocaine can take hold of people with as much tenacity as do other addictive substances. Cocaine causes cognitive impairments, such as difficulty paying attention and remembering (Kring et al., 2007). Crack cocaine is linked to the transmission of HIV/AIDS because some users engage in prostitution to support their habit. In addition, unprotected sex with multiple partners is routine in 'crack houses' (Craig & Baucum, 2001). Dependence on cocaine is

extremely difficult to break, leading to a high relapse after treatment (De Miranda, 1987). Users who take larger doses may die of an overdose, often from a heart attack.

Ketamine of which the street names or slang names are Cat Valium, K, Special K and Vitamin K, forms the next category of substances. Although it is manufactured as an injectable liquid, in illicit use ketamine is generally evaporated to form a powder. Ketamine is odourless and tasteless, so it can be added to beverages without being detected and induces amnesia. The substance is sometimes given to unsuspecting victims and used in the commission of sexual assaults referred to as ‘Drug rape’. Ketamine can cause dream like states and hallucinations. Users report sensations ranging from a pleasant feeling of floating to being separated from their bodies. Low dose intoxication from ketamine results in impaired attention, learning ability and memory. In high doses, ketamine can cause delirium, depression and potentially fatal respiratory problems (De Miranda, 1987; Ketamine Addiction/Effects of Ketamine/Ketamine facts, n.d.).

Crystal methamphetamine is often referred to as ‘crystal meth’ or ‘ice’. Methamphetamine can be taken orally or intravenously. It can also be taken intranasally, that is snorting (Davison et al., 2004; Kring et al., 2007). Craving for methamphetamine is particularly strong, often lasting several years after use (Hartz, 2001 cited in Davison et al., 2004). Several studies conducted indicated that chronic use of amphetamine causes damage to the brain, affecting both dopamine and serotonin systems (Frost & Cadet, 2001 cited in Kring et al., 2007).

Immediately after smoking or injecting the substance, the user experiences an intense sensation, called a ‘rush’ or ‘flash’, that lasts only a few minutes. Snorting or swallowing methamphetamine produces euphoria, a high, but not a rush (Nolen-Hoeksema, 1998). Other possible effects include wakefulness and insomnia, decreased appetite, irritability, aggression, anxiety, nervousness, convulsions, and heart attack. Methamphetamine is addictive and users can develop a tolerance quickly, needing larger amounts. Methamphetamine can also cause strokes and death (Drug abuse and substance abuse information/Partnership for a drug free America, n.d).

From the above discussion, it is evident that substances have a negative effect on the lives of adolescents. Since substances do not only affect the individual user, the next section will explore

the social effects of substances.

Social effects of substances

Dependence to any substance is damaging to the individual as well to society (Alloy et al., 1996; Butcher et al., 2004; Carson et al., 2000). Substance abuse does not only affect the individual, it also affects the family, friends, teachers at school and other members of the community. Adolescents abusing substances may become withdrawn, moody, irritable or aggressive. That often leads to a deterioration in family, peer group, and school relationships (Parrott et al., 2004). These adolescents' academic performance drops and truancy often increases (Berk, 2007; Burger, 2008; Donald et al., 2007; Flisher, 2006; Papalia et al., 2004; Pressley & McCormick, 2007) and they end up being expelled from school due to their behaviour (Council of Ministers of Education, 2003; Donald et al., 2007).

Furthermore, school children who use substances often suffer from impairment of short-term memory and other intellectual faculties, impaired tracking ability in sensory and perceptual functions, preoccupation with acquiring substances, adverse emotional and social development and thus generally impaired classroom performance. Reduced cognitive efficiency leads to poor academic performance, resulting in a decrease in self-esteem and the adolescent may eventually drop out altogether. This contributes to instability in an individual's sense of identity which, in turn, is likely to contribute to further substance consumption, thus creating a vicious circle (Lakhanpal & Agnihotri, 2007).

The more a student uses tobacco, alcohol, cannabis, cocaine, and other substances, the more likely he or she will perform poorly in school, drop out, or not continue on to higher education (Berk, 2007; Davison et al., 2004; Rice, 1992). Furthermore, adolescents who abuse substances may neglect their schoolwork and even be absent from school. They are less likely to value academic achievements; they expect less academic success and do, in fact, obtain lower grades (Braucht, 1984, cited in Conger, 1991; Gladding, 2004). In addition to that, they also become aggressive towards teachers and other learners (Donald et al., 2007). Some substances are expensive, thus a need to sustain the dependence may lead to theft, involvement in violence and eventually even to organised drug-related crime (Donald et al., 2007). Some adolescents drop out of school and turn to other crimes such as robbery and gang-related activities to support their

habit. Previous studies confirm that there is a link between substance abuse and criminal activities (Butcher et al., 2004; Donald et al., 2007; Karen Lesly, 2008; United Nations Office on Drugs and Crime, 2008; Zastrow, 2004). Young people often steal money to buy substances (About the partnership-the partnership for a drug free America, n.d.).

The substance, and obtaining it, become the centre of the abuser's existence, governing all activities and social relationships. The effect of these substances on the general inhibition of impulses, social judgement is often distorted. Involvement in other social problems such as impulsive violence, casual or exploitative sex, racial and other forms of intolerance or abuse may result. It is believed that over half of all murderers are committed under the influence of substances; as are rape, assault and family violence (Davison et al., 2004; Parrott et al., 2004; Zastrow, 2004). This adds to the danger to the adolescents and to others (Donald et al., 2007). Drugs can trigger violent reactions and users can harm themselves or others.

Furthermore, substance abuse issues are encountered at every level of the criminal justice system, from the international trade in substances and the use of the proceeds of that trade for corrupt ends to driving under the influence of alcohol or other substances (Department of Social Development, 2006; United Nations Office on Drugs and Crime, 2008). The high cost of substances means that dependents must either have great wealth or acquire money through illegal activities, such as theft, prostitution or the selling of substances (Davison et al, 2004; Rice, 1992). The correlation between opiate dependence and criminal activities is thus rather high, undoubtedly contributing to the popular notion that substance dependence per se causes crime (Davison et al., 2004). Substance use impacts on the criminal justice system, with evidence of links between drinking at risky levels, committing crime, or being a victim of crime (Karen Lesly, 2008; United Nations office on Drugs and Crime, 2008). Most substance-related crimes, however, are the culmination of a variety of factors. That is, personal, situational, cultural, and economic.

When teenagers depend on alcohol and other substances to deal with daily stresses, they fail to learn responsible decision-making skills and alternative coping mechanisms. These young people show serious adjustment problems, including chronic anxiety, depression and antisocial behaviour, that are both the cause and consequences of taking drugs (Simons-Morton & Haynie,

2003, cited in Berk, 2007). They often enter into marriage, childbearing and the work world prematurely and fail at them. These are painful outcomes that encourage further addictive behaviour (Berk, 2007). Thus substance use does not only have an effect on the adolescents using them, it also has a negative effect on the lives of other people. The next section presents the economic effects of substances as substance use has negative implications for the economy of the country.

Economic effects of substance abuse

Substance abuse has a negative impact on the economy of the country. This includes a range of problems such as inefficiency, impaired work performance, accidents and absenteeism at a considerable cost to both industry and society (Parrott et al., 2004). Work productivity declines. For example, 2.5 million workdays are lost due to absenteeism arising from substance-related illnesses (Department of Social Development, 2006). Furthermore, the use of substances has a negative impact on the health care system including the depletion of scarce resources available to improve the health of people (Department of Health, 2007). Medical resources are wasted and lives are lost in substance-related accidents. High amounts of money is spent in hospitals, on prevention campaigns and in treatment centres for substance dependents (Alloy et al., 1996; Plüddermann et al., 2007; United Nations Office on Drugs and Crime, 2008).

Although most people who abuse substances do not seek professional help, people who abuse alcohol constitute a large proportion of new admissions to mental hospitals and general hospitals (Davison et al., 2004; Department of Social Development, 2006). Other costs include repairs to property damaged by addicts, food and accommodation in prisons, transportation of addicts to courts in terms of those still awaiting trial (United Nations Office on Drugs and Crime, 2008). Medication for treatment of substances is also expensive. The use of alcohol and other substances presents law-enforcement problems as well.

Thus, substance dependence is a financial burden for the country. The adolescent not only suffers progressive physical and psychological deterioration but also loses the ability psychologically, socially and often economically to break out of the cycle of substance abuse (Donald et al., 2007). The health and socioeconomic consequences of substance use and abuse undermine democracy, good governance and has a negative impact on the country. As with alcohol, the

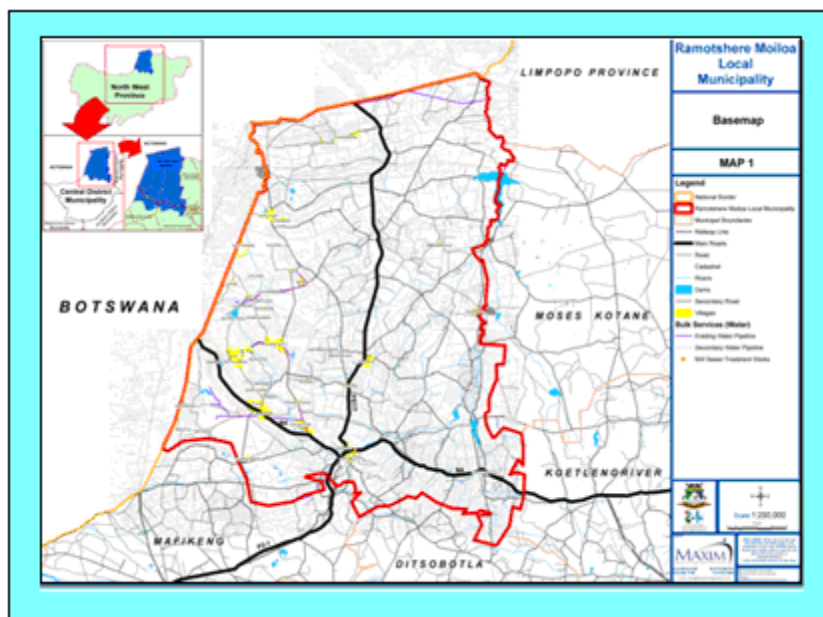
socio-economic cost of smoking is staggering. Each year smokers compile over 80 million lost days and 145 million days of disability, considerably more than do nonsmoking peers (Davison et al., 2004).

SOCIO-ECONOMIC PROFILE OF ZEERUST DISTRICT

This section provides an overview of the socio-economic characteristics of Zeerust, which is in the North West province of South Africa, as the focus of this study was on substance abuse among adolescents in the Zeerust district. After the start of the democratic dispensation in 1994, the name of the municipality of Zeerust was changed to Ramotshere Moiloa, named after a mid-20th century chief of the Bahurutshe boo Moiloa. The Batswana call the town Sefatlhane. The town is a commercial hub for most of the villages situated in the Lehurutshe area (NationMaster-Encyclopedia, n.d.).

The municipality borders Botswana in the north, Moses Kotane and Kgetleng River local municipality in the east and Ditsobotla and Mafikeng in the south. Zeerust is a commercial town situated in central district North West province, in South Africa. It lies in the Marico valley, approximately 240 kilometres northwest of Johannesburg. It lies on the N4, the main road link between South Africa and Botswana (NationMaster-Encyclopedia, n.d.). The geographical area of Ramotshere Moiloa municipality is predominantly rural including considerable land under the traditional authorities. The vast majority of the population live in a rural or peri-urban environment, which for most part is unplanned and poorly serviced (Ramotshere Moiloa reviewed integrated development plan, 2008-2009). The main languages spoken in Zeerust are Setswana and Afrikaans.

Map 1 below indicates the Ramotshere Moiloa local municipal area as well as its locality in relation to the Ngaka Modiri Molema district municipality in the North West province (Ramotshere Moiloa reviewed integrated development plan, 2008-2009).



Map 1: Ramotshere Moiloa Local Municipal area (Map adapted from Ramotshere Moiloa reviewed integrated development plan, 2008-2009, p. 7).

The municipality is characterised by a few urban areas including Zeerust town, Ikageleng, Henryville, Olienhout Park, Wilbedacht (Lehurutshe town) and Groot Marico. The rural part of the municipality is estimated at 70% with over 40 villages over a radius of 120km's. According to the Ramotshere Moiloa reviewed integrated development plan (2008-2009), the municipality is home to 3.8% of the North West population. As is the case with most of the other local municipalities in South Africa, the Ramotshere Moiloa local municipality is marred by high poverty rates and inequalities in the distribution of income between various population subgroups.

Unemployment in South Africa is often a rural phenomenon, many of the inhabitants in this local municipality reside in rural areas where both poverty and unemployment are quite high (Ramotshere Moiloa reviewed integrated plan, 2008-2009).

The next section contains an overview of the demographics, labour, economics, poverty and unemployment in the Ramotshere Municipality. The socio-economic characteristics included are the following: demographic profile, labour market profile and economic profile.

Demographic profile

The following demographic characteristics of the Ramotshere Moiloa Municipality will be discussed: population size and population growth, number of households and urbanisation rate.

Population size and population growth

According to the Ramotshere Moiloa reviewed integrated plan (2008-2009) the population size increased from 127 219 in 1995 to 141 122 in 2004. In all, the number of people residing in Ramotshere Moiloa municipality increased by 13 904 people from 1995 to 2004. The annual increase in the number of people in the municipality was 1.24% which is in line with the population growth in South Africa as a whole over the same period. The population growth rate in the Ramotshere Moiloa municipality declined steadily from 1.31% in 1997 to 1.27% in 2002. Thereafter the growth rate fell quite sharply from 1.23% in 2003 to 1.10% in 2005. A possible reason for this might be due to the increase in the HIV incidence rate in this area over the period (Ramotshere Moiloa reviewed integrated plan, 2009-2009).

Number of households

The number of households increased from 23 091 in 1995 to 37 862 in 2004. In all, the number of households in the municipal area increased by 14 772 households from 1995 to 2004. The average number of households in the Ramotshere Moiloa local municipality over the period was 30 251 (Punt, Pauw & Van Schoor, 2005).

Urbanisation rate

None of the municipal districts or cities in North West has metropolitan status; hence all urban areas are either classified as small cities or towns. Although most coloured, Asian and whites live in urban areas, the majority of blacks live in rural areas. Since the province has a very large black population, the overall urban-rural split is 39.4% versus 60.6%. The proportion is exactly the opposite of the national average 63-37 urban-rural split (Punt et al., 2005).

Labour profile

Key trends in labour characteristics of Ramotshere Moiloa local municipality that will be discussed in this section include the number and rate of unemployment, informal and formal sector employment, poverty rate and educational profile.

Number and rate of unemployment

The Ramotshere Moiloa municipality has a lower unemployment rate. The unemployment rate in urban areas is only marginally less than the rural unemployment rate. The reason for that is because most rural people have given up searching for jobs. Unemployment is also lower among agricultural households than non-agricultural households, mainly because family members would rather participate in the household's farming activities than do nothing (Punt et al., 2005). The average unemployed rate between 1996 and 2005 was 61.06% (Ramotshere Moiloa reviewed integrated plan, 2008-2009).

Informal and formal sector employment

Informal sector employment is the largest in the trade sector (41%), followed by 28% in construction, 17% in community services, 10% in manufacturing, 4% in transport and 0.4% in finance in 2005. Construction and trade are the two sectors that provide the largest informal employment in the abovementioned municipality.

With regard to the formal sector in this municipality, employment is the largest in the community services sector (38%), followed by 22% in agriculture, 19% in trade, 9% in construction, 5% in manufacturing, 3% in transport, 2% in finance and 1% in mining, and electricity in 2005. Community services, agriculture, and trade are the three sectors providing the largest formal employment in the municipality (Ramotshere Moiloa reviewed integrated plan, 2008-2009).

Poverty rate

Poverty rates vary greatly between racial groups in the North West province. There is virtually no poverty among whites and Asian people. In sharp contrast about 32.1% of coloured people are classified as poor. An estimated 56.0% of blacks live in poverty. Poverty is also more pronounced in rural areas, where 60.7% of people live in poverty, compared to 39% in urban areas. The average poverty rate in the municipality was 71.73% in 2005 (Punt et al., 2005; Ramotshere Moiloa Reviewed Integrated Plan, 2008-2009).

Educational profile

In 2001, 35% of the population in the municipality have received no formal education, 22% have some secondary schooling, 17% have some primary schooling, 16% obtained Grade 12, and only

5% have completed their primary and higher education. These figures indicate that the majority of people in this municipality are not educated or have received no formal education (Ramotshere Moiloa Reviewed Integrated Plan, 2008-2009). In 2001, 68% of the population was employed in schools, 4% were employed at pre-school institutions, and 23% in other occupations. Thus the majority of people in the municipality are employed at educational institutions (Ramotshere Moiloa Reviewed Integrated Plan, 2008- 2009).

The next section provides a profile of black adolescents in the Zeerust District. Focus will be on adolescents attending school since the participants in this study are school going black male adolescents.

PROFILE OF ADOLESCENTS IN ZEERUST DISTRICT

Adolescents attending secondary schools in the district are between the ages 12 and 20 years (grade 7-12). Most of these adolescents are performing poorly in their studies and as a result, the district is classified as *trapped*, that is performing below required percentage. Some adolescents drop out of school before completing matric. Many people in the district are therefore not educated or have not completed matric (Ramotshere Moiloa Reviewed Integrated Plan, 2008-2009). The family structures of these adolescents vary from nuclear families, single parent families, child-headed families, and extended families. Most of their parents are working as migrant labourers in Rustenburg and Johannesburg. As a result they are left alone or with their grandparents.

The majority of adolescents are from poverty stricken home environments, which is linked to family and peer contexts that promote drug use (Berk, 2007). Most of their parents are unemployed which is consistent with the findings of previous studies (Punt et al., 2005). Some of these adolescents end up losing hope and fall prey to drugs. Substance abuse is often reported among male adolescents in the district (Parry, 1998). The substances mostly abused include alcohol, tobacco and cannabis (Alcohol and drug abuse module, n.d.; Parry, 1998; Plüdderman et al., 2007).

Reports received from schools indicate that the majority of these adolescents tend to misbehave in school. In addition, there is a high rate of arrests of adolescents in the district. These arrests are due to substance related crimes, ranging from assaults, rape, robbery and illegal possession of

drugs (South African Police Service, 2007). This is similar to findings of studies mentioned earlier in this chapter. From the above discussion, a question arises as to why male adolescents abuse drugs? This question will be addressed in the next chapter.

CHAPTER SUMMARY

The literature review provided an understanding of the substances abused by adolescents as well as theoretical perspectives about adolescent substance use. The causes of substance abuse are complex and multifaceted. The data gathered from the literature suggest that substance abuse cannot be caused by a single particular factor, but by a combination of different aspects such as individual, family, peer, cultural and community factors. Furthermore, the literature review also confirmed that substance abuse has a negative effect on the lives of adolescents, society as well as the economy of the country. The prevalence of substance use, substances used, theoretical perspectives about the origin of substance use, effects of substance and socio-economic status of Zeerust (Ramotshere Moiloa municipality) were discussed in this section.

The focus of this study is to gather information about the substances that are abused by male adolescents in Zeerust, their knowledge of substances, reasons for substance use, their family structure and to identify the strategies that can be employed to address substance abuse among adolescents. The literature reviewed in this section helped me to contextualise my research project within an accepted body of knowledge. Furthermore, it provided a good, solid background knowledge. It helped me to refine questions in order to address the aims of the investigation. Furthermore, literature provided a guideline for the research methods and techniques used by others in similar projects and which proved successful. I then adapted the research instruments for use in this study. Those research methods are discussed further in the next section. Finally, literature review, enabled me to evaluate the project more effectively, by comparing and contrasting the results with what is already known.

CHAPTER 3

RESEARCH METHOD

INTRODUCTION

In this chapter, the research method will be discussed. This entails the selection of a qualitative design and preparation for data collection. Decisions on how the sample was framed and developed, my role in this study, how entry to a research site was gained, data collection methods and a protocol for recording information and analysis of data is discussed (Denzin & Lincoln, 2000; Taylor & Bogdan, 1998). Ethical issues are also discussed in this chapter.

QUALITATIVE RESEARCH DESIGN

A qualitative research design was implemented. Qualitative research is a ‘many labelled tradition’ (Lofland & Lofland, 1984). The most commonly used labels appear to be field research or fieldwork, naturalism, ethnography, interpretive research and constructivist research (De Vos, 1998). A qualitative research design was selected because of the following reasons: The aim of the study was not to explain human behaviour in terms of universally valid laws or generalisation, but to understand and interpret the meanings and intentions that underlie everyday human actions (Mouton, 1986, cited in De Vos, 1998).

The study was conducted with a few participants, that is 12 male adolescents only, in one district, and within the habitat of the participants. Preference was given to the natural setting rather than experimental conditions as the primary source of data (Silverman, 1993), in order to gain understanding of the social worlds of participants through direct personal experiences (Schram, 2006). Triangulation of methods, participants, settings and time was considered in this study in order to secure an in-depth understanding of substance abuse among male adolescents (Flick, 1992). This is discussed later in this chapter.

Qualitative research as a multi perspective approach enabled me to utilise different qualitative techniques and data collection methods to social interaction, in contrast to quantitative studies which emphasise the measurement and analysis of causal relationships between variables, not processes (Morse & Field, 1995). Observations rather than experiments were employed in this

study. Furthermore, these methods were used in order to understand participants' perspectives and actions in their social context (Terre Blanche & Durrheim, 1999). The family background and the social environment of the participants were also considered in this study, in order to understand their substance abuse behaviour. Thus, this study proceeded from an assumption that participants cannot be fully understood if isolated from their circumstances or natural setting (Schram, 2006).

The methods employed were based on the questions of this study (Denzin & Lincoln, 1994) which are discussed later in this section. In addition, the qualitative research design enabled me to describe, make sense of, interpret or reconstruct interaction in terms of the meanings that the participants attached to it (Denzin & Lincoln, 1994). Qualitative research concentrates on qualities of human behaviour, that is on the qualitative aspects as against the quantitative measurable aspects of human behavior (Denzin & Lincoln, 1994; De Vos, 1998; Marshall & Rossman, 1995). Preference was given for unstructured data collection; inductive, hypothesis-generating rather than the testing of theory. I was concerned with generating new concepts rather than testing existing ones (Newman, 1997).

No prior hypotheses were formulated, and the study unfolded naturally in that it had no predetermined course established or manipulated by me such as would occur in a laboratory or other controlled settings (Schram, 2006). Furthermore, words instead of numbers were used to analyse data (Silverman, 1993). The emphasis was on processes and meanings that were rigorously examined and measured in terms of quantity, amount, intensity and frequency (Nelson, Treichler, & Grossberg, 1992). Findings were not reported in terms of complex statistical measures or methods to which quantitative methods are drawn.

Qualitative research was further employed because this study was concerned with capturing the individual's point of view through detailed interviewing and observation (Nelson et al., 1992). The experiences of participants, including their gestures and tone, were recorded using a tape and field notes (Newman, 1997). Thus, qualitative method was logical in this study because the research question required exploration of the occurrence and complexities of substance use.

SAMPLING

The sample in this study was drawn from secondary schools in the Zeerust district (North West province). For the purpose of this study, only four secondary schools were regarded as the population of this study. The four secondary schools are situated in the rural areas of the Zeerust District. These schools were selected because of the high number of reported substance abuse cases among male adolescents lodged with the Department of Education and the Department of Social Development. Furthermore, these schools were selected because even though the 'Ke Moja' drug awareness campaigns had been conducted in them by the Department of Education, Department of Social Development and the South African Police Services, substance abuse was still on the rise. In addition, some of the male adolescents in these schools were arrested because of criminal offences committed under the influence of drugs (South African Police Services, 2007). Furthermore, these schools were selected because they were convenient and participants agreed to participate. A group of 12 male adolescents abusing substances and attending at the above-mentioned schools were in the sample selected to participate in the study.

A purposeful sampling method was used to select the participants (De Vos, 1998; Goodwin, 1995; Greenfield, 2002; Kerlinger & Lee, 2000; Liamputtong & Ezzy, 2005). This sampling method was based on my judgment regarding the characteristics of a sample. The strategy was to select participants that are information rich and illuminative, that is, they offer useful manifestations of the phenomenon. Studying information-rich cases yields insights and understanding rather than empirical generalisations (Newman, 2000; Patton, 2001).

A purposive sampling method was used because adolescents abusing substances are secretive about their behaviour, which makes recruitment more complex. It seemed that the best way to identify the sample was to request lists of secondary school learners who were reported to the Zeerust Area Project Office as abusing substances. Only male adolescents who admitted that they were using substances, and were referred to social services for intervention were selected from the list. I was aware that the results obtained from this study could not be used for generalisation purposes to other adolescents in other schools. However, the data obtained from this study can be useful to other schools with similar circumstances. The sample in this study consists of 12 black male adolescents, between the ages 12 to 15, completing grades 7 to 9. The reason for selecting adolescents in this age group was because of a high number of substance abuse cases that were

reported.

Only male adolescents who are abusing substances were included in the study. The participants were from a lower socio-economic group. There were other adolescents who are abusing substances and not attending school but for the purpose of this study, only male adolescents attending school were considered.

Eligibility criteria

The following criteria were considered in selecting participants for the study: black male adolescents between 12 and 15 years of age who abuse substances, secondary school adolescents, and residents of rural areas in the Zeerust district, North West province of South Africa who were willing to participate in this study.

THE INTERVIEW SETTING

The interviews were conducted in private offices after school hours at the four secondary schools over eight days (two days per school). The offices were situated in quiet places where there were no interruptions. Furthermore, they provided privacy and were non-threatening (De Vos, Strydom, Fouche, & Delpont, 2002). The reason for conducting interviews after school was to respect teaching and learning time. The schools were selected as venues as the participants were attending those schools and they were accessible to them, this reduced the costs of participants' travelling by using these venues. I conducted all the interviews.

RESEARCHER'S ROLE

In this qualitative investigation, as a form of subjective research, I was the research instrument for both collecting and analysing data (Terre Blanche & Durrheim, 1999). I wanted to learn more about substances used by adolescents as well as the reasons for their use and felt compelled to participate in the study to meet the demands of reciprocity (Marshall & Rossman, 1995). The reciprocity that I offered in the interview included my interest in participants' experiences, attending to what they said and honouring their words when presenting data (Seidman, 1998). Furthermore, arrangements were made with the area social worker to assist the participants in case they needed counselling or debriefing after the interview. Permission to do so was first obtained from the participants.

WAYS OF RECRUITING PARTICIPANTS

Permission was requested from the manager of the Zeerust Area Project Office (Department of Education, North West) to conduct the investigation at four secondary schools in the Zeerust district (see Appendix 2). Permission was also requested from the school principals, parents or guardians of the learners and the learners. Letters to undertake the study were sent to the Zeerust Area Project Office Manager, the school principal, parents or guardians and the learners (see Appendix 1). Three meetings were arranged. The first one was a meeting with the manager of the Project Office and the second meeting was arranged with the principals of secondary schools.

The third meeting was conducted with individual parents or guardians and the learners. The purpose of these meetings was to explain the study and to request permission to conduct the study. I explained the purpose of the study to the above-mentioned stakeholders and they were requested to give informed consent in writing (see Appendix 1). Parents or guardians were requested to give informed consent on behalf of their children. Parents and participants were guaranteed that information obtained will not be submitted to the police and that no one will be arrested for abusing substances. This was done to alleviate fears among the participants. Participants were made aware that participation in the study was voluntary and they may withdraw from the study at any time if they wished to do so.

A follow-up letter with dates and venues for interviews was sent to the Area Project Office Manager (Department of Education) and the school principals. Negotiations for entry were aided by the fact that I was a Life Orientation subject specialist in the district, involved in substance abuse awareness campaigns and assisting with referrals of learners to social workers for intervention. At the time of these meetings, I had already started negotiations for entry with the district manager and principals. Formal approval for the study was thus likely.

DATA COLLECTION

The following data collection methods were employed: interviews, genograms and observations. These data collection methods were used by previous researchers in quantitative, descriptive, explorative designs and proved successful (Mhlongo, 2005; Vakalahi, 2001). The study for example, of Mhlongo (2005) was cross-sectional, and that of Vakalahi (2001) was longitudinal. Interviews were employed in the study of adolescents abusing drugs in Swaziland (Mhlongo,

2005) as well as in the study of adolescent substance use and family based risk and protective factors (Vakalahi, 2001).

Unstructured interviews

There are three main types of unstructured interviews; that is, open-ended interviews, unstructured interviews with a guide or schedule and in-depth interviews (De Vos, 1998; Marshall & Rossman, 1995). For the purpose of this study, unstructured interviews with a interview guide were used (see Appendix 3). The schedule or interview guide provided me with guidelines for the interviews and contained questions and themes that are important to the study. I developed the interview guide myself. The questions in the interview guide were based on the research questions of this study as well as the literature study conducted.

The interview in this study consisted of three sections. The first section contained questions about the biographical data of participants. These questions were asked to make respondents feel at ease and comfortable to interact with me. The second section contained a broad general question: How do you feel about alcohol adverts in soccer fields? That was used as an introduction before focusing on the main questions about the study. The broad general question was asked to establish what was important to the participants. The third part consisted of the main questions regarding the study. The questions are as follows: Have you ever used any drug in your life? If yes, which drug did you use? How were you introduced to drugs? With whom do you/did you take drugs? For what reason did you/do you take drugs? Do any of your friends take drugs? If yes, how often do you take drugs? Where do you take drugs? At which places do you usually take drugs? How do you support your drug-taking habit? Does anyone in your family take drugs? If yes, who is it?

The questions in the interview guide were not asked in a particular sequence. The interview guide was used to ensure that all the relevant topics were covered during the interview. Use of the unstructured interviews with a schedule or guide ensured systematic collection of data and at the same time ensured that important data were not forgotten. The interview guide also allowed for the open-ended responses and was flexible because it allowed me to note and collect data on unexpected dimensions of the topic (Bogdan & Biklen, 1992). By using unstructured interviews, I was able to obtain an 'insider view' of the social phenomena and explore other important points

of view emerging from the interviews.

The participants were interviewed one by one for approximately two hours at their schools. A tape recorder was used to record information. Permission to use a tape recorder was requested from the participants beforehand. Two new electric/battery tape recorders were used and I ensured that they were in a good working order. Two tapes were used for back-up purposes. Tape recording do however, have its disadvantages. I was aware of the fact that the participants might not feel happy being taped and may even withdraw from the study. The tape recorder was placed inconspicuously so as not to unnerve the participants (De Vos et al., 2002). After the interviews, I summarised the main points of the interview, checked out inconsistencies and allowed feedback from the participants. In closing, I thanked the participants for taking part in the interview and informed them that their contribution was really helping the investigation.

After each interview, I took 15 minute intervals to check whether the tapes worked correctly and to note all important data that were discussed with the participants as well as notes of their body language. A great deal of information can be recalled if the interviewer makes notes about the conversation immediately after the interview (Liamputtong & Ezzy, 2005). These notes helped me to remember and explore the process of the interviews (De Vos et al., 2002).

I transcribed the interviews and this provided me with an opportunity to get immersed in the data as well as a chance to get a feel of the cumulative data as a whole, an experience that usually generates emergent insights (Patton, 2001; Seidman, 1998). An expert was employed to assist in transcript typing. I worked closely with that person to make certain that the work was accurate.

Interviews were used for the following reasons. Interviews facilitate cooperation from research participants. Immediate follow up can be done in case there are omissions or for clarification purposes. They assist in discovering complex interconnections in social relationships. Data were collected in the natural setting of the participants. Through interviews, I managed to obtain background information about the participants. Furthermore, interviews facilitated analysis, validity checks and triangulation (Greenfield, 2002).

I was aware of the various disadvantages of the interviews, such as the possibility of them being

open to misinterpretation. Interviews are difficult to replicate. Interview procedures are not explicit and depend on researcher's characteristics and interviews depend on the honesty of those providing data (Greenfield, 2002). These weaknesses were overcome by asking questions where clarity was required during the interviews.

For reliability purposes, data were kept safely in case there are queries about them at a later stage. In addition, reliability was ensured through triangulation of data using multiple data sources, multiple methods and data analysts. Reliability issues will further be discussed later in this chapter.

Genograms

A genogram is a format for drawing a family tree that records information about family members and their relationships over at least three generations. Genograms display family information graphically in a way that provides a quick gestalt of complex family patterns and a rich source of hypotheses about how a clinical problem may be connected to the family and context over time (McGoldrick et al., 1999). I drew genograms for each participant based on the information they provided during the interview (see Appendix 5). However, for the purpose of this study, only family members who stay with the participants were included in the genogram. That included nuclear family members and the extended family members depending on the information provided by the participants.

Furthermore, for the purposes of this study, the age of the participant and family members staying with the participant are not given. The substance abuse behaviour of the participants in this study was traced on the genogram from multiple perspectives. The participants in the study were viewed in the context of various subsystems, such as parents, siblings and in relation to the broader systems such as the community and the school. Patterns of substance abuse behaviour among other members of the family were also noted. That is, participants were asked whether there was anyone in their families who abuses substances, and if so, they had to name the substance the person uses. This was done in order to trace the origin of substance abuse behaviour in the families of the participants. The family structures of the participants are presented in Chapter 4.

Observation

I observed and inferred important matters concerning interview interaction, including verbal and non-verbal communication with the participants (see Appendix 4). I also noted their own attending behaviour. Examples of aspects that were observed included the following; appropriate eye contact and facial expression, a relaxed natural posture, encouraging communication by leaning slightly forward, nodding in agreement, and using minimal utterances such as ‘umm’, ‘hmm’ or ‘yes’. This type of attending behaviour demonstrated respect for the interviewees as well as the interviewer’s honesty, sincerity, empathy, understanding and enhance the important sense of equality between the parties. The interviewer’s recognition of the interviewee’s non-verbal communication gives the latter a sense of being understood at a deeper level than the level of the words (De Vos, 1998).

PILOT STUDY

A pilot study is a smaller version of a full-scale study (also called ‘feasibility’ study), as well as pre-testing of a particular research instrument such as a questionnaire or interview schedule or research apparatus such as computers or tape recorders (Berg, 1995; Newman, 2000; Seidman, 1998; Stachowiak, 2008; Van Tejligen & Hundley, 2001; Walliman, 2006).

The study was pretested with two black male adolescents, 12 and 15 years of age in grades 7 and 9 respectively, attending one of the secondary schools. A list of learners abusing substances was requested from the Zeerust Area Project Office (Department of Education, North West). A purposive sampling was used to select two participants for the pilot study. The pilot study was conducted for the following reasons as adapted from Van Teijlingsen and Hundley (2000). The pilot study was used to assess the feasibility of the study, identify logistical problems, to collect preliminary data, to test the adequacy of interview questions, to assess the proposed data analysis techniques in order to uncover potential problems, and to train myself in as many elements of the research process as possible.

The pilot study preceded the main study and it was conducted after separate meetings with the Area Project Office Manager of the Department of Education, principals, parents or guardians and the participants. That was after permission was granted by the Area Project Office Manager, principal of the secondary school where participants in the pilot study were attending school and

informed consent was obtained from both the parents or guardians as well as the participants. It was conducted in one day, in an office at one of the secondary schools where participants are attending school.

The participants were interviewed after school hours. They were very nervous and not willing to share their views on substances. I then had to set them at ease to feel free to talk by telling them that all the information gathered will be used for the purpose of the study only and not to report any findings to the police. After all these explanations, the participants were ready to continue with the interview. The pilot study assisted me to translate questions into Setswana, in case the participant does not understand the original English questions. This was done because the mother tongue of participants is Setswana. The participants were also allowed to answer questions in Setswana.

Furthermore, the pilot study helped me to realise that even though adolescents abuse substances, they are not free to talk about their substance abuse behaviour, for example, when asked about where they bought drugs, they provided brief and vague answers; such as 'In our village'. I then had to ask them to be specific about the place where they bought drugs and then they indicated that they bought them from shops and from someone in the village. I also took note of their non-verbal behaviour. After realising that participants became sad when responding to some questions, I would then move on to other questions and only go back to unanswered ones after doing other questions that respondents were free to answer. They were also evasive when asked why they were using substances. They responded briefly and did not elaborate, for example: 'I saw my friends using drugs'. I then had to probe and ask them to state other reasons.

When conducting the main study, I was subsequently more astute to giving participants a break if they needed one, and to later go back to questions that were not answered in full, or those which needed clarity on. The participants in the pilot study also spoke softly when answering questions, I thus obtained a microphone and requested the participants in the main study to raise their voices so that the tape recorder could capture all the information discussed. Thus, I devised a strategy of engaging the participants and allowing even more time for the interviews. I had to exercise patience when interacting with them. Thus, information gathered in the pilot study was used to refine and modify the research methodology before conducting the large scale study.

I was aware that conducting a pilot study successfully was not a guarantee for the success of the large scale study. There was a possibility of making inaccurate predictions and assumptions on the basis of pilot data. Furthermore, other problems may not become obvious until the large scale study was conducted (Van Teijlingen & Hundley, 2001).

ETHICAL CONSIDERATIONS

Ethical issues that were considered in this study are permission to collect data, debriefing, voluntary participation, informed consent, confidentiality and the protection of participants (Berg, 2001; Kerlinger & Lee, 2000; Newman, 2000; Patton, 2001; Seidman, 1998).

Permission to conduct the study

As mentioned earlier, permission to conduct the study was obtained from the Zeerust Area Project Office leader, school principals, participants and parents or guardians of participants because the participants in this study were minors. Permission to conduct the investigation was approved on 26 May 2008 by the research Committee of the Department of Psychology, University of South Africa.

Debriefing

Before conducting interviews, I explained the purpose and procedures of the study. Participants were informed about all the procedures that were to be followed in this study. Details about dates and venues for the study were clearly explained to participants. An attempt was made to remove any misconceptions that the participants may have about the study (Kerlinger & Lee, 2000).

Voluntary participation

Before conducting the interviews, I made participants aware that participation in the study was voluntary, that they may withdraw from the study at any time if they wish to do so (Kerlinger & Lee, 2000; Newman, 2000; Patton, 2001; Seidman, 1998). However, the participants were informed that their participation was important for this study and that it will contribute to understanding the reasons for adolescent substance use.

Informed consent

Informed consent was obtained from the participants who were willing to participate in the study.

Informed consent was also obtained from the parents or guardians of the participants because participants in this study were minors. The consent was ensured in writing. Informed consent slips were signed by both the parents or guardians of participants and the participants themselves (Berg, 1995; Berg, 2001; Kerlinger & Lee, 2000; Liamputtong & Ezzy, 2005; Newman, 2000; Patton, 2001; Seidman, 1998). The participants were informed that they were free to ask questions.

Protection of participants

The participants were informed that there were no known medical risks associated with the study (Kerlinger & Lee, 2000; Liamputtong & Ezzy, 2005; Newman, 2000; Patton, 2001; Seidman, 1998). Efforts were made to ensure that the participants were protected from any harm or discomfort that may arise from the study. Furthermore, participants were informed that arrangements were made with the area social worker to assist them in case they need counseling or debriefing after the interview. Permission to do so was first obtained from participants.

Confidentiality

The participants were assured that all the information obtained was to be treated as confidential. That is, data will only be used for stated purposes and no other person will have access to interview data. The participants were informed that their names will be omitted and that numbers would be used to identify respondents (Berg, 1995; Kerlinger & Lee, 2000; Liamputtong & Ezzy, 2005; Newman, 2000; Patton, 2001; Seidman, 1998). The participants were also guaranteed that if their anonymity were to be threatened, all the records would be destroyed. This was done in order to avoid biased responses from participants. Data were kept safely in case there were queries about them at a later date. Audio-tapes were locked away. Computer data were protected by a password. At the end of the process, all documents will be shredded and tapes will be erased. (Walliman, 2006). Data will only be destroyed after completion of the degree and when the data are no longer required by the university.

DATA ANALYSIS

Data analysis consisted of systematically searching and arranging the interview transcripts, field notes and other materials that I accumulated in order to increase my understanding of them and to facilitate presentation of what was discovered to others. Furthermore, the analysis involved

working with data, organising it, breaking it into manageable units, synthesising it, searching for patterns, discovering what is important and what is to be learned and deciding what needed to be divulged to others (Bogdan & Biklen, 1992).

The following techniques, adapted from Cresswell (1997) were used to ensure that the qualitative data obtained and subsequent data analysis are dependable and credible: focused observation in the field and triangulation of data using multiple data sources, multiple methods and multiple data analysts. The data will be presented in the form of short quotations from the male adolescents participating in the study. These types of data, known as low-inference data, allow the reader to determine whether the investigator's interpretations are true to the content and intent of the data. After each interview, I summarised the main points of the interview, checked out inconsistencies and allowed feedback from the interviewees. This was done during the interview, through clarity seeking questions to confirm answers obtained from interviewees. I was assisted by two doctoral research students to review the data analysis and interpretation in order to ensure that the data was dependable and credible.

Thematic analysis

Data were analysed thematically. Thematic analysis is a method for identifying, analysing and reporting patterns and themes within the data. It minimally organizes and describes data in detail (Botatis, 1998, cited in Braun & Clark, 2006). Thematic analysis seeks to unearth the themes salient in a text at different levels and thematic networks aim to facilitate the structuring and depiction of these themes. Each stage of data analysis involved data reduction as the large amount of collected data are reduced to manageable parts. It also involved interpretation as I interpreted meaning and insight into the worlds and acts of the participants in the research (Braun & Clarke, 2006).

First, audiotapes were collected to study the discussion in the interviews and the contents were transcribed verbatim to enable thematic analysis. The services of an expert in transcript typing was employed and I worked closely with that person so as to develop a better understanding of the data (Braun & Clark, 2006; Liumputtong & Ezzy, 2005). Furthermore, the transcripts were checked against the original audiotapes for accuracy (Braun & Clark, 2006). I made sure that all

data collected were complete, that no parts of detailed field notes were left out. After checking the quality of the data and filling in any missing gaps, copies of all data collected were made.

Patterns of experience were listed from the transcribed conversations. This came from direct quotes or paraphrasing common ideas (Aronson, 1994). I received assistance from an expert in qualitative data analysis to help analyse data as it seemed that when more than one person is analysing data, important insights can emerge from the different ways in which two people look at the same set of data, a form of analytical triangulation. I read through the data in order to become intimately familiar with the data. During the reading process, the available data were listed on note cards, minor editing was done to make field notes retrievable and to organise voluminous data.

Data were also entered into one of the several software programs for the management and analysis of qualitative data. For the purpose of this study, the NUD*IST computer program was used. The programme works with textual documents and facilitates the indexing of components of these documents. It is able to search for words and phrases very quickly and claims to support theorising through enabling the retrieval of indexed text segments, related memos, text and index searches and through the hierarchically structured tree to order index categories (Qualitative Solutions & Research, 1994 cited in Bryman & Burgess, 1999). The use of the NUD*IST program eased my workload, saved time and generally enhanced the power of qualitative analysis (Bryman & Burgess, 1999).

The following steps adapted from Aronson (1994), Attride-Stirling (2001) and Braun and Clark (2006) were implemented in analysing the data:

Coding the material: The transcripts were dissected into manageable and meaningful segments such as quotations and single words with the use of a coding framework (Aronson, 1994; Attride-Stirling, 2001). The coding framework was based on the theoretical interests guiding the research questions and on the basis of salient issues that arose in the text itself (Attride-Stirling, 2001; Braun & Clark, 2006). Data were coded by writing notes on the text that were analysed and by using highlighters or coloured pens to identify segments of the data (Braun & Clark, 2006).

The most salient constructs in the transcripts were identified and shaped into a finite set of codes

that were discrete enough to avoid redundancy and global enough to be meaningful.

Identifying themes: Once all the text was coded, salient, common or significant themes which were specific to the interest of the study were extracted from the coded segments. This was done by rereading the text segment within the text context under which they had been classified. Selected themes were refined into themes that were specific enough to be discrete and broad enough to encapsulate a set of ideas contained in numerous text segments. Codes that did not seem to fit into main themes were housed temporarily in a theme called ‘miscellaneous’ (Braun & Clark, 2006). Thus data were reduced into a more manageable set of significant themes that succinctly summarised the text.

Constructing networks: Themes identified were arranged into coherent groupings. These groupings became thematic networks. The original set of themes were selected and used as basic themes. Clusters of basic themes were created to make organizing themes. The main claim or assumption about the organizing themes was summarised. The claim is the global theme. After preparation of the basic themes, organising themes and global themes, I illustrated them as non-hierarchical, web-like representations. Each global theme produced a thematic network. Furthermore, I went through the text segments related to each basic theme in order to ensure that the global themes, organizing themes and basic themes reflect the data and that the data supported them (Attride-Stirling, 2001).

Describe and explore the thematic network: The contents of the network were described and explored. The themes that emerged were explored, identifying the patterns that underlie them. Once the networks were constructed, I returned to the transcripts and interpreted them with the aid of the networks. The contents of the network were described and supported by the text segments. As a description was being woven, I began to explore and to note the underlying patterns which emerged. Text segments were presented from the original transcripts or data to support analysis (Attride-Stirling, 2001).

Summarise the thematic network: A summary of the main themes and patterns characterising them were presented once a network was described and explored in full. The objective was to summarise the principal themes that began to emerge in the description of the network and to

make explicit the patterns emerging in the exploration (Attride-Stirling, 2001).

Interpret patterns: Deductions in the summaries of all the networks were brought together to explore the significant themes, concepts, patterns, and structures that arose in the text. I returned to the research question and the theoretical interests underpinning them and addressed that with arguments grounded on the patterns that emerged in the exploration of the texts (Attride-Stirling, 2001).

Advantages and disadvantages of thematic analysis

Cognisance was taken of advantages and disadvantages of thematic analysis (Braun & Clark, 2006) as stipulated below:

Advantages: Thematic analysis is a flexible approach that can be used across a range of epistemologies and research questions. It is a relatively easy and quick method to learn and apply. It can usefully summarise key features of a large body of data and offer thick description of the data set. It can highlight similarities and differences across the data set. It can generate unanticipated insights. The method allows for social as well as psychological interpretations of data. It can be useful for producing qualitative analysis suited to informing policy development.

Disadvantages: Thematic analysis makes developing specific guidelines for higher-phase analysis difficult and can be potentially paralysing to the researcher who has to decide about which aspects of their data to focus on. Unlike narratives or other biographical approaches, one is unable to retain a sense of continuity and contradiction through any one individual account, and these contradictions and consistencies across individual accounts may be revealing. A simple thematic analysis does not allow the researcher to make claims about language use, or the fine-grained functionality of talk. Thematic analysis has no particular kudos as an analytic method. This stems from the fact that it is poorly demarcated and claimed, yet widely used.

RESEARCH BENEFITS

The participants were informed that they would not receive any monetary benefits from the study, however, they were informed that their participation in this study provided both indirect and direct benefits to them and their communities. Indirect benefits include the following: they

increased their knowledge about themselves or their condition through the interaction with me (Polit et al., 2004). Furthermore, participants experienced health and well-being, and relief from stress (Rabkin & Small, 2001).

The study also provided informative debriefing for participants and as such participants were able to discuss their substance abuse behaviour, other challenges that they encounter during the developmental stage of adolescence, as well as in their families. They were also able to share their concerns or interests with me. In addition, as mentioned earlier, a social worker was available in case participants required her services. They were also provided with information about health facilities available at their schools and in their communities. Participation in the study also offered the following indirect benefits: participation in the study provided more understanding about the reasons for substance abuse. It provided advancement of knowledge that may lead to improved conditions for the participants and to society in general (Morgan, Gliner, & Harmon, 2006). In addition, it also increased knowledge that can be used to develop new intervention strategies for others and may also help health practitioners to develop new treatment or interventions for others in future. Furthermore, their participation provided the prestige of being associated with the study and the university under which this study is carried out.

CHAPTER SUMMARY

The following aspects were discussed in this chapter: sampling, setting of the study, role of the researcher, ways of recruiting participants, data collection, ethical considerations, data analysis, thematic analysis and research benefits of the study. Chapter 4 presents the analysis of the data.

CHAPTER 4

FINDINGS OF THE STUDY

INTRODUCTION

The previous chapter outlined the research design. In this chapter, the data analysis is presented. A brief introduction of each participant and his family structures will be presented before moving on the analysis of the data. In order to protect the identity of the participants, numerical numbers are allocated to distinguish the participants.

BRIEF INTRODUCTION OF PARTICIPANTS

Participant number 1 is from a nuclear family, staying with both biological parents and siblings. Only his father is employed at a shop in town. The mother is not employed. The participant is 15 years old, and third born in the family. He is repeating grade 8. He was introduced to substances by a cousin during his visit in Gauteng province. He was in primary school doing grade 4 at the time. He uses beer, cigarettes and heroin. The first substance that he used was heroin. He is dependent on these substances; using them three times a day; that is in the morning, during the day and at night. He also uses substances during weekends. His mode of use of these substances includes smoking, inhaling and drinking.

He uses substances because his cousin introduced him to them, his parents reprimand him a lot at home and because of peer group pressure. These substances are sold in the area where the participant is residing. The participant uses pocket money and works part-time to maintain his habit. He uses substances at the local tavern. He knows the effects of substances. The participant's academic performance is also negatively affected by the use of these substances. He regrets his use of these substances and indicated that he needs assistance to stop using substances. His parents are not aware of his use of substances. See figure 1 for a genogram of his nuclear family.

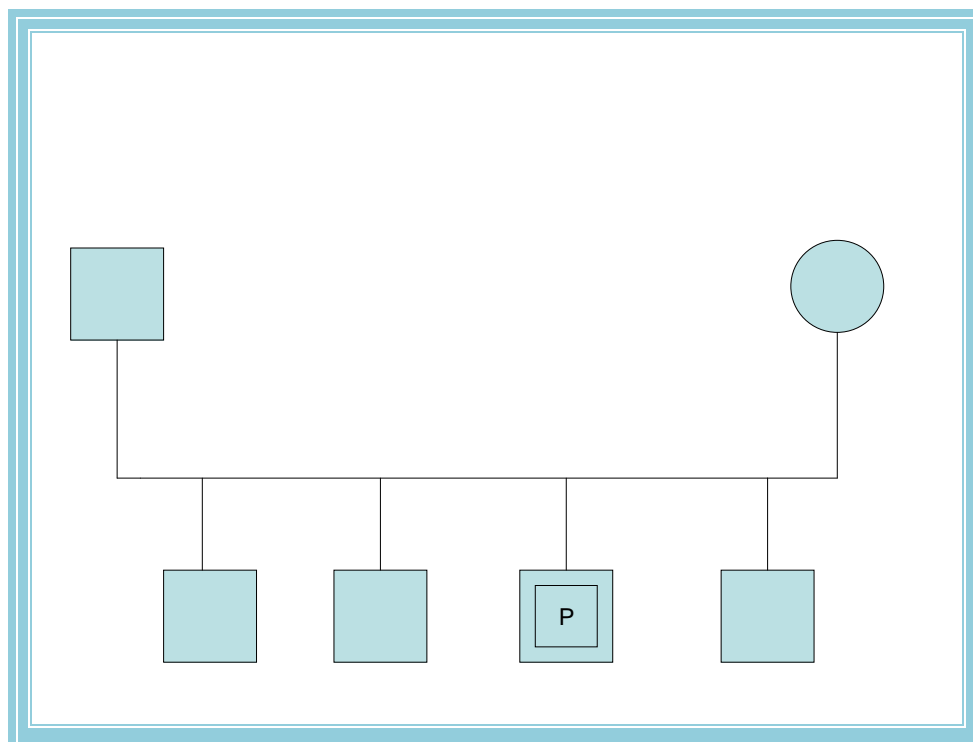


Figure 1: Nuclear family

NB: See Appendix 5 for guidelines to interpret the genograms.

Participant number 2 is 15 years old, in grade 9 and lives with his extended family. He is the eldest at home. He uses tobacco, alcohol and cannabis. The modes of use of these substances are smoking and drinking. The reasons for using substances are that he wanted to experiment or taste the substances and friends influenced him to use substances. He is dependent on these substances and uses them in the morning, during the day and at night. He often absents himself from school and joins his friends in the bush to use substances. He also uses them at the local tavern. He and his friends each contribute money to buy the substances, and also uses his pocket money to buy substances. His parents are not aware that he uses substances. He was arrested for stealing computers at a store with his friends. He is currently serving a sentence every Saturday at the Correctional Services. Substances have affected his academic performance. He is repeating the grade and still obtains low marks. He knows the effects of using substances and regrets his use of substances. He has an uncle who smokes cigarettes. See Figure 2 for a genogram of his extended family.

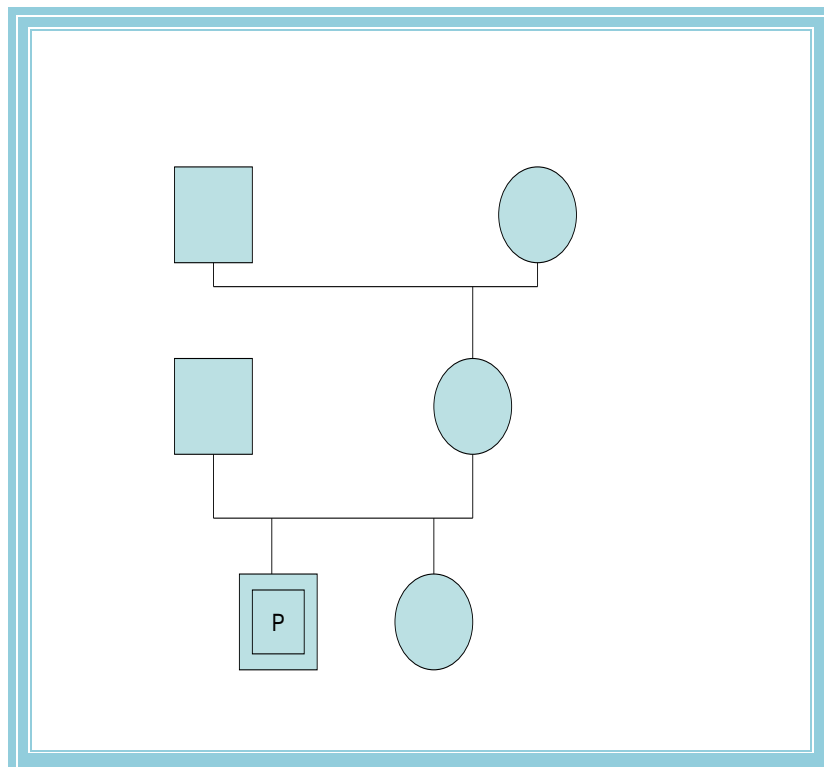


Figure 2: Extended family

Participant Number 3 is 15 years old, currently repeating grade 8 and staying with both of his biological parents. Only his father is employed. Substances used are alcohol and cigarettes. He uses these substances at the tavern with his friends during weekends. He is dependent on alcohol. His reasons for using substances are ill treatment by his parents, an uncle who was arrested, became sick and who later died, peer group pressure, entertainment and the fact that an uncle introduced him to cigarettes because he asked him to light them for him. His parents allow him to go to the tavern. Once he is under the influence of alcohol, he becomes violent and fights with people. He uses his pocket money to buy substances. His academic performance has dropped because of his use of them. He knows the effects of using substances and regrets his use of substances. See Figure 3 for a genogram of his nuclear family

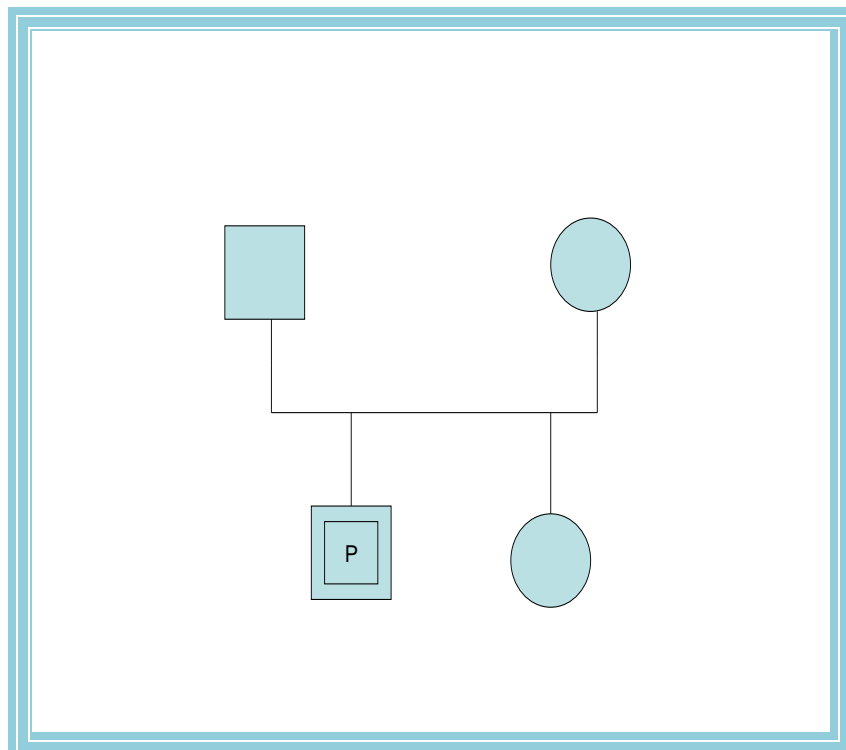


Figure 3: Nuclear family

Participant number 4 is 15 years old, first born at home and is currently repeating grade 8. He is staying with his biological mother, step-father and his younger sister. The mother is unemployed, and only his step-father is working. His biological father is employed as a migrant labourer in Rustenburg, but is not taking care of him. He drinks beer. His friends, who are employed, buy alcohol for him. He drinks alcohol at the tavern with his friends on Fridays and Saturdays. He sleeps in an outside room and his parents cannot see him if he comes home drunk. His reasons for his use of substances are that his step-father treats him badly; and he does not want to see him playing. He sometimes sleeps without eating anything and goes to school on an empty stomach. He is stressed and his friends influenced him to use substances in order to relieve stress. He is unable to talk to his mother because she is too strict. Instead, she feels comfortable expressing his feelings to her grand mother who is not staying with them and is also unemployed. He is overwhelmed by his situation and feels helpless. He even thinks of committing suicide. He is afraid to tell educators about his problems. He indicated that he needs assistance so that he can be like other children. No one in his family is using substances. He understands the effect of using substances, yet continues to do so. See Figure 4 for a genogram of his step-parent family.

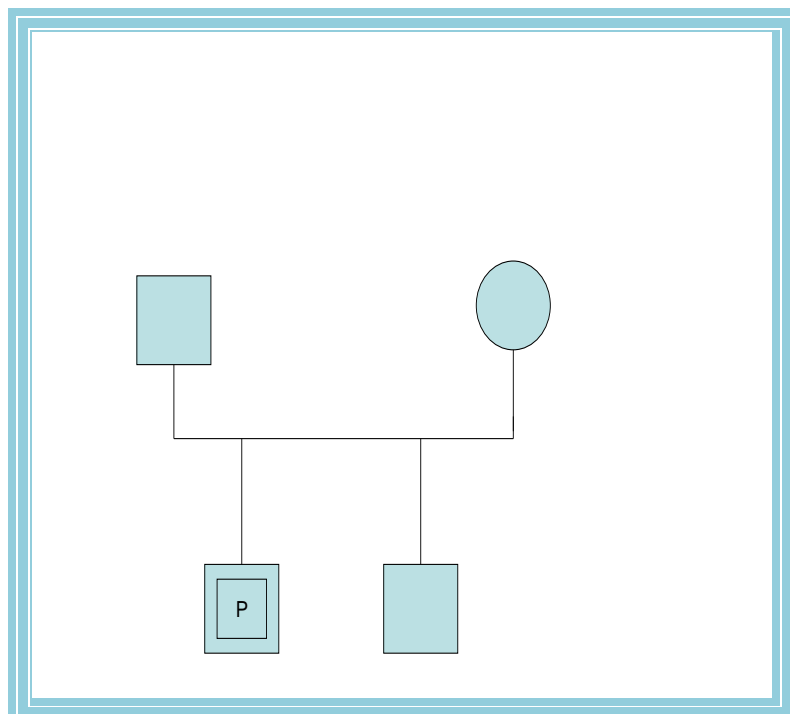


Figure 4: Step-parent family

Participant number 5 is 15 years old, in grade 8 and staying with his grandmother. His biological parents have separated. They are both alive and the father has married another women. His father is employed as a police inspector and takes care of him. The mother is unemployed. He uses cannabis, cigarettes, glue and cocaine. He started using substances on his own; saw other people using substances, thought it was normal to use drugs, thought it makes one cleverer and helps one to concentrate when studying. He buys cannabis in the village and smokes it at home. He is dependent on substances; uses them in the morning, during the day and at midnight. He plays dice in order to ensure that he has these substances. He understands the effects of using substances. He regrets his use of substances and wants to stop using them. He also wants to live a positive life, complete his studies and discourage other teenagers from using substances. See Figure 5 for a genogram of his extended family.

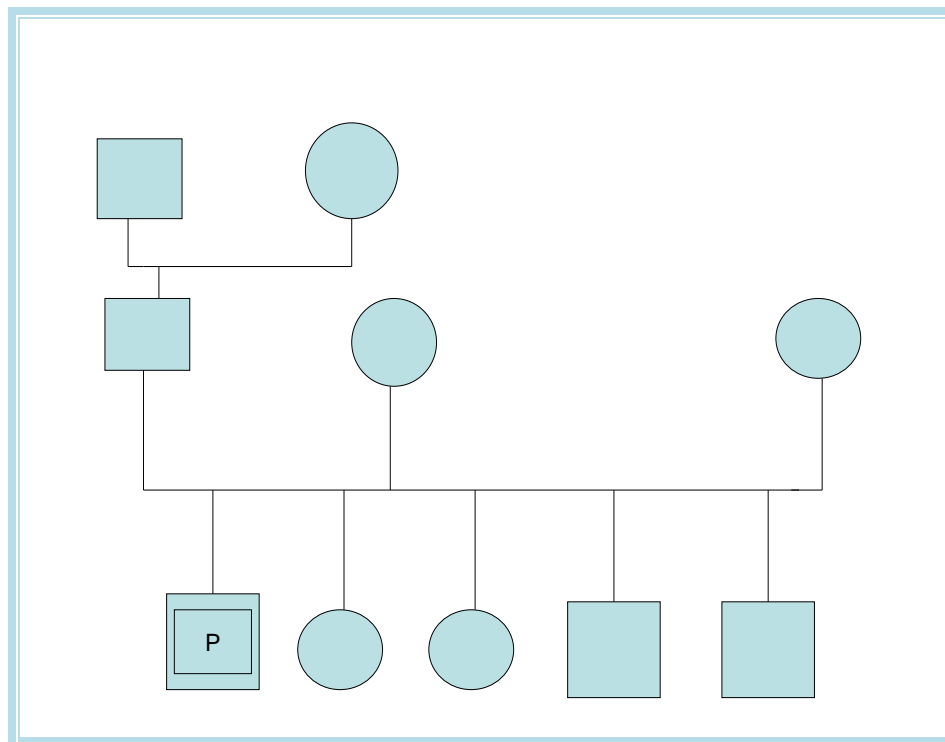


Figure 5: Extended family

Participant number 6 is 15 years old, in grade 8 and staying alone in a child headed household. His mother passed away and his father left after her death. He has an elder brother and two sisters who are staying in Rustenburg. He drinks alcohol and smokes cigarettes with friends, either at home or at the butchery. His reasons for using substances are due to the fact that his mother passed away, he is lonely at home and his father left him and told him to take care of himself because he is now an adult. He relies on his sisters for care and support. He sometimes has to wait long periods for them to send him money or food. He is stressed and friends influenced him to use substances to forget his problems. His friends provide him with food, cigarettes and alcohol. He has no choice but to succumb to peer group pressure to use substances. He relies on his friends who often provide him with food, love and support to survive. The situation is unbearable for the teenager who is always alone at home. He needs someone to take care of him and help him to stop using substances. See Figure 6 for a genogram of his child headed family.

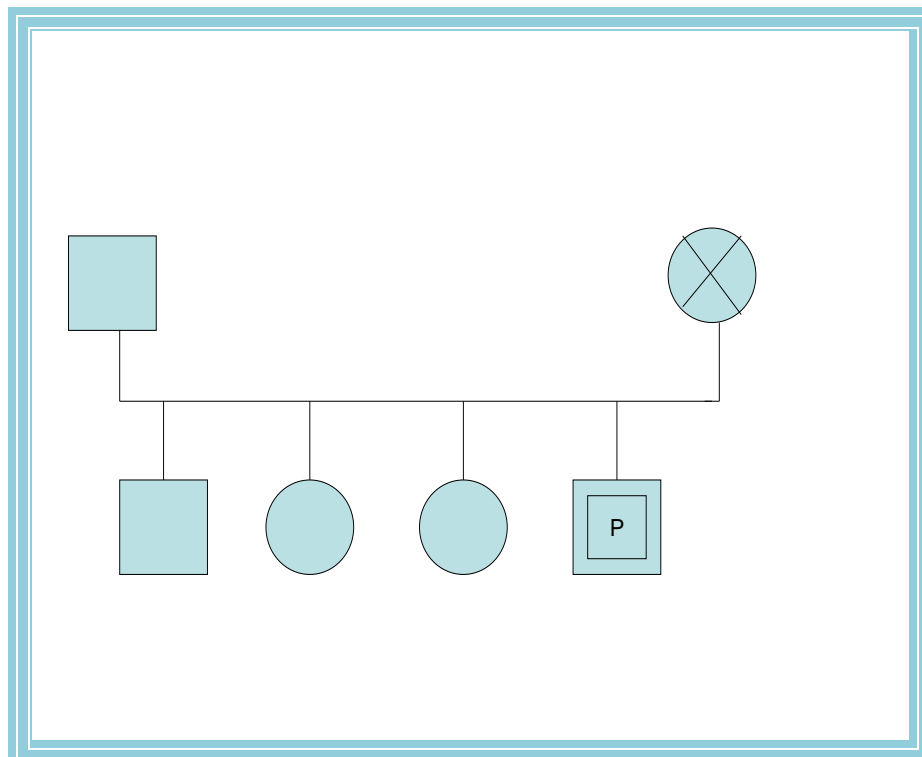


Figure 6: Child headed family

Participant number 7 is 13 years old, completing grade 8 and staying with his father and step mother. His biological mother passed away. He has two brothers, one half brother and two half sisters. His father is a taxi driver and the step mother is unemployed. The substances used are cigarettes and beer. The reasons for his use of substances are attributed to problems he experiences with bleeding and his parents told him to smoke in order to stop bleeding. He has smoked ever since then. After the death of his mother, he mourned for her and could not sleep. Sometimes he would have dreams of his mother. Thus, in order to sleep, he would drink two bottles of beer before sleeping. He also has friends who drink alcohol. They offered him beer during a school trip and he tasted it that day and continued drinking beer after that day. See Figure 7 for a genogram of the step-parent family.

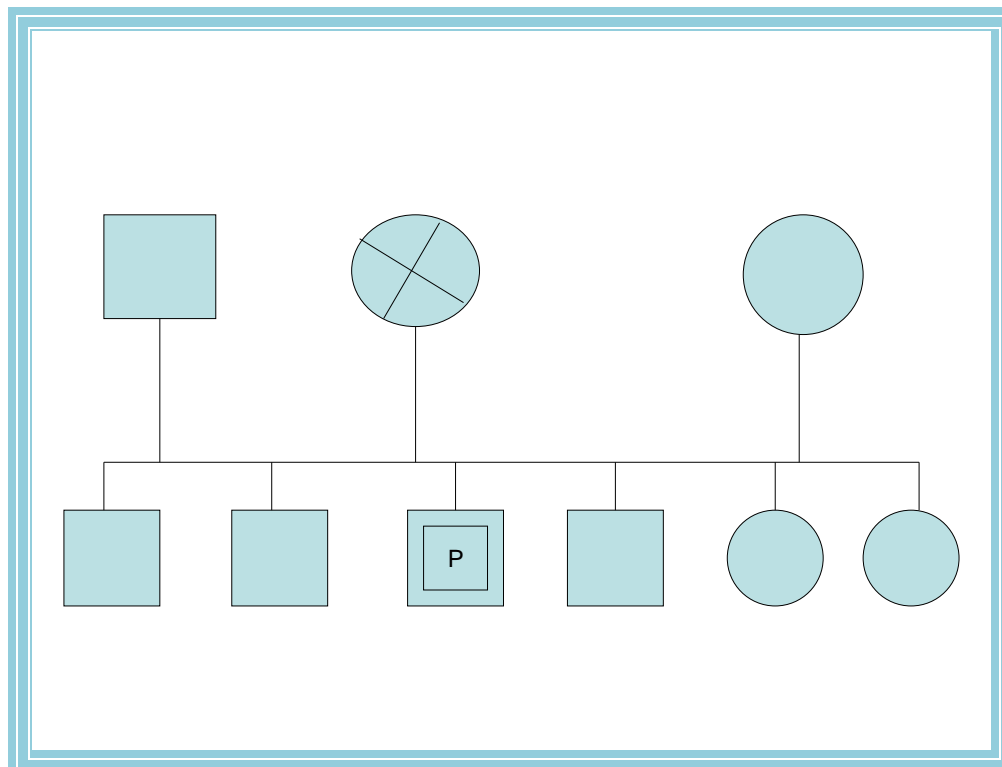


Figure 7: Step-parent family

Participant number 8 is 14 years old completing grade 9. He is raised by his mother. He does not know his father. He has a younger sister. The participant uses the following substances; namely beer, brandy, cigarettes, and cannabis. He gets these substances from friends who buy them in their village. They use these substances at the bush and the mountain. He gets money to maintain his habit by helping people to carry their groceries and cleaning gardens. He uses substances for the following reasons: he encounters problems at home; his mother is unemployed and relies on child support grant for survival, subsequently his basic needs are not met. His friends always help him in that they provide things that he need. He ended up joining his friends in substance use. He saw other people using substances. He is dependent on these substances; using them in the morning, during the day and at night. He knows the effects of using substances yet continues using them. He wants to stop using substances, feels like running away and getting help somewhere. He has an uncle who drinks alcohol and smokes cigarettes. See Figure 8 for a genogram of his single parent family.

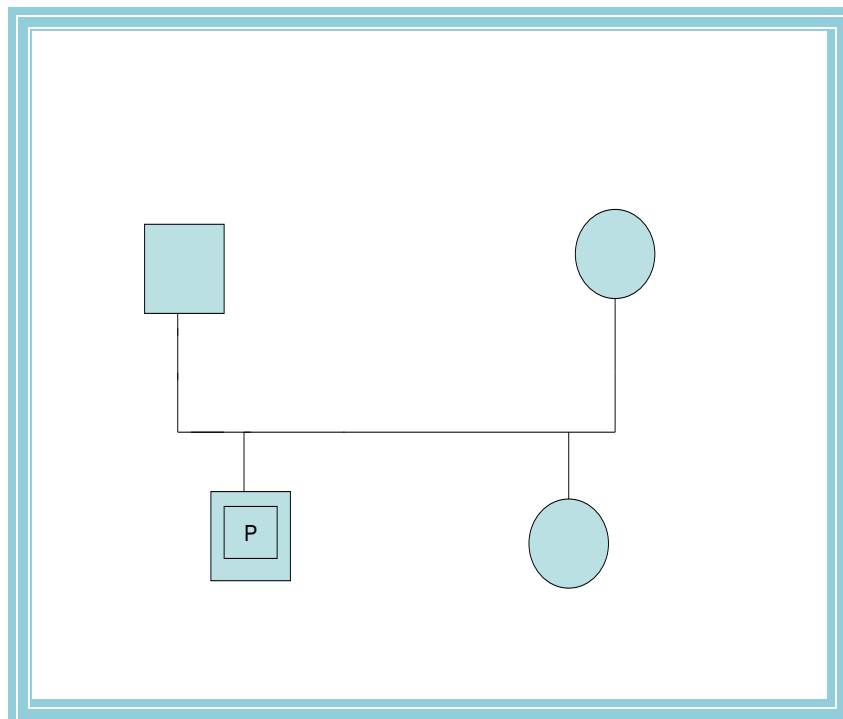


Figure 8: Single parent family

Participant number 9 is 14 years old, in grade 9 from an extended family and lives with his grandmother. The mother is a migrant labourer working in Pretoria. He has an older sister, a brother and a younger sister. The substance he abuses is cannabis. He was introduced to cannabis by a friend who stole part of the substances every time his father sent him to buy for him. He also saw his friend's father smoking cannabis and feeling happy afterwards. He wanted to feel that way. His first substance used was cigarettes. He smokes cigarettes and cannabis with his friends at the bush next to their school. He is dependent on tobacco and smokes these substances in the morning, during school break, during lessons and after school. These substances are sold in their village. He uses his pocket money to buy these substances. He knows the effects of using substances. He also has friends who use substances. His mother has asked him to stop using substances, and has verbalised the need to stop using substances and help other learners who are using to stop. He also has an uncle who drinks African beer. See figure 9 for a genogram of his extended family. See Figure 9 for a genogram of his extended family.

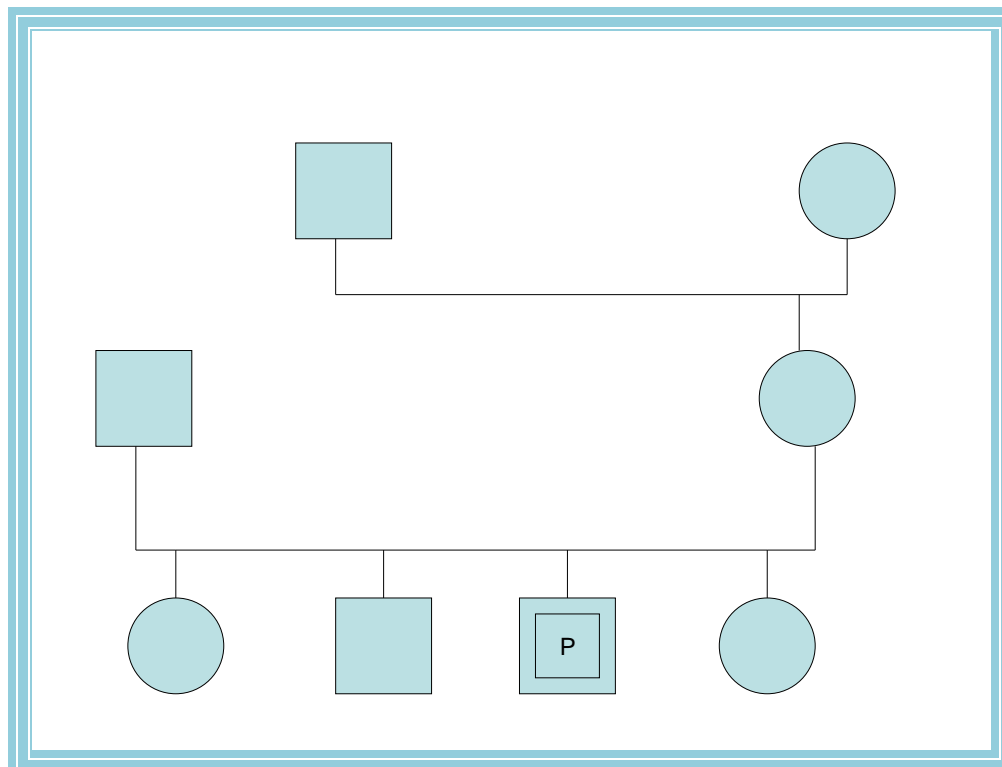


Figure 9: Extended family

Participant number 10 is a 13 years old only child who is raised by a single parent that is unemployed. The family structure is composed of an extended family. Substances used are tobacco and cannabis which he buys from someone in their village. Pocket money is used to buy these substances. He smokes these substances in the bush. His usage depends on the weather. If it is cold or cloudy, he uses them the whole day and on sunny days he uses them once. The reasons for him using substances are that he wanted to feel high, and substances gave him strength and courage to do things. He had trouble sleeping and using substances enabled him to sleep. He did not want to think about anything. His friends influenced him to use substances. He has an uncle who smokes cigarettes and drinks alcohol. The participant knows the effects of taking substances, yet continues to use them. His academic performance has dropped due to substance abuse. He wants to stop using substances and believes that he can only do so once he moves out of the place where they are staying. See Figure 10 for a genogram of his single parent family.

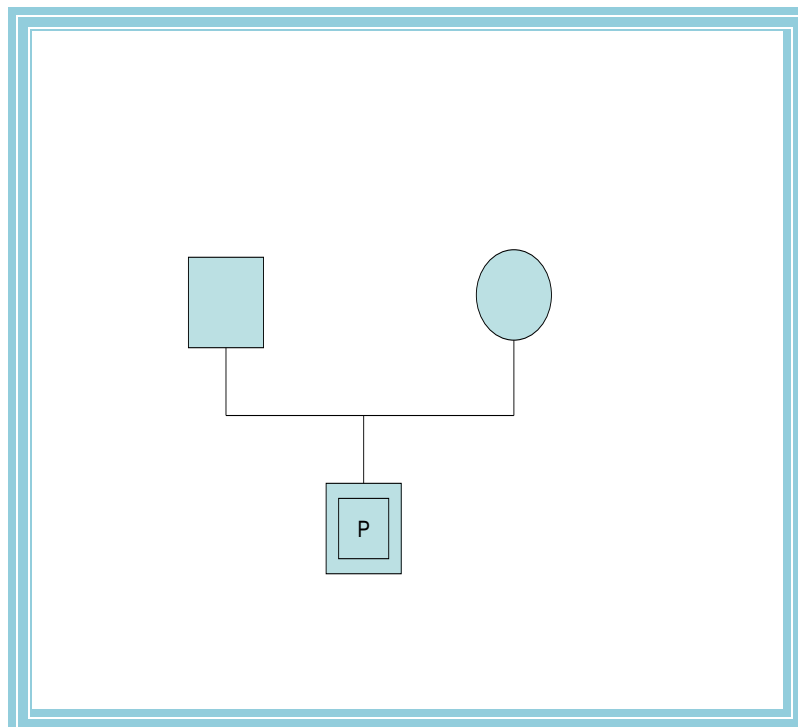


Figure 10: Single parent family

Participant number 11 is 15 years old, in grade 9 and is raised by his mother only. They are a family of three; he is the youngest and has one older brother. He is dependent on cigarettes. He buys cigarettes from the butchery next to their school. He smokes cigarettes in the morning, during break and after school. He also smokes cigarettes at the school toilets during school hours as well as at the butchery next to their school. He asks for money from her mother and buys cigarettes with it. He is not treated well at home; his mother does not talk well to him, she is unable to provide for his needs and told him that she does not love him. He does not know his father. His mother told him about his father after his death. His mother refused to allow him to see his father. His friends smoke cigarettes, so he was worried that he would be the only one who is not smoking. The participant also feared rejection from friends. His friends told him to smoke in order to forget about his problems. He knows the effects of using substances yet he continues to smoke cigarettes. He has tried to stop smoking cigarettes but it is difficult for him and he would like somebody to help him to stop smoking. No one else in his family uses substances. See Figure 11 for a genogram of his single parent family.

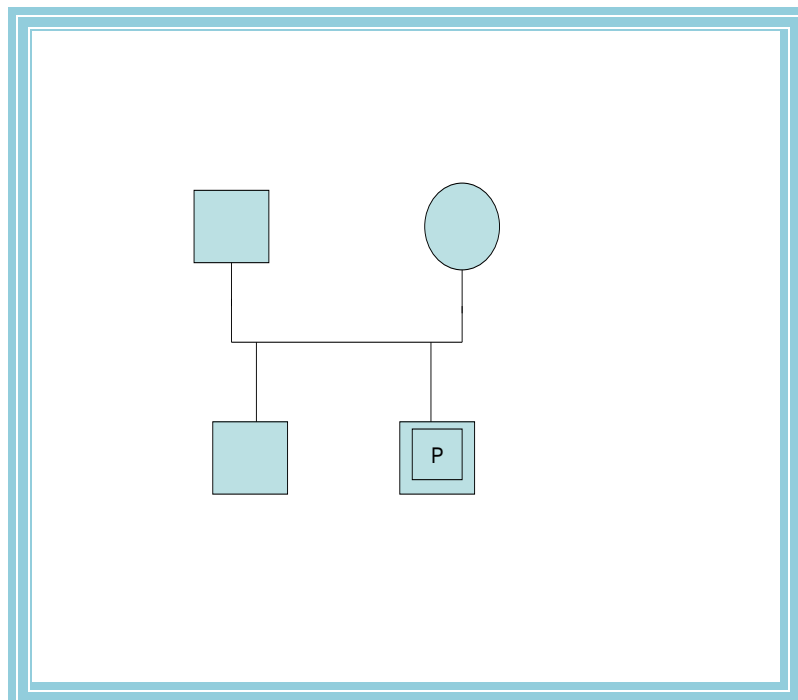


Figure 11: Single parent family

Participant number 12 is 15 years old, in grade 7 and from an extended family. He is raised by a single parent and his grandparents. His mother is employed as a domestic servant in the neighbouring location. He has a younger brother. The mother relies on her meagre income and child support grant for survival. She separated from their father who is not taking care of the children. The teenager smokes cigarettes and drinks beer. He is stressed by the fact that his father is employed but denies the fact and does not take care for them. Their mother has been battling to get financial assistance from their father who is not willing to provide for his children's needs. Her mother is not willing to provide for his needs and that frustrates him. He needs help in ensuring that his father provides for their needs. The situation at home is unbearable and as a result he is now using substances to cope. He is also a member of a traditional dance group. They are normally hired to dance at shopping complexes and then he uses the money earned to buy food, cigarettes and alcohol. He buys these substances at the tavern. He indicates that he had a desire for alcohol and also saw friends and other people drinking alcohol. Drinking alcohol relieves him of stress. See Figure 12 for a genogram of his extended family.

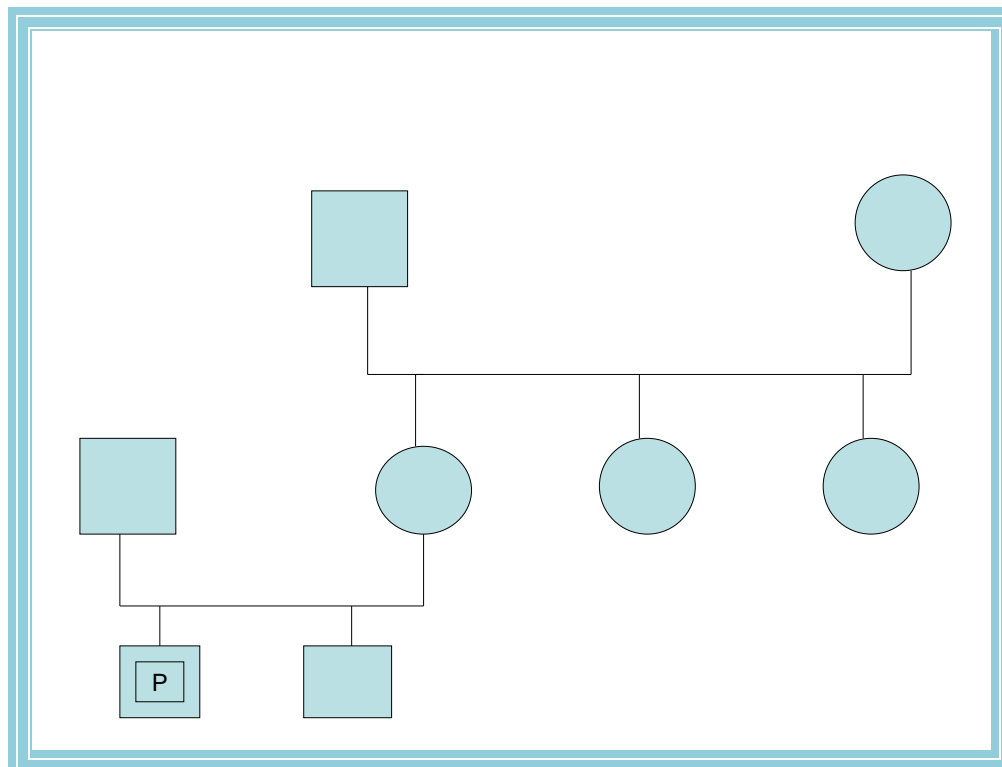


Figure 12: Extended family

THEMATIC DATA ANALYSIS

The next section provides a description of how the data was analysed thematically. The purpose of the analysis was to identify commonalities and differences in male adolescents's conversations about substance abuse. The work of Aronson (1994), Attride-Stirling (2001) and Braun and Clarke (2003) served as a guideline for analysing the data. Firstly, codes were developed. These codes were based on the main questions of the study. This was undertaken in order to keep focus of the study. After identifying codes, all the issues discussed under those codes were identified and put together under the column of issues discussed. The issues discussed were then supported with themes that were identified based on the interview transcripts of all the participants. The identified themes were arranged into coherent groupings (See Table 1).

Table 1: From codes to themes

Codes	Issues discussed	Themes identified
Substance of abuse	Legal and illegal substances	African beer, alcohol, Black Label, brandy, Castle Lager, cigarettes, Fountry, Redds, Boxer, cannabis, glue, cocaine, pills and heroin.
Learning	Friends Family members Adults	‘I saw friends using drugs’; ‘my friends lit a cigarette and smoked it, I also smoked the cigarette and continued ever since that time’. ‘My friends smoke cigarette and drink Castle beer’. ‘I spent time with my friends and joined them in using drugs’. ‘My uncle uses Peter Stuyvesant and Castle Lager’; ‘My uncle smokes Boxer cigarettes’; ‘My two uncles drink beer and smokes cigarettes’. ‘My uncle drinks African beer’. ‘My friends’ father uses dagga’.
Pleasure	Enjoyment	‘I used drugs for fun; I wanted to entertain myself’; ‘I saw my friend’s father laughing after using drugs. I wanted to feel that way’, ‘So I wanted to be happy’; ‘I used drugs because I wanted to feel Iry’; ‘I used drugs in order to feel high’. (Iry is used to describe a feeling of wellbeing associated with the use of substances).
Order and laws	Lack of control Lack of monitoring	‘I am staying alone’; ‘I am staying with my grand parents, my mother is employed in Pretoria and she is not staying with us’; ‘My parents do not reprimand me for coming late’; ‘I do drugs during absence of my parents at home’; ‘I drink alcohol at the tavern’; ‘When I come back drunk, my parents do not see me because I sleep in an

		outside room'; 'We smoke dagga at the bush where no one sees us'. 'We buy cigarettes and beer at the shop and the butchery'; 'We buy cigarette at the school tuck shop'.
Psychopathology	Conduct disorder, Depression, Anxiety, Frustration, Irritation Delinquency	'After using drugs, we fight other people'; 'I am stressed'; 'I always worry about my situation'; 'I feel like running away'; 'I sometimes feel like killing someone'; 'There is no one to help me with my problems'; 'I need someone to help me with my problems'; 'Every time I need things, they do not provide, and that frustrates me a lot'; 'I steal change every time they sent me to buy things at the shop'; 'We stole things at the shop next to our location and we were arrested'.
Source of supply	Local External	'There is someone selling Nyaope in our village'; 'We buy drugs from people in our village'; 'I drink alcohol at the tavern'; 'I bought cigarette from the tuck shop'; 'We bought beer and cigarette at the butchery'; 'My cousin staying in Gauteng bought nyaope for me'; 'When I was staying in Gauteng I used cocaine'.
Maintaining/ sustaining habit	Parents Friends Payment Criminal activity	'I use pocket money to buy drugs'; 'I ask my parents to give me money'; 'Myself and my friends, we each contribute R2.00 and buy dagga'. 'I have a part-time job; by cleaning gardens and use money earned to, buy drugs'; 'I help people by carrying their groceries and use the money they give to me, to buy drugs'. 'I play dice, and use the money that I win to buy drugs'; 'I steal change every time they send me to buy something and use that money to buy drugs'.
Effects	Health	Ill health, lose weight, affect mind, sight, unable to

	Social Economic	concentrate, hangovers, addiction. Lack respect, violence, accidents. Unable to study, absent from school, performance drops, failure, repeat grade, drop out of school.
Progression	Legal and illegal substances	Alcohol, tobacco, cannabis, cocaine, glue.
Multiple substance use	Nature/types	Tobacco, alcohol, cannabis, cocaine, nyaope.
Conformity	Friends, adults	Saw others using them. Spent time with friends.
Socio-economic status	Poor/low	Unemployed parents. No source of income. Do not get things I need.
Setting/place of use	Home, school toilets, shop, tavern, bush	Used substances at home, school toilets, bush, tavern.
Family structure	Nuclear Extended Step family Child headed	Mother, father and children. Grandmother, grandfather, aunt, uncle. Grandmother, grandfather, mother, aunt, and my younger sister. Step mother, stepfather. Staying alone.
Frequency of substance use	Often, dependent	'Use drugs more than once, thrice, early hours of the morning'; 'morning, during the day, at night, mid night, during break, after school, on weekends'.
Relationships	Strained relations	'My mother does not talk to me'. 'Not talking well with my mother'.

		'I am only able to talk to my grandmother'.
Biology	Courage Strength Insomnia	'Drugs helped me to do things'. 'Drugs give me courage to do things'. 'I could not sleep, drugs helped me to sleep'.
Treatment	Bad treatment	'My mother does not love me'. 'I am not treated well at home'. 'My step father ill treats me'. 'I sometimes sleep without eating'. 'I sometimes go to school on an empty stomach'. 'My mother chases me away without any reason'.
Experiment	Taste	'I wanted to taste the drugs'.
Stopping habit	Desire Lack of control Positive talk	'I want to stop using drugs, but I am unable to do so'. 'I have tried to stop but cannot, I need someone to help me stop using drugs'. 'I want to stop using drugs and be the father of the future'. 'I want to tell other learners to stop using drugs because they are not good'. 'I can stop using drugs, if I can stop going out with friends using drugs'. 'I can stop using drugs, if I relocate from this area'.

To juxtapose the findings into a meaningful whole, a table of themes and supporting data from all 12 respondents was created (see Table 2). This process revealed the global themes, organising themes and basic themes. There is one global theme, five organising themes and fifty-five basic themes. The global theme is substance abuse. The organising themes are substances abused and setting, reasons for substance abuse, maintaining habit, stopping substance abuse and the effects of substance abuse. The global themes, organising themes and basic themes are discussed later in the next section.

Table 2: From basic themes to organising and global themes

Basic themes	Organising themes	Global themes
Alcohol, tobacco, cannabis, heroin, glue, cocaine home, school toilets, bush, tavern	Substances abused and Setting	Substance abuse
Fun, entertainment, feels high, unfulfilled needs, friends, uncle, sold in our village, tavern, shop, butchery.	Reasons for drug use Experimentation Family factors Peer group pressure Role models Depression Availability Media	Substance abuse
Pocket money, friends, part time jobs, gambling, stealing	Maintaining habit	Substance abuse
Unable to concentrate, ill health, flue, damage lungs, affect mind, bronchitis, sight, headache, hangover, addiction, lose weight, death. Lack of respect, violence, rape, accidents Sleep in class, difficulty studying, absent from school, performance drops, failure, repeat grade, drop out of school	Effects of substance abuse Health Social Academic	Substance abuse
Difficult, need help	Stopping habit Seeking solutions	Substance abuse

After the original set of themes were selected and used as basic themes, clusters of basic themes were created to identify organising themes. The main claim or assumptions about the organising themes were summarised. In Figures 1 to 7 I illustrate the non-hierarchical, web-like representations of the data in thematic networks.

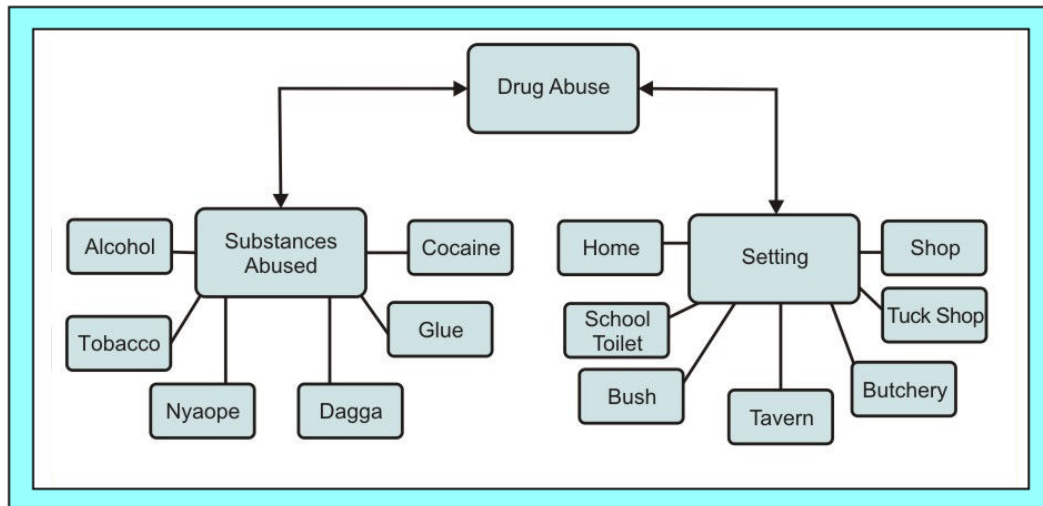


Figure 1: Substances abused and setting

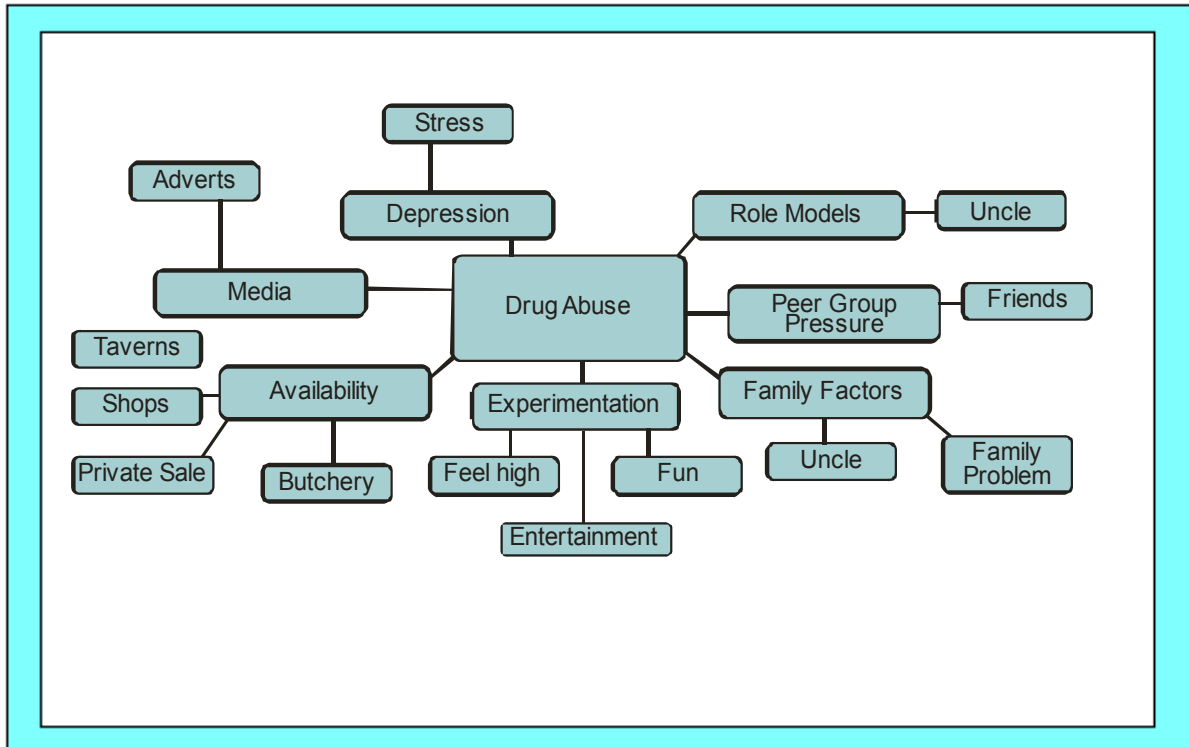


Figure 2: Reasons for substance use

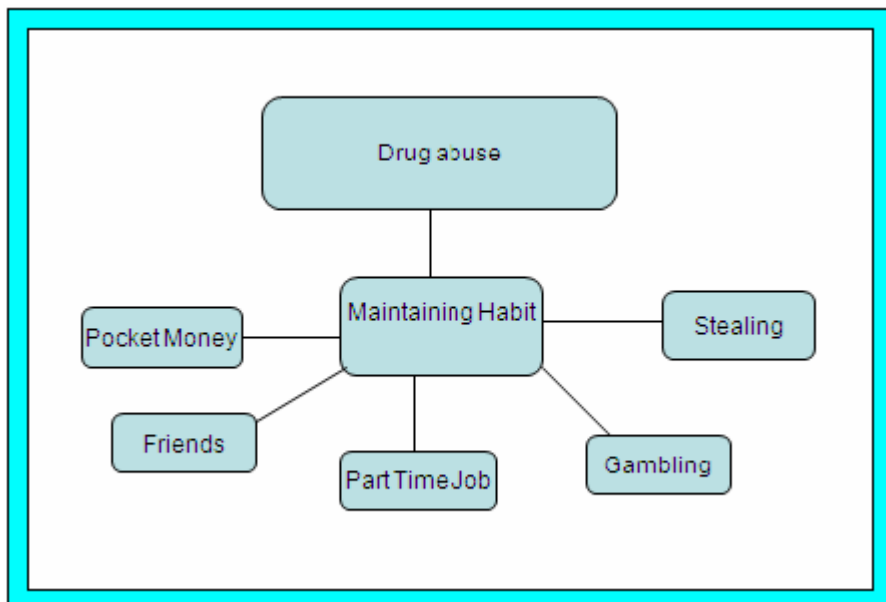


Figure 3: Maintaining substance abuse habit

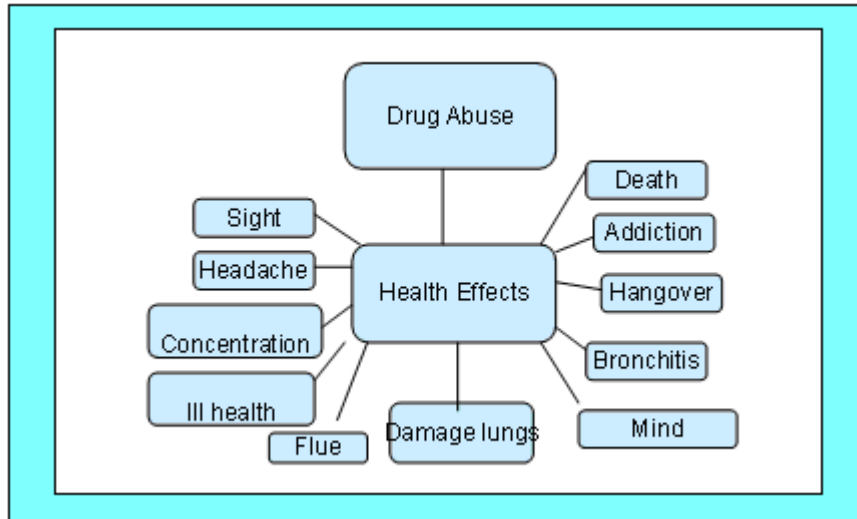


Figure 4: Health effects for using substances

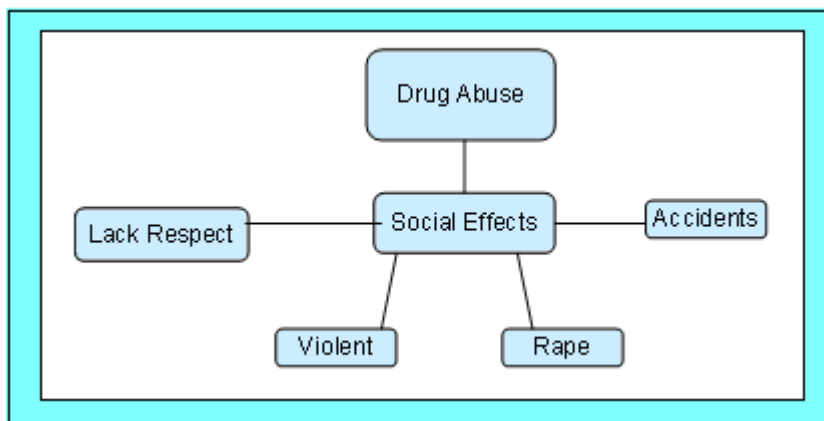


Figure 5: Social effects of substance abuse

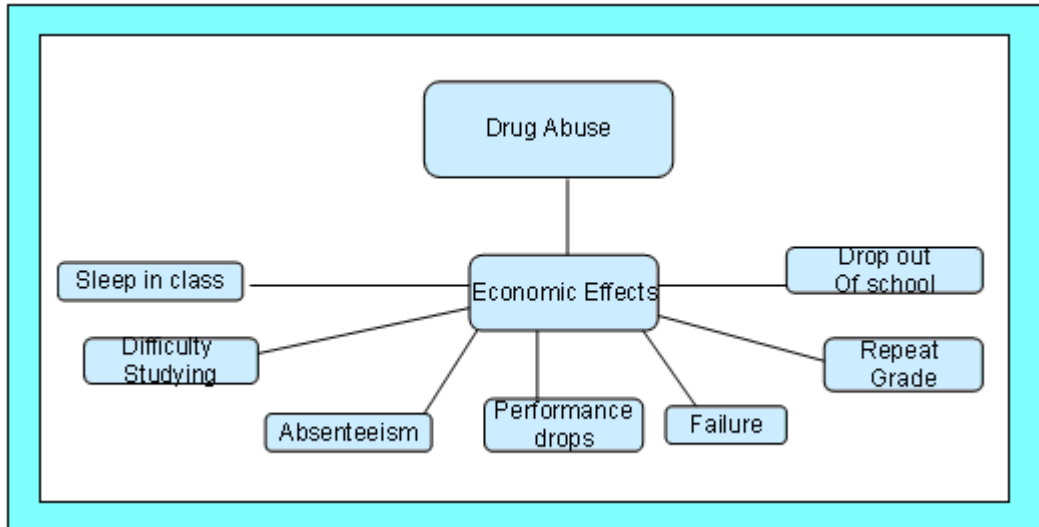


Figure 6: Economic effects of substance abuse

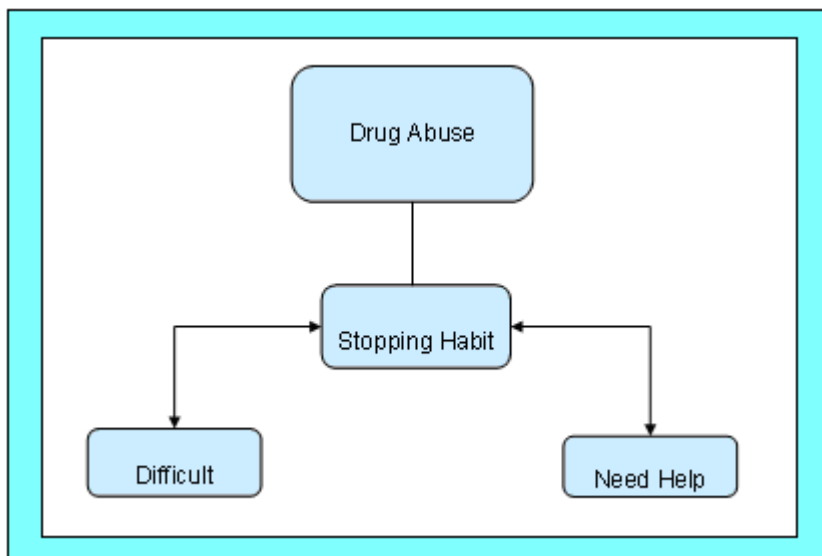


Figure 7: Stopping substance abuse habit

The global theme produced a thematic network. Furthermore, I went through the text segments related to each basic theme in order to ensure that the global themes, organising themes, and basic themes reflect the data and the data subsequently supported them (Attride-Stirling, 2001).

RESULTS

This section outlines the findings of this study. The research findings are presented as follows: First, the basic themes and organising themes are presented and secondly, the themes are supported by extracts from the participants' responses. The following themes are discussed in this section: age and grade of substance use, reasons for substance use, maintaining the substance abuse habit, stopping the substance abuse habit and the effects of substance abuse.

Age and grade for substance use

The age for first time use of substances in this study was between 12 and 15 years among the male participants. Furthermore, participants in this study started abusing substances in grade 7 to 9. One participant reported that he started using substances in grade 4.

Substance of abuse and setting

All the participants reported that they are using substances. The nature of substances abused includes both legal and illegal substances. The legal substances abused by the adolescents in this study are beer, ciders and tobacco. Illegal substances abused include cannabis, cocaine and heroin. Some participants also reported poly-substance use. Thus, common themes were identified among more than one participant in some instances, for example, 'I drink alcohol and smoke cigarettes' (Participant 7, 8, 11, 12); 'I smoke cigarette and dagga' (Participant 1, 2, 3, 5, 10); 'I drink brandy and black label beer' (Participant 8); 'I smoke cigarette and drink Black Label' (Participant 6); 'I use dagga and pills'; 'I smoke cigarette, dagga, glue and cocaine' (Participant 5); 'I drink fountry, Amstel and Black Label' (Participant 4); 'I smoke PeterStuyvesant and drink Amstel' (Participant 3).

In addition, participants reported that they use substances at the following places: 'I used drugs at home' (Participant 5); 'I smoke cigarette at the school toilets' (Participant 11); 'We bought beer from the butchery and drank it outside the butchery' (Participant 5). 'I drink alcohol at the tavern' (Participant 1, 3, 4, 12); 'We smoked dagga at the bush' (Participant 2, 8, 11).

Reasons for substance use

Participants mentioned various reasons for their use of substances. Their reasons include the following: experimentation, biological, depression, peer group pressure, availability and family

structure.

Experimentation

Participants do experiment with substances during adolescent stage. They used substances in order to taste them, and to feel high. The participants reported that: 'I had a desire for alcohol' (Participant 12). 'I wanted to taste it', 'I saw my friend's father laughing after smoking dagga, so I wanted to feel happy'; 'I wanted to feel Iry' (Participant 11) and 'I wanted to enjoy myself' (Participant 3). One participant reported that: 'My cousin introduced me to drugs during school holidays while visiting Gauteng' (Participant 1). In addition, one participant reported that: 'I started on my own, I thought it was normal or right to use it' (Participant 5).

Depression

Most of the participants reported stress as the cause for their use of substances. One of the participants reported that: 'I feel stressed' (Participant 12); 'I worry a lot, that stresses me a lot'. 'I am unable to sleep' (Participant 10). Furthermore, most of the participants mentioned the function of using substances as relieving stress. Other components of depression described by the adolescents included irritability, unrelenting anger and powerlessness. As they explained: 'I feel like running away' (Participant 8) and 'I sometimes feel like killing someone' (Participant 4). Most of the participants indicated that they had problems at home. As participants reported: 'I had problems at home' (Participant, 4, 8, 11, 12); 'My uncle ill-treated me, I also saw him beating his wife with an axe, was arrested, released and later died' (Participant 3); 'I need someone to help me' (Participant 6, 8) and 'I want to be assisted so that I can be like other children' (Participant 4). This will be further discussed in the next chapter.

Biological reasons

One participant indicated that he used substances because it helped him with his sleeping problem; others reported that substances helped them to accomplish things that they wanted to do: This is how participants related their stories: 'drugs helped me to do things'; 'If I was lazy, and want to do something, drugs give me courage or strength to do things (Participant 10)'; 'I had a problem of bleeding and at home, they told me to smoke cigarette in order to stop my bleeding problem'; 'I smoked cigarette and it stopped my bleeding problem' (Participant 7); 'I worried a lot about my mother who passed away in the year 2000'. I drank alcohol before I sleep because I

dreamt about my dead mother' (Participant 7). 'If you want to sleep and cannot sleep, and you do not want to think about anything, then drugs can help you'. I could not sleep so drinking beer before sleeping enabled me to sleep' (Participant 10). 'I thought using drugs will make me cleverer' (Participant 5).

Peer group pressure

In adolescents' talk about substances, the influence of friends was articulated as a key factor. The frequency of the talk about the influence of friends was perhaps to be expected, given that peer group is frequently perceived as the major reason or cause of substance abuse among adolescents. In the following extracts, participants explained how their friends influenced them to use substances: 'I used drugs because of my friends'; 'my friends introduced me to drugs, they asked me to contribute money so that we can buy two Amstel Lagers' (Participant 3); 'my friends told me to smoke, at first I refused but later on I joined them' (Participant 10); 'it was because of my friends'. 'I smoked cigarette and drink alcohol with my friends' (Participant 7); 'my friends told me to smoke and drink alcohol' (Participant 4); 'my friends told me to smoke dagga' (Participant 2) and 'my friends told me to use drugs in order to forget my problems' (Participant 6, 11). 'I was lonely and my friends told me to use drugs to relieve stress' (Participant 6); my friends told me not to be stressed because I will die of heart attack' (Participant 12). 'I was worried that I will be the only one not smoking' (Participant 11).

'I relied on my friends for care and support, thus I had no choice but to join them in using drugs' (Participant 6, 8); 'I started drinking alcohol during a school trip with my friends' (Participant 7). Another participant reported that: 'my friends father used to send his son to buy dagga for him. We stole part of it. We saw his father laughing after smoking dagga, so we wanted to feel that way. We felt happy after smoking it' (Participant 9).

Availability

Substances are easily available in the participants' communities. When participants were asked about where they bought these substances, they indicated that they bought them in their locations or villages. Majority of the participants mentioned that they were able to buy substances in their local shops, taverns, and butchery (Participant 1, 2, 4, 5, 6). 'I bought alcohol and cigarette at the shop' (Participant 7). 'I bought alcohol at the tavern' (Participant 4, 12); 'I bought them from the

butchery' (Participant 11); 'I buy cigarette from our tuck shop' (Participant 11); 'I bought them from someone in our village' (Participant 1, 2, 5, 10) ; and 'We bought drugs from the son of the chief' (Participant 8). Drugs are within easy reach of the participants and as such they afford to buy them.

Family factors

Family structure: The family structures of the participants are different. Some participants are from nuclear families, single parent families, extended families, step parent families and child headed families. As participants explained: 'I am staying with my mother, father and siblings' (Participant 1, 3); 'I am staying with my grandmother' (Participant 5); 'I am staying with my grandmother, grandfather, my mother, aunt and my younger sister' (Participant 12); 'I am staying with my grandmother, my mother, stepfather and siblings' (Participant 2); 'I am staying with my mother, my step father and younger brother' (Participant 2, 3); 'I am staying with my father, step mother, my two brothers, one half brother and two half sisters' (Participant 7); 'I am staying with my mother and my brother' (Participant 11); and 'I am staying alone' (Participant 6).

Communication: Some participants reported closed communication channels between themselves and their parents. These varied from being afraid of talking to their parents to not being able to communicate to their parents. As participants explained: 'I am not able to talk to my mother' (Participant 4); 'I am not able to talk my mother, we never sit down and talk, she does not talk well with me (Participant 11); 'My mother does not want me to talk to my father, she refuses, that makes me not to talk well with my mother' (Participant 8); 'I can only express my feelings to my grandmother who is not staying with us' (Participant 2, 4); and 'I am afraid to tell my mother my problems, she is too strict' (Participant 4). There are no open lines of communication between parents and their children.

Parenting style: Some participants reported permissive and authoritarian parenting styles in their families, the following was expressed by the participants: 'my mother is too strict, she is ok but at the same time strict' (Participant 4); 'my step-father does not allow me to play he always wants me to work at home' (Participant 3); and 'my mother does allow me to go to the taverns she only tells me not to come back late' (Participant 3). Participants also reported that they were illtreated

at home, for example, ‘my uncle ill-treated and bit me a lot’ (Participant 3); and ‘my mother ill-treats me, keeps on telling that she does not love me and chases me away without any reason’ (Participant 11). In addition, one participant reported that he was reprimanded for coming home late (Participant 2).

Heredity: There is evidence of substance use in the families of the participants. This was reported by some participants that there is someone using substances in their families: ‘my uncle smoke cigarette’ (Participant 2, 3); ‘My uncle requested me to lit cigarette for him’ (Participant 3); ‘my uncle smokes boxer cigarette’ (Participant 4); ‘my uncle smokes cigarette and drinks alcohol’ (Participant 4, 8, 10); ‘My uncle drinks alcohol’ (Participant 1, 7, 8); and ‘My uncle drinks african beer’ (Participant 5, 9). There is also evidence of no use of substances in the families of some participants, for example: ‘No one is using drugs in my family’ (Participant 11); ‘I am the only one using drugs’ (Participant 4).

Socio-economic status: The majority of participants in this study are from lower socio-economic status. They either have one parent employed or all the parents are not employed. Participants reported that: ‘only my father is employed’ (Participant 1, 2, 7); ‘my mother is not employed’ (Participant 11); ‘my mother is not employed and I do not get things that I need, we rely on the social grant of my younger sister’ (Participant 8); and ‘my mother is not employed, only my stepfather is employed’ (Participant 4). Furthermore, one participant is from a child headed family. He indicated that: ‘my father left me and told me that I am a man’; ‘I rely on my friends for help and support’ (Participant 6). Only one participant is from a middle class family. The participant reported that: ‘my father is employed as a Police Inspector’ (Participant 5). The socio-economic status of the participants was also identified as a risk factor for substance use. Thus, the reasons for substance use as reported by the participants include individual, family and social factors.

Maintaining the substance abuse habit

The means of obtaining substances varied amongst the participants. Other participants obtained money from home, whereas others used their pocket money or earned a salary that could support their substance use. In some instances their friends bought substances for them, for example, as participants explained: ‘I used pocket money’ (Participant 1, 9, 10); ‘We contributed money with

my friends' (Participant 3); 'We contributed R2.00 each to buy dagga' (Participant 2); 'If I do not have money to buy drugs, my friends bought them' (Participant 11); 'I have friends who are employed, they buy alcohol for me' (Participant 4); During holidays, friends from Gauteng brought some drug in the form of a pill for us' (Participant 9); 'I do part-time jobs and use money earned to buy drugs' (Participant 1); 'I help people to carry their groceries and use money earned to buy drugs' (Participant 8); 'We do traditional dance, and I use money earned to buy alcohol' (Participant 12); 'I requested money from my mother' (Participant 11); and 'I gamble by playing dice' (Participant 5) . Thus participants use various means to ensure that they have substances.

Stopping substance abuse

All the participants emphasised that they want to stop using substances and as such need assistance. As participants respond to this question: Would you like to stop using drugs? Responses of participants: 'I want to stop using drugs' (Participant 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12). 'I need someone to guide me' (Participant 6); 'I need help and will appreciate it if I can be helped' (Participant 10); 'I have tried to stop using drugs but I am unable to stop' (Participant 11); 'I am addicted to alcohol' (Participant 3); 'I need someone to help me stop using drugs' (Participant 1, 4, 6); 'I can stop using drugs if I can stop going out with friends using drugs and live on my own' (Participant 8); and 'I can stop using drugs if I can stop going out with friends using drugs and relocate from this place' (Participant 10). 'I want to stop using drugs and be father of the future, I am considering my future, and I also want to encourage others that it is not good to use drugs, and that they must stop using drugs' (Participant 5); 'I want to stop using drugs and need someone to take care of me' (Participant 6); and 'I want to stop using drugs and be like other children' (Participant 4). The participants in this study are aware that substances are not good for them. They regret their use of substances, and as such would like to stop using substances. They have also indicated their need to get help in order to stop using substances. However, some participant reported that they had stopped using substances: 'I have stopped using drugs' (Participant 5); 'I had stopped using drugs after realising that drugs are not good' (Participant 2); and 'I stopped using drugs after my mother requested me to do so' (Participant 9).

Effects of substance abuse

All the participants in this study are aware of the effects of abusing substances. They mentioned the following health, social and economic effects of substance abuse:

Health Effects: One participant reported that people become slaves to substances (Participant 10). Most of the participants indicated that substances affect their lungs (Participant 5, 6, 10, 11), heart, eye sight, movement, as well as the mind (Participant 5). Furthermore, other participants noted that: ‘drugs abuse cause heart disease’ (Participant 6)’; and ‘eyes become red’; ‘I am not able to see properly’ (Participant 1). One participant reported that: ‘drug abuse cause muscle disease’ (Participant 6); ‘drug use affect the brain and can make one to be mad’ (Participant 8); and ‘drugs destroy lives’ (Participant 7). Furthermore, one participant reported that: ‘I know someone who died because of drugs’ (Participant 9).

Dependence: Most of the participants reported that they were dependent on substances. Participants described their continuous use of substances as follows: ‘I use drugs twice or even thrice in a day’; ‘I use drugs in the morning, during the day and at night’ (Participant 1, 2, 5, 6, 8); and ‘I use drugs on my way to school, during break, during the lessons, and after school’(Participant 9, 11). However, other participants reported that they used substances during the weekend only: ‘I use drugs during weekends; on Fridays, Saturdays and Sunday’ (Participant 1, 2, 4, 12); and ‘I am addicted to alcohol and drink it during weekends’(Participant 3). Thus, most of the participants in this study are addicted to drugs.

Social effects: All the participants were aware that their use of substances also affects other people, for example, they mentioned that substances: ‘make people not to respect others and may do anything wrong’ (Participant 1, 8); ‘make people tease you’ (Participant 7); ‘make people aggressive; ‘make people violent’; ‘I fight with other people after using drugs’ (Participant 3, 4); ‘make people to rape’ (Participant 4); ‘drugs make people to think of raping’ (Participant 7); and ‘people using drugs end up in jail’ (Participant 8). One participant indicated that: ‘after using drugs, he feels like killing someone’ (Participant 4). In addition, other participants reported that: ‘drugs make me not to respect the educators and other learners’ (Participant 1); and ‘drugs make people do bad things’ (Participant 11). Another participant reported that: ‘I was forced to keep friends using drugs, otherwise, I would not get things that I need’; ‘I ended up supporting friends doing funny things because they were not going to buy me food, if I had not supported them’ (Participant 6). ‘Drugs make people think of stealing’ (Participant 7); ‘We used drugs, went to steal computers at a shop not far from or village and we were arrested and sentenced for two years’ (Participant 2).

Economic effects: Majority of the participants indicated that substances affect their academic performance and that one may end up dropping from school. Furthermore, the participants mentioned that substances affect their studies, as participants explained: ‘Drugs affect me at school, I am not able to do homework’ (Participant 11); ‘I am not able to concentrate in the classroom’ (Participant 4, 9); ‘I am not performing well in my studies’ (Participant 9, 10); ‘I pass some subjects and fail other subjects’ (Participant 11); ‘Academic performance become poor, I did not pass well’ (Participant 1, 9, 10); ‘I was absent from school’; ‘I did not get a chance to study’; ‘Performance drops, low marks and one ends up failing’ (Participant 2, 9); and ‘I am repeating the grade’ (Participant 1, 2, 3, 4). The use of substances had a negative impact on the academic performance of these participants. However, one participant reported that his use of substances enabled him to make plans: ‘I was able to make chairs and tables’ (Participant 2). Thus, the use of drugs had health, social and economic effects on the adolescent drug user.

CHAPTER SUMMARY

In this chapter, the data analysis was presented. The profile of participants in this study was presented as well as the steps that were followed in analysing data were discussed and the identification of basic themes, organising themes and global themes were explained. The basic themes, organising themes and global themes were presented in tables and in web like structures. Genograms were used to display the family structure of the participants. Furthermore, the findings of the study were discussed and supported with the extracts that were derived from the interview transcripts. The results of this study will be further discussed further in the next chapter.

CHAPTER 5

DISCUSSION

INTRODUCTION

The previous chapter outlined the results of this study. In this chapter, the findings of the study will be discussed in relation to the literature review. Furthermore, the following aspects are discussed: age and grade for use of substances, nature of substances abused by male adolescents, mode of substance use, progression in the use of substances, setting for substance use, maintaining the substance abuse habit, reasons for substance abuse, developmental stage of adolescence, depression, family structure, parenting style, educational level of parents, availability of substances, learned behaviour, media, the school environment, effects of substance abuse; social effects, health effects, and economic effects.

AGE AND GRADE FOR USE OF SUBSTANCES

This study supported the notion that adolescence is the developmental stage during which adolescents start abusing substances. That is, male adolescents who are between 12 and 15 years of age abuse substances. This was also confirmed by previous studies that the mean age for the onset of substance abuse is 12 (Karen Lesly, 2008; Parrot et al. 2004). In addition, this study found that two adolescents began using substances at an even earlier age of 11 while still in grade 6. The participants exposed their developing body to substances at an earlier age than normally expected.

NATURE OF SUBSTANCES ABUSED BY MALE ADOLESCENTS

As in the studies of Craig and Baucum (2001), De Miranda (1987), and Parry (1998), male adolescents in this study abuse both legal and illegal substances. Substances abused by participants include, alcohol, tobacco, cannabis, cocaine, glue and heroin. These substances, except for glue and heroin, have been reported by previous studies as common primary substances of abuse among young people (Plüdderman et al., 2007). Glue and heroin are most commonly used in other provinces and not in the Zeerust district of North West. These are new substances that are being abused by male adolescents in the district.

MODES OF SUBSTANCE USE

The modes of using substances include swallowing, drinking, sniffing, smoking and inhaling. The majority of the participants reported that they drink alcohol, smoke cigarettes and cannabis. Only one participant reported that he inhaled the smoke coming from a pill of heroin that was put under a burning bottle. These modes of using substances were also mentioned in previous studies (Plüdderman et al., 2007). However, that of burning a bottle and putting a pill of nyaope was a new mode of use in this study.

Furthermore, the participants are poly-substance users, in other words they use more than one substance, for example, some male adolescents use alcohol in combination with tobacco, as well as other combinations such as alcohol and cannabis (Parry, 1998). Furthermore, one participant indicated that he uses alcohol, cigarettes, cannabis and heroin. The findings also revealed the use of cigarettes, cannabis, glue and cocaine.

Furthermore, this study supported previous investigations that the nature of substances abused by adolescents vary from one area to another (Parry, 1998; Plüddermann et al., 2007). This study revealed that the most abused substances in the rural areas of Zeerust are cigarettes, alcohol and cannabis. Even though heroin is often reported to be prevalent in the Gauteng province, (Institute for Security Studies, 2008; Times Live, 2009), this study has revealed that it is also available in Zeerust district, North West province of South Africa.

PROGRESSION IN THE USE OF SUBSTANCES

There is evidence of progression in the use of legal and illegal substances. Participants reported having used alcohol and then cannabis. However, unlike in other studies wherein adolescents often began using mostly acceptable such as tobacco and alcohol, and then proceeded to using cannabis, that was not always the case in this study. While previous studies indicated that adolescents begin experimenting with the casual use of less serious substances often referred to as gateway substances and then progressing to illegal substances (Berk, 2007; Donald et al., 2007; Pressly & McCormick, 2007), some participants in the current study began with hard substances such as cannabis and heroin and then used more socially acceptable substances like alcohol and tobacco. Participants in this study begin with both 'hard' and socially acceptable substances.

SETTING FOR SUBSTANCE USE

The setting for substance abuse in this study varied from home, school toilets, shops, butchery, tavern, bush and the mountain. This study revealed that substances are also sold at the butchery in rural areas. This then raises the question of lack of monitoring to ensure that entrepreneurs only sell goods that are stipulated in their business licenses. Furthermore, this study indicated that learners buy cigarettes at the tuck shop next to their school. This also raises serious concerns about a lack of monitoring products that are sold to learners during breaks at the tuck shops next to the schools.

The use of substances in school toilets also raises concerns of monitoring and control in schools. That also endangers safety in schools for both the educators and the learners. Furthermore, it is a threat for the good intentions of our government to promote safety in schools (South African Schools Act no. 84 of 1996). The findings revealed that adolescents in rural areas have a lot of hiding places where they can use substances. This includes the bush and the mountains, where no one can see them. Thus, it will take time to notice that adolescents abuse substances because they do substances in private places such as mountains and the bush.

MAINTAINING SUBSTANCE ABUSE HABIT

Adolescents obtain substances by various means. These range from using pocket money, change, stealing money, doing part-time jobs, assisting people to carry groceries and obtaining substances from their friends. In some instances, they also contribute money in order to buy the substances. This means that they do not struggle to buy substances; they have found the means to do this. Some participants even did part-time jobs to earn money to buy substances. Their intentions of doing part-time jobs are positive in that they gain working experience, but they do not use the money wisely. Furthermore, their idea of each member contributing to buy substances is not positive because it can encourage them to steal money at home in order to buy substances. As previously mentioned, friends do contribute to substance abuse, because they are the ones who will buy substances if their fellow friends do not have the money to do so.

The participants also seem to abuse their pocket money. This implies a lack of responsibility by these adolescents, in the sense that they are not using the money provided to them for its intended purpose. They might end up growing up as irresponsible parents who will not be able to use their

own salaries or money earned efficiently. As a result they may fail to provide for themselves and their own families. Parents are also giving their children money and not monitoring how they use it. This causes many adolescents to fall prey to substance abuse because they have the means to buy them. They know that their parents will not ask them how they spend their pocket money.

REASONS FOR SUBSTANCE USE

Participants in this study reported various factors that contributed to their use of substances, these include personal, family and environmental factors.

Developmental stage of adolescence

Participants start abusing substances during the adolescent stage, since that is a time of exploration and risk taking as discussed in Louw et al., (1998). Some adolescents in this study reported that they wanted to experiment with substances. They wanted to taste the substances and feel high after using them. This was also confirmed by previous studies (Donald et al., 2007; Parrott et al., 2004). However, this study reported a new concept that is used by adolescents when they refer to feeling 'high'. The concept is 'Iry'. One participant briefly reported that while he was using substances, he wanted to feel Iry. In short, feeling high.

Some participants in this study further indicated that they had a strong desire for substances. That is because these substances are easily available in their communities and they afford to buy them. Thus, they were able to satisfy their desire to use these substances. In addition to that, some participants indicated that they wanted to be happy because they saw people laughing after using substances.

As mentioned previously, some of the participants were experiencing a lot of stress, and the use of substance use was the only available means to make themselves happy and to forget their problems. Another reason for trying substances was for fun (De Miranda, 1987; Rice, 1992; Rice & Dolgin, 2008). Adolescents in this study used substances to entertain themselves. There are no entertainment centres for the youth in rural areas where these adolescents are residing; as a result substance abuse might have been the only available way of entertaining themselves.

Depression

Depression also seems to be one of the reasons for substance abuse among adolescents. The findings revealed that adolescents are overwhelmed by the challenges in their own lives, their families, and the society in which they live. The majority of the participants are from poor families which makes it difficult for their parents to provide for their needs. These adolescents become stressed if their needs are not met. This then leads them to abuse substances in order to forget their problems. They then resort to substance abuse as a way of coping with their problems, not realising that their use of substances will not solve their problems. Instead, the use of substances aggravates their problems.

Family structure

The family structures of these adolescents vary from single parent, nuclear, step parent, extended, up to child-headed families. The majority of the participants do not have father figures at home, and this lead to male adolescents expressing a need to want to know their fathers. Some participants even indicated that their fathers were not taking care of them. As a result, these male adolescents looked up to the behaviour modeled by other male figures in their environment and media. Participants from nuclear family also used substances even though they had a father figure in their family. This may imply that their fathers did not guide them or even advise them not to use substances.

Child-headed families also proved to be a risk factor for substance abuse because such adolescents are lonely and rely on their peers for support. They do not have anyone to guide them or provide moral support during this challenging stage of development. Thus, the family structure of the participants in this study proved to be a risk factor for their use of substances. The developing adolescents are vulnerable; they need the care of parents, other family members, as well as other elders in the community. It is not easy to raise a child alone, hence the African proverb that 'It takes the whole community to raise a child'. That means that children thrive when parents, educators, caregivers, doctors, nurses, psychologists, police officers, business people, volunteers, community members and community leaders care enough to provide for their needs. Together, these stakeholders can ensure that children are provided with opportunities, skills and support required to enable them deal effectively with their substance abuse problem and to help them succeed in life (Success by 6, 2005).

The majority of the participants are left in the care of grandparents while their parents are working as migrant labourers. One participant was left alone without anyone to take care of him, while his brother and sisters were working as migrant laborers. Such children are prone to substance abuse because there is no one to guide and monitor them. Educators end up being parent figures for such children, only if they keep a record of such vulnerable children and provide the necessary support. However, with peer group pressure that is always in conflict with adult values, it becomes difficult for educators alone to prevent adolescents from indulging in substance abuse behaviour.

Adolescents have more freedom and independence than younger children; they are less closely supervised and monitored (Donald et al., 2007). Adolescents also spend more time with their peers and less with their families which then puts them more at risk of substance abuse. There is lack of proper monitoring and control over male adolescents. Parents are no longer taking full responsibility once their children reach adolescence and attend secondary schools as compared to when they were young and attending primary school. This puts adolescents at risk of substance abuse because they know that no one is monitoring their movements.

Parenting style

Parenting style also contributes to substance abuse. Parents who allow their children to go to taverns without reprimanding that type of behaviour encourage their children to abuse substances. Adolescents from such families are free to use substances because no one corrects such behaviour or even guides them. This confirms findings of previous studies that permissive parenting styles contribute to substance abuse (Baumrind, 1991; Hawkins, Catalano, & Arthur, 2002). In addition to this, authoritative parents who do not allow their children time to relax may frustrate them. Such children may end up abusing substances. Parent-child conflicts were also noted as a cause of substance abuse in this study. These conflicts often lead to poor communication and strained relations between parents and their children. According to the participants, parents do not always maintain good relations with their children, leading even to poor communication or no communication with their children. This too may lead to substance abuse by adolescents (Liddle & Rowe, 2006).

Adolescents who are in conflict with their parents end up not being able to communicate with their parents. That puts them at risk of abusing substances because they will then spend most of their time with friends who will give them the love and support that they lack at home (National Institute on Drug Abuse, 2003). Their peers become the only people with whom they are able to communicate. Furthermore, these adolescents may end up not being able to relate well with others and grow up as parents who will not be able to relate well with their own children. This strained parent-child relations frustrate these adolescents and they end up being depressed.

Educational level of parents

The majority of the participants' parents do not hold a post- matric qualification, and this is also indicated by the Ramotshere Moiloa reviewed integrated plan (2008-2009). This shows that the majority of the parents are not aware while others are literate, which may be the reason for not being employed. Those who are employed are either working as domestic servants or as sales persons in shops. That makes it impossible for some of the parents to provide for the needs of their children.

As a result, some of these adolescents became frustrated and end up turning to substances or relying on friends for support. This may be a risk factor for substance abuse as these adolescents have to conform to whatever their friends will tell them to do because they rely on them. Furthermore, other parents may find it difficult to monitor the academic performance of their children because they are not educated. Some children end up not respecting their parents and abuse substances. Thus, these parents may end up not serving as role models for their children.

Availability of substances

The findings revealed that despite the high rate of poverty, the male adolescents in this study can afford to buy substances which seem readily available in their communities. This was also reported in previous studies (Kawaguchi, 2004; Liddle & Rowe, 2006). Therefore, one may assume that there are too many outlets that sell alcoholic beverages and other substances and that adolescents have the means to buy these substances. Furthermore, it implies that laws prohibiting the sale of substances to minors are not implemented and adhered to in rural areas. This then contradicts government strategy of providing services to previously disadvantaged areas and ensuring that all policies and laws protecting the rights of children and minors are adhered to at

all times.

In addition to that, it seems that parents do not always monitor their children during adolescence. There is lack of monitoring and control from both the parents and Liquor boards. The Liquor boards do not ensure that the liquor act is implemented in shops and taverns in rural areas. The lack of parental control can be ascribed to the migrant labour system as some parents are compelled to work far away from home, leaving their children in the care of grandparents who cannot monitor the movement of their grand children. The role of community policing forums becomes questionable in this context. This may mean that such structures are either not established or although established, are not functional.

Learned behaviour

Substance abuse may also be perceived as learned behaviour. Adolescents learn either from adults, role models or friends that substance abuse is something that one has to do to relieve stress and to be happy. As social learning theory postulates, these adolescents learn this behaviour both at their homes and from other people in their communities (Burger, 2008; Carson et al., 2000; Rice & Dolgin, 2008). However, other adolescents' parents do not abuse substances. Thus, adolescents learn to use substances from their peers and other adult figures in the community. This contradicts other findings that adolescents who abuse substances have parents who abuse substances (Conger, 1991). The majority of participants in this study had parents who did not use any form of substances. Adolescents can abuse substances even though there is no one in their families who uses substances. This study revealed that adolescents learn to use substances from their peers, other family members and other adults in their communities (Carson et al., 2000; Papalia et al., 2004; Sue et al., 1994).

Peer group pressure is one of the major factors for the use of substances. This study revealed that adolescents rely on their peers for care and support; as such they had no option but to succumb to everything that their peers offered them. Adolescents are influenced by their friends to use substances. They also provide them with substances if they do not have them as mentioned in the previous paragraph. This is simply because their peers are the only people who are available when they need help, they are able to talk to them and they spend most of the time with them.

Media

The media play a role in the use of substances by adolescents. Alcohol adverts encourage adolescents to have a desire to use substances. These adverts are appealing to adolescents and have a persuasive effect on them. Adverts make adolescents aware of new alcoholic beverages and tobacco products which they may obviously want to taste or test. Adolescents are in a vulnerable stage in which they are likely to be persuaded by these messages (Alloy et al., 1996). Thus, adverts do influence adolescents to abuse substances as postulated by the symbolic interaction theory in Chapter 2. Some participants in this study also indicated that alcohol adverts encourage people to want to use substances. All these factors have a negative impact on the lives of the adolescents.

The school environment

Adolescents abuse substances in schools even though they have signed the code of conduct that prohibit the possession and use of substances on the school premises (South African Schools Act no. 84 of 1996). The high prevalence of substance abuse among adolescents makes the school environment unsafe to both the educators and learners. That is why learners are unruly and do not respect educators and fellow learners. That ultimately leads to poor academic performance. These adolescents fail tests, repeat the grades, and ultimately might drop out of school. Thus, effective teaching and learning cannot take place if learners are under the influence of substances. This revelation was also confirmed in other studies, namely that substance abuse has a negative effect on the academic performance of learners (Berk, 2007; Gladding, 2004). The participants in this study reported that their use of substances made them fail and repeat grades. Furthermore, they regret their use of substances.

This then becomes a waste of scarce financial resources which could be used for other important resources needed for improving the quality of education in our country. Furthermore, failure and dropping out of school by these adolescents also add to the high rate of illiterate and unemployed people in our country. That also aggravates the already existing problem of illiteracy, unemployment and poverty in rural areas (Ramotshere Moiloa reviewed integrated plan, 2008-2009).

EFFECTS OF SUBSTANCE ABUSE

The participants know the effects of taking substances and even regret their use thereof, but they continue using substances despite the negative effects of these substances. Their knowledge of substances is limited in the sense that they are not aware that alcohol and cigarettes are substances even though they are socially acceptable. Thus they are not aware of the other life threatening effects of these substances. The use of substances will shorten their life span and impact negatively on the already depleted scarce health resources. A lot of money will have to be spent in health and rehabilitation centres to help these adolescents.

Social effects

The use of substances by adolescents has a negative impact on the welfare of society (Alloy et al., 1996; Butcher et al., 2004; Carson et al., 2000). If these adolescents are not monitored, they end up getting involved in criminal activities such as robbery, theft, rape and murder (Department of Social Development, 2006; Donald, et al., 2007; United Nations Office on Drugs and Crime, 2008). Their use of substances endangers the lives of both their families and other people in their communities (Donald, et al., 2007). They become dangerous to everybody. They end up being rejected by the very society that is supposed to nurture and guide them. That implies moral decay. These adolescents end up being arrested for their criminal activities and add to the already existing high rate of inmates in prisons (Butcher et al., 2004; United Nations Office on Drugs and Crime, 2008). Furthermore, they will have criminal records even before completing matric; that puts them at risk of being expelled from schools, not being accepted in tertiary institutions or securing employment because of a bad criminal record. Their future may therefore be doomed due to their substance use. These criminal activities also undermine democracy, good governance and have a negative impact on our country as mentioned in the previous section.

Health effects

Adolescents in this study were dependent on substances and unable to stop using these substances. They reported that they want to stop using substances and that they need someone to assist them. This means that adolescents are aware that substances are dangerous, they have tried to stop using them but they could not do so. These adolescents are helpless and desperate and this may put them at risk of further abusing substances if they do not get help timeously. Furthermore, they may fall prey to the wrong people who may give them the wrong information if they do not

know where to get help.

These findings also reveal that adolescents are not informed about the services available in their communities. Furthermore, this means that the services of life orientation educators, social workers and psychologists are not visible or accessible. If these services are indeed available, these learners are not using them. This then implies that there is a need for full time psychologists and social workers in schools who will assist these adolescents with challenges that they face on a daily basis (Department of Education, 2007). Furthermore, this study proves that there are no youth centres or recreational facilities in rural areas where adolescents meet and discuss the challenges that they face. This implies that the only recreation facility that was available to teenagers in this study is taverns. Thus the health of these teenagers is at risk (Berk, 2007; Donald et al., 2007; Rice & Dolgin, 2008).

Economic effects

Dependent adolescents are absent from school while spending their time abusing substances. They end up obtaining poor marks and failing at the end of the year. Most of the participants in this study indicated that they are repeating the grade. That has a negative impact on the budget allocated to schools. Those repeating grades create a shortage in staff, learner furniture and stationery. In addition, strategies that may be employed to improve academic performance of these adolescents may be costly in terms of time and finances required to implement such strategies. The strategies may include, but not limited to convening meetings, writing letters and contacting parents through telephone calls to discuss learner behavior and academic performance (Department of Education, 2007).

Furthermore, educational psychologists and social workers may be required to assess and refer learners who indulge in substances to rehabilitation centres. That may be costly, since admission to rehabilitation centres is expensive (Plüddermann et al., 2007; United Nations Office on Drugs and Crime, 2008). In addition, money may be required to empower adolescents to refrain from substance abuse, through campaigns such 'Ke Moja, No thanks, I am fine with drugs', and support structures such as Teenagers Against Drug Abuse (National Drug Master Plan, 2006).

Financial resources may also be required to strengthen safety and security in school to counteract

adolescents who abuse substances and behave violently towards their educators and other learners. If these adolescents are not assisted with their substance abuse problem, we may end up with a country of young adults who are not making any contribution to the economy of our country because they are dependent on substances (Davison et al., 2004). The rate of people who are not educated in rural areas will not improve because these adolescents are using substances, and may end up dropping out of school or expelled because of their use of substances. Thus, the effort mandated by the South African constitution of availing opportunities and empowering the youth in particular as well as previously disadvantaged communities will be a fruitless and wasteful expenditure (Constitution of the Republic of South Africa, 1996).

CHAPTER SUMMARY

In this chapter, the findings of this study were discussed in detail and related to previous studies. Adolescents use both legal and illegal substances. Substance abuse among adolescents is caused by personal, family and environmental factors. Substance abuse does not only affect the person using them, they also affect other people. Thus, substance abuse by the adolescents has health, economic and social implications. The next chapter will outline and discuss the conclusion, limitations, recommendations and reflections of this study.

CHAPTER 6

CONCLUSION

INTRODUCTION

The findings of this study highlighted a few issues that should be attended to in order to address substance abuse among adolescents. In this chapter, the conclusion, limitation and recommendations of this study are presented. Furthermore, my personal reflections on this study are alluded to in this section.

CONCLUSION

Adolescents are in a very important developmental stage of their lives. They are faced with physiological development as well as pressures from their families and their social environment. They are also vulnerable to environmental pressures from their peers, role model, and the media. If they are not prepared for these developmental changes and challenges of adolescence, they may end up being frustrated, confused and helpless when confronted by them. In trying to cope with such challenges, adolescents may end up indulging in a variety of substances that endanger their own lives as well as the lives of other people.

The voices of adolescents in this study are clearly saying that *we are abusing substances due to various reasons and we need help to stop the behaviour*. Parents, educators, health professionals, social workers and the community at large must be at the fore front in the fight against substance abuse by adolescents. The substance abuse problem affects everybody. Thus, in order to be addressed, it requires the effort of all the stakeholders including the adolescents themselves.

It is indeed upsetting, discouraging and sad to note and see male adolescents being under the influence, and dependent so badly into these substances. As future leaders of our country, they should be loved, guided and supported so that they are able to deal with their substance abuse behaviour and refrain from further abuse of substances as it impacts negatively on their lives as discussed under the effects of substances. Support structures such as Teenagers Against Drug Abuse (TADA) may be established in schools (National Drug Master Plan, 2006) and male adolescents may be encouraged to participate in such structures. However, the challenge may be

that some of male adolescents may take time to acknowledge their substance abuse problem and because of fear of being labelled as substance dependents, they may refuse to participate in such a structure. In such instances, there is a need to obtain assistance from other adolescents who were once hooked in substances, and are no longer using substances, to take a lead in encouraging adolescents to participate in such structures. In addition, topics that are handled during such sessions should not only cover substance abuse topics, but may include other health and wellness topics affecting male adolescents.

This study managed to achieve its goals of investigating how it came about that male adolescents abuse substances, investigating the complexities of substance abuse among a small, group of adolescents in secondary schools in the Zeerust district, North West province of South Africa, finding out their knowledge of substances and the effects thereof, identify the family structure and the social environment where the adolescents are living, and identifying strategies to prevent substance abuse amongst male adolescents. However, there are limitations to this study. The next section discusses these limitations.

LIMITATIONS OF THIS STUDY

The study was conducted in one district with only twelve black male participants, between the ages 12 and 15, completing grade 7 to 9, which makes it difficult to generalise the findings of this study. A larger randomly selected sample from more than one district with similar situations might have improved the generalisability of the findings. Furthermore, a mixed sample with both males and females could have improved the generalisability of the findings as female adolescents also use drugs. The questions in this study were asked in English and were not translated into the participants' language, Setswana. They were only verbally translated into Setswana during my interaction with the participants. This might have had undesirable effects. For instance, I might have wrongly interpreted the questions and the responses of participants resulting in the intended meaning being lost in the translation. Thus, translating questions and responses into participants' language posed a serious challenge for this study.

Even though I tried to make the participants feel free throughout the interview sessions, they were not free. I observed that they had reservations. This had a limiting effect on the participants' interaction with me. This study was only conducted by me, thus the findings might not have been

objectively analysed. This study did not address the support structures that can be developed to assist adolescents during this challenging stage of their lives. This study also did not take into consideration the educational qualifications of parents. This was only addressed by asking the participants whether their parents were employed or not. If employed, they had to indicate the type of job that their parents were doing. From that, I was able to detect the educational level of the parents of participant.

Furthermore, this study only focussed on the adolescents attending schools in rural areas. Adolescents who do not attend school were not included in this study. That also limited the findings of this study. In addition, other stakeholders such as parents, teachers and other people involved in substance abuse activities were not part of this study. This had a limiting effect on the data obtained about the reasons for substance use.

Genograms undertaken in this study were only limited to family members living with the participants. Information about other extended family members could not be obtained during interviews. Furthermore, important data about the ages of parents could not be obtained during the study. Participants were requested to bring along that information at a later date scheduled by myself. The date of birth of other extended family members could not be obtained during interviews because of time constraints.

This study employed a qualitative methodology. Limitations in terms of measuring the magnitude of substance abuse among adolescents in the Zeerust district can be discerned. One cannot measure how many male adolescents are using substances in terms of percentages. Furthermore, only interviews were used as the main tool for acquiring information from participants. This had a limiting effect as most of the participants were not willing to talk about their substance abuse behaviour. Alternatively, information could have been obtained through questionnaires as participants might have felt free to write down their responses instead of talking to someone. In addition, other means such as letters could have been used and that could have given participants an opportunity to express their reasons for substance use more easily.

Despite its limitations, the study has assisted in identifying the reasons for substance abuse among adolescents, which may assist policy makers in developing effective evidence-based

intervention strategies that are relevant to the needs of rural adolescents. Furthermore, this study afforded disadvantaged adolescents the opportunity to express their views about the challenges that they are facing. The open-ended nature of this study enabled me to gather data that is illustrative and rich. The next section, provides recommendations of this study as well as topics for future research.

RECOMMENDATIONS

Future research

It is recommended that a larger sample, inclusive of female participants, covering a wider geographical area be drawn in future investigations, in order to improve the generalisability of the findings. In addition, adolescents who do not attend schools should also be part of the study. Furthermore, the study should also include other racial groups. Interview questions must be translated into the participants' preferred language before interviews are conducted. Furthermore, in addition to face-to-face interviews, it is also recommended that participants be allowed to write down all the other aspects that relates to the study which they find difficult to express during interaction with the interviewer.

Information about the educational level of the parents can be acquired during meetings. Requesting permission to conduct the study with parents can also be further explored. Alternatively, parents can also be involved as important stakeholders who can either be interviewed or asked to complete questionnaires in order to get a broader picture of substance abuse among adolescents. Information can also be obtained from other important stakeholders involved in programmes that address substance abuse among adolescents in rural as well as urban areas.

This study recommends further research undertaking regarding parental support during adolescence. In addition, this study calls for research on substance abuse monitoring devices that can be used in schools to curb substance abuse behaviour. Furthermore, more than one researcher could collect data in order to ensure objectivity during data analysis. Both qualitative and quantitative approaches can be used to gather information about substance abuse among adolescents. By combining both approaches, I could have maximised the strength and minimised the weaknesses of each approach. This may have strengthened the results and contributed to

theory and knowledge (Morse, 1991). In addition, since multiple and diverse observations could be used, the study could have enriched the understanding of the substance abuse problem among adolescents. However, the volume of data produced, would have been immense and an extremely broad knowledge base was required to analyse it. The investigator would then have had to contract other researchers to work on the different parts of the analysis (Miles & Huberman, 1994).

Policy implications

This study recommends that a database of child headed families and adolescents abusing substances be developed and such adolescents be referred to social workers for intervention. Most of the participants reported that they bought cigarettes and alcohol from the shops and butchery in their villages. Other participants indicated that they drank alcohol in taverns. This evidence shows that even though the Liquor Act is implemented, some of the tavern owners do not comply to it. Furthermore, this means that some entrepreneurs do not only sell goods that are stipulated in their business licenses. This has implications for policy makers to strengthen strategies employed to implement, monitor and evaluate policies. In addition, there is a need to educate entrepreneurs, tavern owners, parents, adolescents and community members in rural areas about the Liquor act because they are important stakeholders who may play a role in ensuring that the act is implemented. They may also assist in reporting cases of non compliance of the Liquor act by some entrepreneurs and tavern owners (Liquor Act no. 59 of 2003).

The majority of the participants reported that they used substances in the bush and mountains where no one sees them. This study recommends that South African Police Service collaborate with communities through Community Policing Forum to address substance abuse problem among adolescents. Furthermore, adolescents need to be empowered through victim empowerment programmes to stop abusing substances because they have a right to develop to the fullest and be protected from harmful use of substances. In addition, there is a need for proper monitoring to control the influx of substances from urban areas to rural areas. Teenagers should be encouraged to participate in community policing forums because they seem to know the sources of the substance supply (South African Police Service Act no. 68 of 1995; The Strategic Plan for South African Police Service, 2005).

As mentioned earlier, Teenagers Against Drug Abuse (TADA) support groups need to be established in schools (National Drug Master Plan, 2006). These groups help in encouraging peers to refrain from substance abuse. In addition, no adolescent should be allowed to enter school premises if he or she is under the influence of substances, as he or she can endanger the lives of other learners (South African Schools Act no. 84 of 1996). The services of police officers that are adopted in schools must be fully utilised to address substance abuse behaviour among adolescents and to ensure substance free schools.

There is a need for recreational facilities in rural areas in order to curb the high rate of substance abuse among adolescents (Parliamentary Monitoring Group, 2000; Reitzes, 2009). Availing recreational facilities in rural areas may help to keep adolescents active in constructive ways and take them away from abusing substances.

Traditional leaders in rural areas should also be engaged in curbing substance abuse problems because rural communities seem to respect their leaders. As it is normally said: 'Lefoko la kgosi le agelwa mosako'. This means that people respect the orders from their traditional leaders. Intervention by traditional leaders can really make a difference (United Nations Economic Commission for Africa, 2007).

Training and development

There is a need by experts to train parents on adolescent substance abuse. Training is currently undertaken in schools for parents. The Department of Education, Health and Social Development are the primary actors in raising awareness of and educating them about the dangers of substance abuse (National Drug Master plan, 2006). However, some of the parents seem not to be reached. This study therefore recommends that substance abuse training workshops be conducted for parents of adolescents abusing substances. That will enable them to know the nature of substances abused by male adolescents, signs and symptoms of substance abuse and the services available in their communities to provide care and support to adolescents abusing substances (National Drug Master plan, 2006). However, these training workshops must be tailored to suit the cultural and educational backgrounds of the rural parents.

In addition, parents can also be encouraged to establish support groups in their communities. This

will assist parents to share their experiences about the substances that are used by adolescents and also facilitate the supporting of each other regarding the growing substance abuse among their adolescents. This will also help in raising awareness about substance use and how they can support their children. Through such interactions, they will be able to deal with stigma of substance abuse and that will relieve them, as they will realise that they are not alone, other parents are also facing the same challenge. Through such support structures, an opportunity is created to bring together parents, community organisations dealing with substance abuse and health experts to address substance abuse issues in a locally and appropriate manner (Rural Health Policy Institute, 2009).

Furthermore, this study recommends that parent-child relations be strengthened to avoid tensions which ultimately lead to adolescent substance abuse, for example, parents need to have time to talk to their growing children about substances and their effects. If they know other adolescents in their communities who are using substances, or see them while in company of their children, they can also use that moment to talk about substances that are used and their negative effects. They should make their children aware that they love them, believe in them and care about their well-being. Furthermore, they need to allow their children to be free to talk to them about challenges that they face. That will assist in building confidence in their children, which in turn may help them open up to their parents and explain the challenges that they are facing in order to stop abusing substances (National Institute on Drug Abuse, 2003).

Comprehensive information about substances need to be covered during Life Orientation lessons, substance abuse awareness campaigns and workshops need to be implemented. Where possible, site visits to hospitals and rehabilitation centres need to be arranged for adolescents so that they can witness the hardships of people who abuse substances. Abstinent substance dependents may be used to encourage adolescents not to use substances. Adolescents need to be taught refusal and coping skills when encountering difficult situations in their lives (The partnership for a drug free America, 2009). Furthermore support groups should be established in rural areas to provide care and support to adolescents and their parents. Additionally, parents and educators need education in recognising and intervening with adolescents who abuse substances.

Parents need to be supported by experts such as social workers, psychologists, and health

practitioners on how to improve their relations and communication with their children. There is a need for knowledge about substance abuse to be disseminated to children as they approach adolescence as well as other people in the communities. The earlier intervention is undertaken, the better chance that children will regain their health and return to a substance free life (The Partnership for a drug free America, 2009). Information provided to these adolescents must at all costs clarify all the myths pertaining to substance abuse. There is a need to challenge media's role in perpetuating unhealthy images and to use the media to disseminate information. Furthermore, adolescents must be taught that even though they are exposed to substance use either by role models through all kinds of media, they must value their lives and learn to resist such pressures.

Parents in rural areas need to be assisted by educators, health practitioners and social workers in their communities to be fully involved in the development of their children. They should also ensure that they love their children, have open communication channels with them and support them (Kosterman, Hawkins, Spoth, Naggerty & Spoth, 1997). Parent behaviour may reduce later risks for substance abuse (Spoth, Redmond, Trudeau & Shin, 2002b). In addition, parental monitoring and supervision are critical for substance abuse prevention. These skills can be enhanced with training on rule setting; techniques for monitoring activities, praise for appropriate behaviour and moderate consistent discipline that enforces defined family rules (National Institute on Drug Abuse, 2003).

Substance abuse peer education programmes should be implemented in schools, for example, Teenagers Against Drug Abuse (National Drug Master Plan, 2006). Support structures like that can be effective when they employ interactive techniques such as peer discussion groups and role playing. This allows for interactive involvement in learning about substance abuse and reinforce skills (National Institute on Drug Abuse, 2003). This will provide an opportunity for adolescents to discuss their challenges with trained peers and learn from them, since adolescents are more willing to discuss their challenges with their peers than with their parents (National Institute on Drug Abuse, 2003).

There is a need for knowledge about substance abuse to be disseminated to children as they are approaching adolescence as well as people around them. The social, health and economic effects of substances must be emphasised to the adolescents, their parents and other community

members. Motivational talks need to be conducted in schools to encourage adolescents that even though they face many challenges, they must not turn to substances as a way of solving their problems as that may aggravate the situation instead of alleviating it.

The migrant labour system seems to be a cause of substance abuse, thus this study recommends that where possible parents may take their children along to where they are working. If that is not possible, they may request assistance of other adults to take care of their children and act as guardians in their absence. Furthermore, foster parents may be requested through social workers to take care of child headed families. That may assist in monitoring these adolescents to avoid further abuse of substances.

Most of the participants indicated that they are dependent on drugs and need assistance to stop abusing substances. Such adolescents may be referred to social workers so that they may be referred to subsidised rehabilitation centres (National Drug Master Plan, 2006). However, permission to do so, must be obtained from both the adolescents themselves and their parents. In addition, after-care support programs must be availed, to enable them to cease substance abuse and become normal and productive members of society. Family members and communities need to be provided with information, support and counselling to assist with relapse prevention (National Department of Social Development, 2006). They may also attend counselling and support groups for recovering dependents. For this to be successful, after-care support programmes need to be conducted in their communities so that family members and adolescents recovering from substance dependence may attend on a regular basis. However, these adolescents need to be made aware that aftercare may only work if they abide by the rules.

Finally, all the above mentioned prevention programmes if implemented, need to be evaluated. However, evaluating these programmes can be challenging. Thus, there is a need to employ the services of experts in designing and implementing evaluation procedures. Such services may be obtained from government departments, non governmental institutions, private consultants and institutions of higher learning as part of their community outreach programmes (National Institute on Drug Abuse, 2003).

The next section contains reflections on this study.

REFLECTIONS

The motivation behind the study: I served as an educator, Life Orientation subject specialist, and member of a drug abuse forum. I was exposed to male adolescents abusing substances. Furthermore, cases of substance abuse by male adolescents were often reported at the district office where I was employed as a Life Orientation subject specialist. As a member of the substance abuse forum, concerted attempts were made to raise awareness of the dangers of substance abuse among adolescents, parents, and communities in the Zeerust district, however, substance use remained on the rise among adolescents. That raised the question: why do male adolescents abuse substances? I wanted to know why they continued using substances as strategies were in place to curb substance use among adolescents. One of these strategies was 'Ke Moja, I am fine with drugs' campaign.

I was concerned about the poor economic conditions under which these adolescents live and the future implications that the use of substances may have on them. Furthermore, there was also evidence of poor academic performance among some of the adolescents abusing substances. I wanted to make a difference in the lives of rural adolescents. In addition, I wanted to obtain information from these adolescents and develop intervention strategies based on the specific needs of these adolescents, not just one strategy designed for all. In a nutshell, I wanted to be remembered by having tried to serve humanity. Conducting a study with adolescents abusing drugs was quite a wonderful and fulfilling experience. I learnt a lot from my interaction with rural male adolescents. It was indeed fulfilling to realise that even though the study was aimed at obtaining information from the participants, this was also reciprocal. The participants indicated that they were really happy to have someone to talk to. I was really humbled by how they appreciated my interaction with them. At least, the participants also benefitted from this study during interviews through expressing their concerns and having someone to talk to. It was not easy at first when I conducted the pilot study. Participants were nervous and not willing to share ideas or even answer questions.

Even though they were guaranteed that all the information discussed in the interview will be treated with confidentiality, and that the information gathered will not be submitted to the Police, they were still reluctant to respond. As I interacted with the male adolescents, I discovered that even though they abuse substances, it is not easy for them to talk about it. They are ashamed to

talk about it. At some instances, we had to take a break and continue the next day; simply because they were not ready to talk about their substance abuse behaviour. One may think that adolescents are not afraid of anything. However, this is not true.

Adolescent stage

Adolescence as a stage, can pose serious challenges to our teenagers. They need care and support from parents, educators and other members of the community. It was really sad to realise that sometimes as parents or elders in the community, we become risk factors for substance abuse among adolescents through the way we treat these young adults. Our male adolescents are hurting because of the way they are treated at their homes. The only way they use to overcome such challenges is to abuse substances.

Peer group pressure

Peer group pressure plays an important role in the lives of the adolescents. They serve as reference for the teenagers. They do provide emotional, social as well as financial support. At some points they become dangerous to their peers and they are left helpless and having to succumb to pressure because they do not want to be rejected.

Poverty

It is really hurting to realise that other people go to bed without eating anything. In some instances they go to school with an empty stomach and they are expected to concentrate in class. No one even notices such children in secondary schools. Instead, friends are the ones who will know about it. This shows that educators are no longer focusing on the holistic development of their students. They only concentrate on the intellectual, and no longer care about the wellbeing of students. Poor learners do not even know where to get assistance. Those who are supposed to provide assistance are either not visible or even away from easy reach of our rural communities.

Child headed family

It was really painful to realize that there are adolescents staying alone, without any parental supervision. Yet those adolescents are expected to behave and even perform well academically. Such adolescents may end up dropping out of school, because no one monitors their school work or even provide for their educational needs. As previously indicated, the question is where are the

community development workers? These people are supposed to assist such families. Really, this adolescent is denied his basic human rights.

I now view male adolescents differently. I understand that they go through a lot and at times feel helpless. One must not focus on their substance abuse behaviour, but must always have interest in knowing who they are, where they come from and what makes them behave as they do. One must acknowledge that substance abuse affects all of us. It does not only affect the person who uses it. As individuals, we are sometimes the very risk factor for substance abuse among adolescents. That may be because of our actions; ignoring the needs of adolescents and not providing the necessary support. Therefore, all the stakeholders are important in addressing the substance abuse problem in our rural areas. Otherwise, illiteracy, poverty, HIV/AIDS and crime rates will be on the rise in rural areas. Adolescents from rural communities deserve better lives just like other people in urban areas. Thus, rural development requires a concerted effort of all role players. Personal experiences about the study and motivation for conducting the study were discussed in this section. The next section provides a summary of this chapter.

CHAPTER SUMMARY

In this chapter, the conclusion, limitations of this study, recommendations and researchers' personal reflections were highlighted. Furthermore, this section highlighted the strategies that can be used to address substance abuse among adolescents in rural areas as well as urban areas. This then calls for recognition that our adolescents are indeed in a difficult development stage, faced with so many challenges and need to be given all the necessary support they deserve as human beings. However, this is a responsibility for youth leaders, parents, educators, police officials, department of health and social development, department of justice, department of economic development, department of foreign affairs, religious leaders, traditional leaders, as well as political structures. This study supported the notion that substance abuse is a problem which requires a concerted effort by all the stakeholders involved in youth development so that this problem can be fully addressed. Indeed, 'Kgetsi ya tsie, e kgona ke go tshwaraganelwa'. This means that we can address the substance abuse problem if we work together as a team.

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APPENDICES

APPENDIX 1: LETTER OF INFORMED
CONSENT

DEPARTMENT OF PSYCHOLOGY
COLLEGE OF HUMAN SCIENCES
UNIVERSITY OF SOUTH AFRICA
P.O. BOX 392
PRETORIA
0003

IRENE PATIENCE MOHASOA
P.O. BOX 340
LERATO
2880

LETTER OF INFORMED CONSENT

I....., the undersigned, consent to participate in the Masters degree research investigation to be conducted by Ms I.P. Mohasoa, Life Orientation Specialist at Zeerust Area Project Office (North West Department of Education), registered at the University of South Africa, under the supervision of Mr M.E. Fourie (Department of Psychology). The title of the research is “Substance abuse amongst male adolescents”.

The purpose of the research is to investigate the reasons for and the complexities of substance abuse among male adolescents. Special attention will also be given to the family background of the adolescents abusing substances.

The procedure in the study will include the use of unstructured interviews. The information gathered will be treated as strictly confidential. Interviews will take approximately two hours.

There are no known medical risks or other discomforts associated with the research. I understand

that there are no personal benefits for me participating in the study, but the results of the study may help researchers and counselors to gain a better understanding of substance abuse among youngsters. It was made clear to me that I may withdraw from participating in the study at any time. I agree to it that there is no financial compensation for participating in this study.

I agree that the results of this study may be published in professional journals and conferences but the records will not be revealed and the participants will remain anonymous.

I understand my rights as a research subject and I voluntarily consent to participation in this study. I understand what the study is about, how and why it is being done.

I will receive a signed copy of this consent form.

..... (Participant's signature)..... (Date)

..... (Signature of Researcher)

Date..... (Place).....

APPENDIX 1: LETTER OF INFORMED CONSENT FOR PARENT/GUARDIAN

DEPARTMENT OF PSYCHOLOGY
COLLEGE OF HUMAN SCIENCES
UNIVERSITY OF SOUTH AFRICA
P.O. BOX 392
PRETORIA
0003

IRENE PATIENCE MOHASOA
P.O. BOX 340
LERATO
2880

LETTER OF INFORMED CONSENT

I....., the Parent/Guardian of grant permission for my child to participate in the Masters degree research investigation to be conducted by Ms I.P. Mohasoa, Life Orientation First Education Specialist at Zeerust Area Project Office (Department of Education, North West Province), registered at the University of South Africa, under the supervision of Mr M.E. Fourie (Department of Psychology). The title of the research is “Substance abuse amongst male adolescents.”

The purpose of the research is to investigate the reasons for and the complexities of substance abuse among male adolescents. Special attention will also be given to the family background of the adolescents abusing substances.

The procedure in the study will include the use of unstructured interviews. The information will be treated as strictly confidential. Interviews will take approximately two hours.

There are no known medical risks or other discomforts associated with the research.

I agree that the results of this study may be published in Professional Journals and conferences but the records or identity will not be revealed and the participants will remain anonymous.

I understand what the study is about, how and why it is being done. I will receive a signed copy of this consent form.

..... (Signature of Parent/Guardian) Date

..... (Signature of Investigator)Date

Place

APPENDIX 2: PERMISSION TO CONDUCT THE STUDY

P.O. BOX 340

Lerato

2880

20th April 2008

The Area Project Office Leader

Department of Education

Private Bag X6335

ZEERUST

2865

Dear Sir/Madam

REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN SECONDARY SCHOOLS IN THE ZEERUST AREA PROJECT OFFICE.

I humbly request permission to conduct research at the following Secondary Schools:

N.R. Mandela Secondary School.

Ikageleng High School.

Rearabilwe Secondary School.

Tsholofelo Mangope Middle School.

I am presently registered at the University of South Africa, for Masters Degree in Psychology, under the supervision of Mr M.E. Fourie (Department of Psychology). The title of the research is "Substance abuse amongst male adolescents."

The purpose of the study is to investigate the reasons for and the complexities of substance abuse among male adolescents. The procedure in the study will include the use of unstructured interviews. The information will be treated as strictly confidential. Interviews will take approximately two hours.

There are no medical risks or other discomforts associated with the research.

The results of the study may help researchers and councilors to gain a better understanding of substance abuse among adolescents.

Thanking you in advance.

Yours Faithfully

.....

I.P. MOHASOA
(RESEARCHER)

APPENDIX 3: INTERVIEW GUIDE

Where do you stay?

With whom do you stay?

How old are you?

How do you feel about alcohol adverts in soccer fields?

Have you ever used any drug in your life?

If yes, which drug did you use?

How were you introduced to drugs?

With whom do you/did you take drugs?

For what reason did you/do you take drugs?

Do any of your friends take drugs?

If yes, how often do you take drugs?

Where do you buy drugs?

At which places do you usually take drugs?

How do you support your drug taking habit?

Does anyone in your family take drugs?

If yes, who is it?

APPENDIX 4: OBSERVATIONS AND CODING CATEGORIES

The following observation and coding categories will be used. They are adapted from Marshall and Rossman (1995).

I. Power Language

A. Tone

1. Pitch
2. Loudness
3. Intonation

B. Duration

1. Length of sentence
2. Conciseness

C. Content

1. Tag questions
2. Phrases of tentativeness: I believe, I guess, I think
3. Apologies
4. Power language: aggressive

D. Silences

1. Wait time

II Non-verbal

A. Kinesics

1. Face
2. Eyes
3. Rest of face
4. Hands
5. Legs

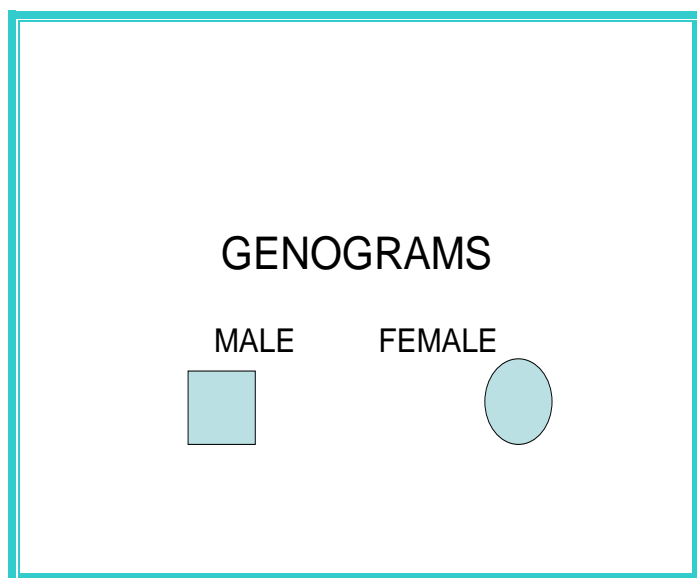
B. Appearance

1. Dress
2. Hair
3. Accessories

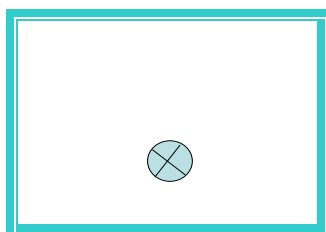
C. Engagement and Feedback

1. Looking at speaker
2. Eye contact
3. Head nodding
4. Verbal agreements
5. Smiling
6. Asking questions
7. Body positioning

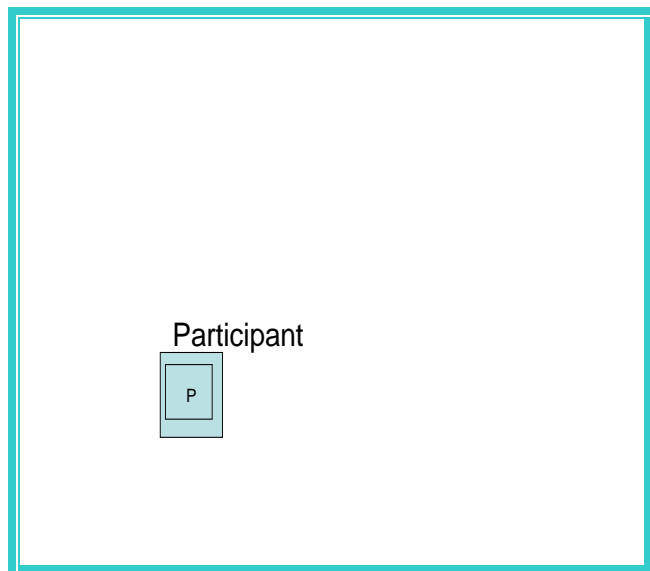
APPENDIX 5: GENOGRAMS



Males are represented with a square sign while females are represented with an oval sign



An oval sign with a cross inside represent a mother who has passed away.



Participant in the study. The participants in this study are represented with a square with double lines and a letter P in the square.

NB: The genograms are represented by male figure and then followed by female figure. In terms of children, the family structures start with the eldest on the left hand side, followed by the youngest on the right hand side.