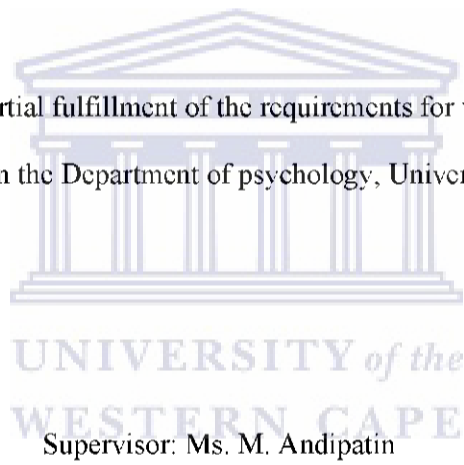


**EXPERIENCES AND PERCEPTIONS OF RISKY SEXUAL BEHAVIOURS IN THE
CONTEXT OF CRYSTAL METH USE AMONG FEMALE ADOLESCENTS AT
REHABILITATION CENTERS IN CAPE TOWN**

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A mini-thesis submitted in partial fulfillment of the requirements for the degree of Magister Artium
(Research Psychology) in the Department of psychology, University of the Western Cape



December 2010

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Keywords

Crystal methamphetamine

Risky sexual behaviours

Adolescents

Female

Perceptions

Experiences

Phenomenology

Interpretative phenomenological analysis

Qualitative

Drug rehabilitation centers



Abstract

Drug abuse as well as risky sexual behaviours has been identified, globally as well as in South Africa, as social problems with dire consequences. Research suggests that crystal methamphetamine use leads to risky sexual behaviours such as having unprotected sex, which can lead to unplanned pregnancies, and sexually transmitted infections (STI's) including HIV infection. Adolescents as well as females have been identified as risk populations for both sexual risk behaviours and drug abuse. Furthermore, the Western Cape showed high rates of crystal methamphetamine addiction, especially in the under 20 age category, and the highest increase in the incidence of HIV infections in South Africa. This may be indicative of the magnitude of the problem of risky sexual behaviours in the context of crystal methamphetamine use in the Western Cape. Consequently, the purpose of this research study was to illuminate the participants' experiences and perceptions of their crystal meth addiction and how it fed into their sexual behaviours and their understanding thereof. Subsequently, the overall aim of this study was to gain a deeper understanding about how and why adolescent female crystal methamphetamine recovering addicts experienced and perceived sexual behaviours in relation to crystal methamphetamine use. The sampling method was purposive, and the sample consisted of six participants. The sampling criteria included being a crystal meth addict, being an adolescent female ranging from 17 to 21 years, and attending a drug rehabilitation center in the Mitchell's Plain or Lavender Hill residential areas. Semi-structured interviews were conducted, which were analysed using interpretative phenomenological analysis. Various psychosocial reasons for their initial crystal meth use were found; not all of the participants indicated a clear understanding of the concept of risky sexual behaviours, but using their own experiences and perceptions of their lived world they indicated a clear understanding of the consequences of risky sexual behaviours

in the context of crystal meth use. With regards to the participants' sexual behaviours it was found that they were involved in risky sexual behaviours, which included having multiple sex partners, having unprotected sex, having anal sex, and having sex in exchange for crystal meth. With regards to the overall aim the participants explained that the effect of crystal meth on one's sexuality and the constant need to use crystal meth renders one powerless in sexual decision making. The loss of power to their crystal meth addiction was present in various spheres of the participants' lives, and reinforced the priority that crystal meth took in their lives whereby it affected their relationships with significant others as well as their personal well-being.



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Thank you to the participating rehabilitation centers for allowing me access to the participants in my study. To all the participants in my study, thank you for allowing me into your lives. By sharing your most intimate experiences and understandings with me you have enriched my life and my research study in a manner which can only lead to greater endeavors.

Declaration

I declare that *Experiences and perceptions of risky sexual behaviours among female adolescents at rehabilitation centers in Cape Town* is my own work, that it has not been submitted before for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged as complete references.

Jessica Lynn Paulse



December 2010

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Table of Contents

Keywords	i
Abstract	ii
Acknowledgements	iv
Declaration	v
Table of Contents	vi
CHAPTER 1	1
INTRODUCTION	1
1.1 Introduction and rationale	1
1.2 Aim of this research study	6
1.3 Objectives of this research study	6
1.4 Defining concept of adolescents	6
1.5 Chapter organisation	8
CHAPTER 2	10
LITERATURE REVIEW	10
2. Introduction	10
2.1 Crystal methamphetamine	10
2.2 Age of onset	12
2.3 Dependence	13
2.4 Effects of crystal meth abuse	14
2.5 Factors contributing to initial crystal meth use	17
2.5.1 Reasons for initial crystal meth use	17
2.5.2 Gender differences in the reason for crystal meth use	19
2.5.3 Family environment	20
2.5.3.1 Parental Monitoring	20
2.5.3.2 Family Cohesion	22
2.5.3.3 Family history of substance abuse	22

2.5.3.4 <i>Additional family dynamics identified as risk factors for drug use</i>	23
2.5.4 Gateway model	23
2.6 Risky sexual Behaviours	24
2.6.1 Trading sex for drugs or money	24
2.6.2 Number of sex partners	25
2.6.3 Unprotected sex	26
2.6.4 Anal intercourse	28
2.7 Consequences of risky sexual behaviours	28
2.7.1 Unplanned or unwanted pregnancy	28
2.7.2 Sexually transmitted infections	29
2.7.3 HIV infections	30
2.8 The prototype/willingness model of adolescent risk behaviour	31
2.8.1 Image based decision making	33
2.8.2 Perceived personal vulnerability	34
2.8.3 Willingness and intentions	34
2.8.4 Summarising the prototype/willingness model	36
2.9 Stages of drug use and abuse	36
2.10 Theoretical framework	37
2.11 Conclusion	41
CHAPTER 3	42
METHODOLOGY	42
3. Introduction	42
3.1 Research Design	42
3.2 Participants	44
3.2.1 The social context of Mitchell's plain and Lavender Hill	45
3.3 Procedures	45
3.4 Data collection	47
3.4.1 Semi-structured interviews from a phenomenological perspective	48
3.5 Data Analysis	51
3.6 Ethical considerations	52

3.7 Trustworthiness	54
3.8 Reflexivity	54
3.9 Significance of the study	56
CHAPTER 4	58
ANALYSIS AND DISCUSSION	58
4.1 Introduction	58
4.2 Becoming the addict	59
4.3 The effects of using crystal meth	60
4.3.1 Physical effects of using meth	60
4.3.1.1 <i>Sexually related effects</i>	61
4.3.1.2 <i>Increased energy</i>	63
4.3.1.3 <i>Loss of sleep</i>	64
4.3.1.4 <i>Weight loss</i>	64
4.3.1.5 <i>Skin erosion</i>	65
4.3.1.6 <i>Hair damage</i>	66
4.3.2 Emotional effects	66
4.3.2.1 <i>Self-confidence</i>	66
4.3.2.2 <i>Aggression</i>	67
4.3.3 Psychological effects of using crystal meth	68
4.3.3.1 <i>Becoming emotionally distant</i>	69
4.3.3.2 <i>Psychosis</i>	71
4.3.3.3 <i>Suicide</i>	72
4.3.4 The social effects of crystal meth use	73
4.3.4.1 <i>Getting involved in the wrong crowd.</i>	73
4.3.4.2 <i>Family rejection</i>	74
4.3.4.3 <i>Manipulation</i>	75
4.4 The reasons for initial crystal meth use	76
4.4.1 Curiosity and experimenting	76
4.4.2 Peer pressure	77
4.4.3 Willingness to initiate crystal meth use	79

4.4.4 Family dynamics	81
<i>4.4.4.1 Coping with family difficulties</i>	81
<i>4.4.4.2 Lack of parental attention</i>	82
<i>4.4.4.3 Lack of parental monitoring</i>	84
<i>4.4.4.4 Continued crystal meth use due to drug use in the home</i>	85
4.4.5 Crystal meth as a progression from other drugs	86
4.5 An ongoing cycle: Wanting the first hit back	87
4.6 The priority that crystal meth has in the life of the addict	89
4.6.1 Not wanting to face reality	90
4.7 Defining risky sexual behaviours and the consequences thereof	91
4.8 Sexual risk behaviours of crystal meth addicted teenage girls	94
4.8.1 Multiple sex partners	94
<i>4.8.1.1 The challenge in maintaining long-term relationships</i>	96
<i>4.8.1.2 Enslavement to sex</i>	97
4.8.2 Oral sex, anal sex, and orgies	100
4.8.3 Condom use	101
4.8.4 Sex in exchange for drugs	102
<i>4.8.4.1 Getting involved with gangs</i>	103
4.8.5 The vulnerable crystal meth addict	105
<i>4.8.5.1 Not having control over sexual decision making</i>	106
<i>4.8.5.2 State of mind</i>	108
<i>4.8.5.3 Preying on the crystal meth addict</i>	109
<i>4.8.5.4 Manipulation: Using other crystal meth addicts to score</i>	110
4.9 The addict, the teenager	112
4.10 Power dynamics where both partners used crystal meth	114
4.10.1 Aggression due to crystal meth use in an intimate relationship	114
4.10.2 Sex in exchange for drugs	115
4.10.3 Obligated sex	117
4.11 Regret	118
4.12 Putting the findings into perspective	119

CHAPTER 5	121
CONCLUSION AND RECOMMENDATIONS	121
5.1 Introduction	121
5.2 Summary of key findings	121
5.2.1 The objectives and overall aim	121
5.2.2 Factors strengthening the experience of losing power to crystal meth	123
5.2.3 Regret	125
5.2.4 Locating the adolescent in risky sexual behaviours	125
5.3 Limitations	126
5.4 Recommendations for future research	127
5.5 Conclusion	128
5.6 Reflections	129
References	131
List of appendices	
A. Information sheet	
B. Consent form	
C. Interview schedule	



CHAPTER 1

INTRODUCTION

1.1 Introduction and Rationale

Like all countries, South Africa is faced with numerous social problems. These problems are often found to be interlinked, and reinforce or magnify the other. In South Africa two of these social problems are the high rates of HIV/AIDS infections and drug addiction. Additional problems include other sexually transmitted infections, and unplanned or unwanted pregnancies, which like HIV/AIDS infections can be a product of risky sexual behaviours. Therefore, when grouped together one can present these problems to be risky sexual behaviours and drug abuse. In lieu of this, risky sexual behaviours and drug abuse is a health threat to adolescents, especially female adolescents, who have been identified as risk populations for both sexual risk behaviours and drug abuse. Though there is a dearth of literature in South Africa with regards to heterosexual risky sexual behaviours in the context of drug use, the available literature indicates an association between the two social-health concerns. This association will be discussed in more depth in my literature review chapter.

Several studies identify people in the 15-24 age group as well as women as at risk populations for risky sexual behaviour, which can lead to HIV/AIDS, sexually transmitted infections (STIs) and unplanned pregnancies. Yan, Chiu, Stoesen, and

Wang (2007) has documented unsafe sexual practices such as having multiple sexual partners and having unprotected sex as risk behaviours for sexually transmitted infections and/or HIV infection. Likewise, in a group of young people aged 15-24 it was found that risky sexual behaviours were linked to STIs and pregnancies (Bana et al., 2010). In South Africa 11 million STI cases are reported annually (Sonko et al., 2003). Analysis of the South African national HIV household survey found that individuals who were HIV positive in their study reported not having sex in the past 12 months (Rehle et al., 2007). Further analysis revealed that some of these individuals had a recent sexually transmitted infection where females had 3.1% infections and males 2.5% (Rehle et al., 2007). For adolescent pregnancy rates, the Department of Health, South Africa (2002) indicated a rise from 2% at age 15 to 35% at age 19. Therefore, it is evident that risky sexual behaviours have serious implications for females and adolescents in the 15-24 age range.

South Africa has the world's fastest growing AIDS epidemic (UNAIDS/WHO in Simbayi, Kalichman, Cain, Henda & Alliance et al., 2006; Parry & Pithey, 2006). Literature indicates that in Africa the majority of HIV transmissions occur through heterosexual intercourse (Harrison, 2009; Hayward, 1990 in Mwale 2009). According to the "South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey 2005" the overall prevalence for HIV in South Africa among persons aged 15-49 years is 20.2% for females and 11.7% for males (Shisana et al., 2005). Other studies highlight that the incidence of HIV is particularly alarming for young females in their prime child-bearing age, where females age 15-24 years

account for 90% of recent HIV infections (Degenhardt et al., 2010; Rehle et al., 2007). According to Degenhardt et al. (2010) the HIV prevalence in the general population is four times higher amongst females than males in the 15-24 age range. Likewise, Harrison (2009) found that there is a spike in HIV infections in late adolescent females which is sustained into adulthood. In addition, the HIV incidence gap between males and females younger than 30 years of age were especially large (Rehle et al., 2007). This was especially the case for the 20-29 age group where females had more than 6 times the incidence of men in the same age group (Rehle et al., 2007). The “South African Department of Health Study, 2006” indicates that about 29.1% of pregnant women were living with HIV in 2006; and the HIV prevalence rate for adolescents was 15.9% (Shisana et al., 2005). Therefore, from the literature it is evident that young people between the ages of 15 and 24 as well as females are population groups in South Africa who are at risk for contracting HIV (Degenhardt et al., 2010; Parry & Pithey, 2006; Rehle et al., 2007). In the light of sexually transmitted infections, HIV/AIDS infections can be perceived as a grave outcome of risky sexual behaviours in South Africa.

The literature indicates that risky sexual behaviour often occurs in the context of drug use (Bana et al., 2010; National Institute of Drug Abuse, 2002; Boskey, 2008).

Likewise, the literature indicates that drug use is related to unsafe sexual behaviours that place the adolescent at risk for pregnancy (Bana et al., 2010, Donovan, Jessor & Costa, 1991 in Hamerlynck et al., 2007; Fergusson & Woodward 2000; Ramrakha, Caspi, Dickson, Moffit & Paul, 2000) or contracting sexually transmitted infections

such as HIV (Boskey, 2008; Bana et al., 2010; National Institute of Drug Abuse, 2002; Yan et al., 2007). Therefore, drug use has been linked to risky sexual behaviours, which can lead to HIV and other sexually transmitted infections as well as unplanned or unwanted pregnancies.

Studies indicate a global rise in the dependence on methamphetamine (Springer, Peters, Shegog, White & Kelder, 2007). South Africa has been identified as being one of the countries globally in which methamphetamine use and harm are more prevalent (Degenhardt et al., 2009). According to Andreas Plüddemann, Cape Town has the highest methamphetamine addiction in the world (Kapp, 2008). In addition the South African Community Epidemiology Network on Drug Use (SACEDU'S), 2006 in van Heerden et al. (2009) documented that since 2004 methamphetamine became the primary drug of abuse in the Western Cape, replacing alcohol and marijuana. Statistics indicate that there was a 47% increase in patients who used methamphetamine as the primary and secondary substance of abuse from the second half of 2002 to the first half of 2007 (Plüddemann, Myers & Parry, 2008). According to SACEDU there is a 70% prevalence rate of methamphetamine abuse among the under 20-year-old age group (Kapp, 2008). According to the Medical Research council (MRC) there could be as many as 200 000 "tik" users in and around Cape Town (Kapp, 2008). Recently a study on methamphetamine use among high school students in Cape Town, South Africa indicated a life-time prevalence of methamphetamine use of 9%, which is higher than the lifetime-prevalence in America (Plüddemann, Flisher, Mcketin, Parry, & Lombard, 2010). These statistics

indicate the magnitude of the methamphetamine addiction problem in Cape Town with specific reference to individuals who fall under the under 20 year old age group.

Several countries worldwide show a concern that an increase in crystal methamphetamine use is closely tied to an increased HIV incidence (Bolding et al., 2006; Parry et al., 2008; Simbayi et al., 2006; Wechsberg et al., 2008, Zule et al., 2007). Therefore, risky sexual behaviour in the context of crystal methamphetamine use may also leave the individual at risk for sexually transmitted infections and unplanned pregnancies. Shisana and Simbayi (2002) found that 'Coloured' communities in Cape Town had a HIV prevalence rate that was significantly lower than the national average rate of 11%. According to Plüddemann et al. (2008) the term "coloured" originates from the apartheid era and serve as demographic markers without signifying any inherent characteristics. In addition, "coloured" refer to people of European, African and mixed (African, European and/or Asian) ancestry, respectively (Plüddemann et al., 2008). Therefore, the terms "coloured" and "black" will serve the same purpose in my study. Furthermore, Plüddeman et al. (2008) found that the Western Cape Province has recently experienced the highest increase in the incidence of HIV in South Africa. Therefore, this may be viewed as running parallel with the increased rates of crystal methamphetamine use. This is indicative of a link between Crystal methamphetamine use and the rise in HIV infections in the Western Cape.

1.2 Aim of this research study

The aim of this study is to gain a deeper understanding about how and why adolescent female crystal methamphetamine recovering addicts experienced and perceived sexual behaviours in relation to crystal methamphetamine use.

1.3 Objectives of this research study

The objectives of the study is to gain a deeper understanding regarding the reason(s) for initial crystal methamphetamine use; the participants' perceptions of risky sexual behaviours and its consequences; as well as their sexual behaviours in relation to crystal methamphetamine use.

1.4 Defining concept the concept of adolescence

In general the term adolescence refers to the period between childhood and adulthood. Owens (2002) described adolescence as a developmental stage, which starts from 11 to 13 years of age and end from 17 to 22 years of age. It is a time of dramatic biological and psychological changes which prepare the individual for adulthood (Greydanus & Patel, 2005). Biologically, the central nervous system undergoes neurobiological changes with a massive removal of cortical synapses through the process of programmed cell death; and the excess of neurons that are found in the utero is reduced by the process of puberty (Tarter, 2002; Greydanus, Pratt & Patel, 2004 in Greydanus & Patel, 2005). According to Tarter, (2002) the

changing brain of the adolescent is more sensitive to the effects of drugs than the adult brain, which may lead to a greater consumption of chemicals, greater resultant toxicity, changes in neurotransmitters (such as dopamine) activity, and the prevention of the normal neurobiological development.

According to Hogan in Greydanus and Patel (2005) the psychological development of the adolescent is characterised by the need for emancipation from parents and to establish a secure identity. Likewise, for Erikson (1968) adolescence is characterised, as a time of “identity crisis” in which adolescents attempt to define who they are, where they are heading and how they fit into society. This may be in terms of religion, sexual identity, their career and so forth (Sigelman & Rider, 2006). Erikson (1968) termed this conflict experienced by the adolescent as “identity versus role confusion”. Greydanus and Patel (2005) further emphasised that a sense of invulnerability and immortality, along with the absence of concern about the adverse consequences of substance abuse are major developmental factors that influence the progression of drug abuse in adolescence. Other factors that increase the adolescent’s vulnerability to drug abuse patterns include limited coping strategies and social skills (Greydanus & Patel, 2005). In addition, youth who perceive their life choices and options as limited are more likely to engage in high risk behaviors such as unprotected sex and substance abuse (Greydanus & Patel, 2005). The literature identifies such risks as sexual activity (Bachanas et al., 2002), substance use (Bachanas et al., 2002; Cardoso & Verner, 2007), reckless vehicle use, and delinquency, which have been shown to increase with age during adolescence (Igra,

1996 in Yan et al., 2007). Likewise, the participants in my study comes from disadvantaged backgrounds that is characterised by social concerns such as crime, domestic violence, drug abuse, and gangsterism (McAlister, n.d.), which may leave them with the perception that they have limited life choices and options. In addition, Hamerlynck et al. (2007) found that sexual activity increases with age and other aspects of risky sexual interaction such as not using contraception at intercourse in adolescence. Therefore, one can perceive adolescence as a period of conflict as indicated by Erickson (1968) and Greydanus and Patel (2005) which is often accompanied by risks such as sexual risk behaviours and drug use.

My study will follow a phenomenological theoretical framework, because it is concerned with individuals' lived experiences (Langdrige, 2007) and how they make sense of their lived world (Langdrige, 2007; Terre Blanche, Durrheim & Painter, 2006). Therefore, the phenomenological framework will fit well with the overall aim and objectives of my study.

1.5 Chapter organisation

Chapter 2: This chapter will primarily consist of literature concerning drug use and risky sexual behaviours. The specific drug of reference is crystal methamphetamine. However, a large amount of the literature will refer to methamphetamine and not specifically crystal methamphetamine. This is largely due to the dearth of literature on crystal

methamphetamine and risky sexual behaviours; and the fact that crystal methamphetamine falls under the group of methamphetamine-type stimulants. In addition the last section of this chapter will consist of a description of my theoretical framework and its linkage to this study.

Chapter 3: This chapter describes the research methodology used for this study. It has been detailed with methodological procedures and decision making with a particular focus on interpretative phenomenological analysis. In addition the significance of my study is highlighted at the end of this chapter.

Chapter 4: This chapter contains the discussion of the results of the interpretative phenomenological analysis of the conducted interviews for this study. This is in terms of the themes that emerged from the data, which is indicative of the similarities and differences among the participants' experiences and perceptions of risky sexual behaviours in the context of their crystal meth addiction

Chapter 5 As the concluding chapter, this chapter will include a summary of my findings, the limitations of my study, recommendations as well as an overall conclusion for this study.

CHAPTER 2

LITERATURE REVIEW

2. Introduction

This chapter highlights the literature pertaining to crystal meth addiction with a focus on the effects, factors contributing to initial crystal meth use, risky sexual behaviours in the context of crystal meth use and the consequences of such risky sexual behaviours. A large amount of the literature will refer to methamphetamine and not specifically to crystal methamphetamine, which is due to the dearth of literature on crystal methamphetamine and risky sexual behaviours; and the fact that crystal methamphetamine falls under the group of methamphetamine-type stimulants. The last section of this chapter will consist of a risk behaviour model for the period of adolescence, MacDonald's scale of drug use and abuse stages, as well as a description of my theoretical framework and its linkage to my study.

2.1 Crystal methamphetamine

Methamphetamine falls under the group of amphetamine-type stimulants (Schifano, Corkey & Cuffolo, 2007). It stimulates the central nervous system (Buxton & Dove, 2008; Degenhardt et al., 2009; National Institute of Drug Abuse, 2002; Saul, 2005 in Russell et al., 2008); and also affects the brain (National Institute of Drug Abuse, 2002; Saul, 2005 in Russell et al., 2008). Methamphetamine induces a feeling of great pleasure, which is due to the excess production of dopamine (National Institute of

Drug Abuse, 2002). Melis and Argiolas, 1995 in Corsi and Booth (2008) explains that the excess dopamine production and feeling of great pleasure is the reason why individuals crave for the drug when they do not have it, because they want to attempt to reach that state of pleasure again. Adding to this explanation Corsi and Booth (2008) emphasise that methamphetamine creates a rapid high, which is followed by an immediate low, which is caused by a rapid tolerance that develops within minutes of using the methamphetamine. The Illicit Drug Reporting System in Australia suggests that there are at least four forms of methamphetamine which is considered distinct products (Topp, Degenhardt, Kaye, & Darke, 2002 in Degenhardt & Topp, 2003). These are: (1) 'speed' a powdered form of methamphetamine; (2) 'pills'; (3) 'base' or 'paste', which is gummy, pasty or oily form of methamphetamine; and (4) 'crystal methamphetamine' which is produced as translucent to white crystals that are usually smoked or injected (Topp et al., 2002 in Degenhardt and Topp 2003). Amongst these four forms of methamphetamine it was found that crystal methamphetamine is the most purified form (Topp et al., 2002 in Degenhardt and Topp 2003; Schifano et al., 2007).

Crystal methamphetamine, which is the focus drug for this study, is known as ice, glass, tina, Christine, yaba, and crazy medicine (Schifano et al., 2007) as well as crystal, fire, crank, meth, and chalk (Greydanus & Patel, 2005). There are many additional street names for crystal methamphetamine, but in the Western Cape it is more commonly known as 'tik' (Berg, 2005; Kapp, 2008; Kredo & Blockman, 2007). For this study 'crystal meth' or 'crystal methamphetamine' will be used. The most

common form of intake is orally; and for recreational purposes it is via smoking, swallowing, injecting, anal insertion or into the urethra (Ellison & Dobies, 1984 in Schifano et al., 2007). Injecting and smoking are the fastest mechanism, which is followed by snorting, anal insertion, and swallowing (Schifano et al., 2007). According to Schifano et al. (2007) the smoked form of crystal meth has a more pronounced psychoactive effect. It must be heated to achieve the desired smoke, and is commonly smoked in glass pipes or in aluminum foil with a flame underneath (Schifano et al., 2007). Therefore, the smoked form may have a higher potential for dependence (Degenhardt et al., 2010; Greydanus & Patel, 2005). Degenhardt et al. (2010) found methamphetamine users are more likely to smoke or inject the drug in countries where the crystal form of methamphetamine is available. In South Africa it was found that 90% of the users at rehabilitation centers smoked the drug (Degenhardt et al., 2010), which is indicative of the high dependence in South Africa.

2.2 Age of onset

A study on 352 Californian methamphetamine users found that the average age of onset for methamphetamine was 19 years (Brecht, Greenwell & Anglin, 2007). For this group the onset of regular methamphetamine use only occurred in almost two years after their initial use (Brecht et al., 2007). Likewise, another study found that the average initiation age for methamphetamine use, for both males and females, was approximately 18.98 years (Brecht, O'Brien, von Mayhauser & Anglin, 2004). In addition, gender differences in age of onset for methamphetamine indicate that

females are younger than males when they first start using the drug. Hser, Evans and Haung (2005) reported a significantly earlier age of onset in women in comparison to men for methamphetamine use in California with men having an average onset age of 20.6 years and women 19.2. Therefore, in terms of age the literature indicates that adolescents are a vulnerable group for methamphetamine use. This may be more so for the female adolescent who is susceptible to initiating methamphetamine use earlier than males.

2.3 Dependence

Though methamphetamine abuse has become a major concern due to its increased use over the past decade, little is known about the patterns of drug use development for this drug (Brecht et al., 2007). However, the literature suggests that females are more likely than males to use methamphetamine. In a study for treatment seeking for methamphetamine users in Californian it was found that older adolescent females (17-18 years) were more likely to use methamphetamine than younger adolescents (13-14 years) and adolescent males (17-18 years) (Rawson, Gonzales, Obert, McCann & Brethen, 2005). Therefore, this study indicated that age and sex were predictors of methamphetamine use (Rawson et al., 2005). In their study, Brecht et al., (2004) found that females transitioned from initial to regular use of methamphetamine more quickly than males. Another study, for the age group 9-18 years, found that girls had a higher dependence than boys (Kim & Fendrich, 2002). In addition, a systematic review on methamphetamine use among populations 18 years and younger found that

being female was significantly associated with methamphetamine use (Russell et al., 2008). While, two other studies found a significant association which indicates that males are more likely than females to use methamphetamine (Russell et al., 2008). This gender difference in methamphetamine use, especially for adolescence, is indicative of female adolescents as a risk population for methamphetamine use.

2.4 Effects of crystal meth abuse

Morojele, Brooks and Kachieng'a (2006) found that adolescents' perceptions regarding the pharmacological effects of drugs are that it brings about sexual arousal, impaired judgement and lowered inhibitions. Likewise, George, Rogers & Duka, (2005) found that that alcohol and illicit drug use may impair judgement and decision-making and thus lead to risky sexual behaviours. Adrian (2006) also emphasised that such impaired judgement may lead to unprotected sexual behaviours. Becker and Murphy, 1988 in Adrian (2006) further emphasised that this impaired judgement may be further compromised by poor decision making skills where the individual is more concerned with the immediate gratification of attaining a drug and not its long term effects.

The literature indicates various effects of crystal meth, which fall under the umbrella of physical, physiological and mental effects. The physical effects include feeling powerful and confident (Buxton & Dove, 2008; Degenhardt et al., 2010; Marcelle, 1999 in Russell et al., 2008), endless energy (Buxton & Dove, 2008; Degenhardt et

al., 2010; Degenhardt & Topp, 2003; Marcelle, 1999 in Russel et al., 2008; Schifano et al., 2007), increased productivity (Batki & Harris, 2004; Buxton & Dove, 2008; Marcelle, 1999 in Russel et al., 2008), sleeplessness (Brecht et al., 2004; Dawe, Davis, Lapworth, McKetin, 2009 in Plüddeman, Flisher, Mcketin, Parry & Lombard, 2010), skin problems (Brecht et al., 2004), dental decay (Davey, 2005); enhanced sexual performance and arousal (Brecht et al., 2004; Buxton & Dove, 2008; Degenhardt et al., 2010; Degenhardt & Topp, 2003; Diaz et al., 2005; Halkitis, Fischgrund & Parsons, 2005; Marcelle, 1999 in Russel et al., 2008; McKirnan et al., 2001 in Degenhardt et al., 2010; Ross, Mattison, & Franklin, 2003), sexual disinhibition (Lorvick, Martinez, Gee & Kral, 2006; Wechsberg et al., 2008), loss of appetite (Buxton & Dove, 2008; Degenhardt et al., 2010, Schifano et al., 2007), and a sense of euphoria (Buxton & Dove, 2008; Degenhardt et al., 2010; Marcelle, 1999 in Russel et al., 2008). With regards to the sexual effects of methamphetamine Corsi & Booth (2008) emphasised that methamphetamine use may leave an individual helpless to protect themselves against risk behaviours due to the nature of the drug and the influence it has over the individual's brain.

The physiological effects include an elevated blood pressure (Degenhardt et al., 2010; Marcelle, 1999 in Russel et al., 2008; Schifano et al., 2007), an elevated heart rate (Degenhardt et al., 2010; Marcelle, 1999 in Russel et al., 2008; Schifano et al., 2007), hyperthermia (Saul, 2005 in Russel et al., 2008; Slavin, 2004 in Russel et al., 2008; 2000 in Russel et al., 2008), chest pain (Saul, 2005 in Russel et al., 2008; Slavin, 2004 in Russel et al., 2008; Wray, 2000 in Russel et al., 2008), increased respiration

(Saul, 2005 in Russel et al., 2008; Slavin, 2004 in Russel et al., 2008; Wray, 2000 in Russel et al., 2008).

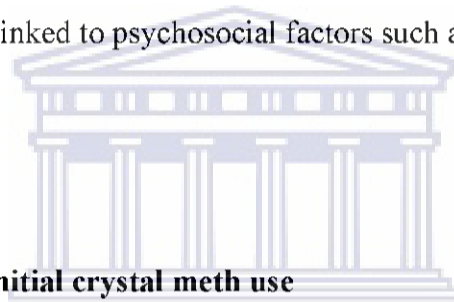
Other negative effects include anxiety (Buxton & Dove, 2008; Degenhardt & Topp, 2003; Saul, 2005 in Russel et al., 2008; Slavin, 2004 in Russel et al., 2008; Wray, 2000 in Russel et al., 2008), depression (Buxton & Dove, 2008; Degenhardt & Topp, 2003), mental confusion (Buxton & Dove, 2008; Degenhardt & Topp, 2003; Saul, 2005 in Russel et al., 2008; Slavin, 2004 in Russel et al., 2008; Wray, 2000 in Russel et al., 2008), fatigue and headaches (Buxton & Dove, 2008; Saul, 2005 in Russel et al., 2008; Slavin, 2004 in Russel et al., 2008; Wray, 2000 in Russel et al., 2008).

Long term effects of crystal meth use include paranoia (Brecht et al., 2004; Buxton & Dove, 2008; Degenhardt & Topp, 2003; Plüddeman et al., 2010; Saul, 2005 in Russel et al., 2008; Slavin, 2004 in Russel et al., 2008; Wray, 2000 in Russel et al., 2008), violence (Brecht et al., 2004; Buxton & Dove), aggressiveness (Plüddeman et al., 2010; Saul, 2005 in Russel et al., 2008; Slavin, 2004 in Russel et al., 2008; Wray, 2000 in Russel et al., 2008) and weight loss (Brecht et al., 2004; Buxton & Dove, 2008; Saul, 2005 in Russel et al., 2008; Slavin, 2004 in Russel et al., 2008; Wray, 2000 in Russel et al., 2008). Like violence and aggressiveness the long term use of crystal meth was also found to lead to homicidal and suicidal ideation (Klasser & Epstein, 2005). In their study Brecht et al. (2004) found that 27% of methamphetamine users in their study had attempted suicide. Interestingly, a review on gender differences in methamphetamine use highlights that violent behaviours are more characteristic of female methamphetamine abusers than male abusers (Hser et

al., 2005; Zweben et al., 2004). Another long term effect is the irritability and psychosis known as 'tweaking', which may result in the user having many scabs from picking imaginary insects crawling on or under his/her skin (Buxton & Dove, 2008).

2.5 Factors contributing to initial crystal meth use

Some of the perceived positive effects can be linked to the reasons for initiating crystal meth use or the prolonged use of it. However, the reasons for initial crystal meth use can also be linked to psychosocial factors such as the family environment and other stressors.



2.5.1 Reasons for initial crystal meth use

Morojele et al. (2006) found that adolescents' dominant explanation for their peers' drug use was that it was positively reinforcing, which included pleasurable consciousness states and heightened attention. In addition, peer pressure, modeling of parental and peer behaviour and accessibility to drugs also contributed to drug use (Morojele et al., 2006). Likewise, in a study on methamphetamine it was found that the participants were predominantly introduced to crystal meth by a friend, followed by spouses, boyfriends, girlfriends, family members other than parents, parents, coworkers, dealers, and others (Brecht et al., 2004). Brecht et al. (2004) also emphasised that females were more likely than males to be introduced to methamphetamine and continue to gain access to it via their spouses or boyfriends.

Another study found peer pressure to be a risk factor for methamphetamine use (Sattah et al., 2002 in Russell et al., 2008).

Recreationally it is used to experience increased socialability, loss of inhibitions, a sense of escape, or to enhance sexual encounters (Diaz, Heckert, & Sanhces, 2005; Halkitis et al., 2005; McKirnan, Vanable, Ostrow & Hope, 2001 in Degenhardt et al., 2010; Ross et al., 2003). Likewise other studies indicate wanting to enhance sexual encounters (Brecht et al., 2004; Buxton and Dove, 2008; Degenhardt & Topp, 2003; Dluzen & Liu, 2008), and wanting to escape as reasons for initial methamphetamine use (Brecht et al., 2004). In their study among “black” and “coloured” women in the Western Cape, South Africa Wechsberg et al. (2008) found that alcohol, cannabis, and methamphetamine was used as a coping strategy for interpersonal conflicts, and physical, sexual and emotional abuse. Likewise, in their sample of methamphetamine users Brecht et al. (2004) found that a significantly higher amount of females (44%) experienced childhood sexual abuse than males (24%); and more females than males reported physical abuse during their childhood. Likewise, a study on street kids found that the use of methamphetamine was a means to cope with negative emotions (Bungay et al., 2006 in Buxton and Dove, 2008). Other reasons for methamphetamine use include wanting to get high (Brecht et al., 2004), to have fun (Brecht et al., 2004), to get energy (Brecht et al., 2004; Buxton and Dove, 2008; Degenhardt & Topp, 2003); to experiment (Brecht et al., 2004); having friends who facilitated the initiation (Brecht et al., 2004), staying awake (Brecht et al., 2004; Bungay et al., 2006

in Buxton and Dove, 2008), losing weight (Brecht et al., 2004), and to work more (Brecht et al., 2004; Chouvy & Meissonnier, 2004 in Degenhardt et al., 2010).

2.5.2 Gender differences in the reasons for initial crystal meth use

One of the reasons that makes crystal meth popular is its aphrodisiac effect (Rang & Dale, 2003 in Schifano et al., 2007), which causes increased libido, delayed ejaculation, longer intercourse, and decreased humoral secretions causing raw genitalia, which may contribute to increased chances of sexually transmitted infections (Gay & Sheppard, 1972 in Schifano et al., 2007). However, Cretzmeyer et al. (2003) reported that the main reason for women and men using methamphetamine was its easy availability; and the second most common reason for using methamphetamine for women was increased productivity and for males it was curiosity. In addition to these gendered reasons Buxton and Dove (2008) indicates that women are more likely than men to use crystal meth for weight loss purposes; while men are more likely to use crystal meth to improve their sexual performance. Another study found that five times the percentage of females than males attributed their initial methamphetamine use to a desire to lose weight (36% vs. 7%), and more females reported using methamphetamine for energy than males (Brecht et al., 2004). On the other hand males were more likely than females to report using methamphetamine due to the desire to work more hours (Brecht et al., 2004). However, in their review on gender differences in methamphetamine use Dluzen and Lui (2008) found that for both women and men sexual thoughts, behaviours and activities were enhanced with the

use of methamphetamine. More importantly, a study focusing on crystal methamphetamine use identifies the relationship between crystal methamphetamine and sexual disinhibition and sexual pleasure as an important aspect of sexual risk behaviours (Lorvick, Martinez, Gee & Kral, 2006). Another study found that 27% of the sample reported usually engaging in sexual activity while using crystal meth, and 22% reported intense sexual arousal related to crystal meth use (Degenhardt & Topp, 2003).

2.5.3 Family environment

The literature indicates that the family environment can present risk factors as well as protective factors for drug use. This can be in a number of ways including parental monitoring and the lack thereof, family cohesion and the lack thereof, exposure to family violence, and family history of drug use. According to Cardoso and Verner (2007) the impact of the family background and the occurrence and timing of family events are important factors to consider in youth risk-behaviour.

2.5.3.1 Parental monitoring

According to Kliewer et al. (2006) parental monitoring refers to the extent that parents keep track of their adolescents, and know with whom and how they are spending their time. In this light parental monitoring can serve as a protective factor, because the adolescent will know that there are boundaries to his/her behaviour, and that their parent(s) will check up on them (Kliewer et al., 2006). This may reduce the

opportunities to use drugs (Kliewer et al., 2006). An explanation provided by Kliewer et al. (2006) is that youth who had parent(s) who knew what was going on in their lives were less likely to have problems with drugs or alcohol. In their study Kliewer et al. (2006) found that parental monitoring were negatively associated with risk of exposure to drug use and with problems with drugs and alcohol. Likewise, Benjet et al. (2007) found that adolescents in their study with high parental monitoring had 64% less odds of drug use. A study on childhood factors preceding drug injection found that injection drug users scored significantly low for measures of parental monitoring during their childhood (Corsi, Winch, Kwiatkowski & Booth, 2007). For Corsi et al. (2007) the lack of parental monitoring and involvement may lead to early initiation of drug use.

The literature linked specifically to methamphetamine also link parental monitoring to adolescent methamphetamine use. In a systematic review on methamphetamine use in youth it was found parental monitoring was found to be a protective factor among youth at risk (Shillington et al., 2005). Another study on adolescent methamphetamine use found that parental monitoring had a significant relationship to the males in the study, but not to the females (Embry, Hankins, Biglan & Boles, 2009). Linked to this is the finding that females in this study were more likely to use methamphetamine if their parents did not enforce rules or if this reinforcement was inconsistent (Embry et al., 2009).

2.5.3.2 Family cohesion

According to Kliewer et al. (2006) family cohesion reflects an environment where there is mutual care among the members and they enjoy spending time together. Kliewer et al. (2006) emphasised that adolescents who have a sense of family connectedness may be less likely to use substances. In their study Kliewer et al. (2006) found that family cohesion were negatively associated with risk of exposure to drug use, and problems with drugs and substances. The specific reasons why family cohesion served as a protective factor in this sample included having a sense that they matter to their parent(s), they may have had their needs for safety and security met more than youth with a lesser sense of family cohesion, which may reduce the need for stress reduction via substances, and parents in cohesive families are more likely to monitor their children (Kliewer et al., 2006). Likewise, according to Garbarino, 1999 in Kliewer et al. (2006) a sense of mattering to someone is consistently identified as a protective factor in resilience research.

2.5.3.3 Family history of substance abuse

Research indicates that parental substance use may be associated with adolescent methamphetamine use (Rawson et al., 2005; Yen, Yang & Chong, 2006). Likewise, Benjet et al. (2007) found that adolescents in their study whose parents have had drug problems have more than twice the odds of lifetime drug use than those adolescents who have dropped out of school. On the other hand Benjet et al. (2007) found that parental drug problems were not associated with the adolescent's continued drug use

in the preceding 12 months. Another study which was specifically related to methamphetamine, found that family history of drug misuse was significantly associated with methamphetamine use (Miura, Fujiki, Shibata & Ishikawa, 2006).

2.5.3.4 Additional family dynamics identified as risk factors for drug use

Research indicates additional familial factors that may contribute to initial substance use of an adolescent, which include a violent family environment (Cardoso & Venter, 2007; Kliwer et al., 2006), parent's divorce (Brecht et al., 2004; Cardoso & Verner, 2007; Rawson et al., 2005), family dysfunction (Greydanus & Patel, 2005), family instability (Benjet et al., 2007), living in a single-headed household (especially with mothers) (Rawson et al., 2005), and poor relationships with stepparents (Rawson et al., 2005). Likewise, Murray in Bachanas et al. (2002) found that adolescents from mother-alone or mother-absent families tend to become sexually active at a younger age.

2.5.4 Gateway Model

According to the Gateway Model the use of one drug progresses from no drug use to beer or wine, which is followed by the use of cigarettes or hard liquor, to marijuana, and eventually to other illicit drugs (Kandel & Logan, 1984 in Greydanus & Patel, 2005). According to Greydanus and Patel (2005) this model is associated with observations that youth start with chemicals that are easily available and affordable to them, and many progress to other substances that are socially acceptable as

opportunities change from early to middle and late adolescence. The literature indicates that methamphetamine use occurs after gateway drugs such as marijuana, alcohol and cigarette smoking. In a study of 352 methamphetamine users Brecht, et al. (2007) found that nearly 95% of methamphetamine users used alcohol, marijuana, and tobacco before proceeding to the use of methamphetamine. Here, the onset age for gateway drugs were from the ages 13-14, and initiation into methamphetamine use at age 19 (Brecht et al., 2007). Another study indicates that only 20% of participants reported that methamphetamine replaced another drug (Brecht et al., 2004). Likewise, Rawson et al. (2005) indicate a development pattern of initial use of various substances where methamphetamine follows alcohol and marijuana use. Therefore, one can assume that some individuals progress from the gateway drugs to crystal methamphetamine.



2.6 Risky sexual behaviours

2.6.1 Trading sex for drugs or money

In comparison with non-meth users Simbayi et al. (2006) found that crystal meth users were more likely to exchange sex for money or material. This is in line with findings from other literature indicating that methamphetamine users exchange sex for money or drugs (Brecht et al, 2004; Mehrabadi et al., 2007; Morojele et al., 2006; Parry et al., 2008). Sawyer, Wechsberg and Myers (2006) also found that “Coloured” women often trade sex for drugs. Nemoto, Operario and Soma (2002) found that 16% of Filipino methamphetamine users in San Francisco had sex in exchange for drugs or

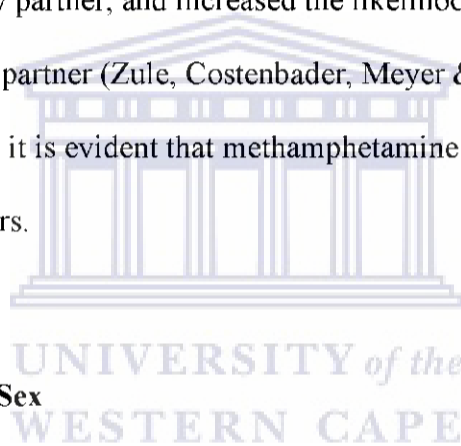
money; 25% had given drugs or money to an individual for sex; and 6% reported giving or receiving money or drugs in exchange for sex. In addition, it was found that many sex trade workers are willing to have unprotected sex with their clients if the clients are paying more for the services provided (Parry et al., 2008). In a study in Cape Town, South African participants agreed that having unsafe sex for drugs was one of the high-risk sexual behaviours when using drugs (Parry, Petersen, Carney, Dewing & Needle, 2008). In the light of these findings, selling sex puts the individual at further risk for risky sexual behaviours.

2.6.2 Number of Sex Partners

The literature indicates that substance use predisposes individuals to having multiple sex partners. A study on 5745 adolescents indicated that those individuals who had multiple sexual partners were 3.5 times more likely to use alcohol or drugs before the most recent sexual intercourse (Yan et al., 2007).

Simbayi et al. (2006) found that meth users reported having a greater number of sexual partners in comparison to non-meth users. A study among women found that the odds of having more than 5 sexual partners over a period of 6 months were significantly higher for methamphetamine users than among non-methamphetamine users (Lorvick et al., 2006). Another study focusing on female methamphetamine users indicated that they had multiple sex partners (Semple, Grant & Patterson, 2004). In a study on Filipino methamphetamine users in San Francisco it was

reported that of the 85% participants who engaged in sex in the preceding 6 months, 53% had sex with more than one partner, and 83% of sexually active participants had sex at least once a week (Nemoto et al., 2002). According German et al. (2008) women using methamphetamine, who have multiple sexual partners, are likely to have a partner who uses methamphetamine, and are likely to receive less emotional support from their partners which may present further barriers to safer sex. In addition methamphetamine by either or both partners also increased the odds of having sex with a new partner, and increased the likelihood that individuals will have more than one sexual partner (Zule, Costenbader, Meyer & Wechsberg, 2007). In the light of these findings it is evident that methamphetamine makes its users vulnerable to multiple sex partners.



2.6.3 Unprotected Sex

Studies indicate that drug use increases the chance of unprotected sex. A study consisting of 5745 adolescents found that substance use was significantly associated with unprotected sexual behaviours (Yan et al., 2007). The findings also indicated that boys were less likely than girls to report having unprotected sex (Yan et al., 2007). In contrast, Morojele et al's. (2006) study found that while adolescent males know the risks of unprotected sex they did not use condoms.

Simbayi et al. (2006) found that meth users were significantly more likely to use condoms than non-meth users, which suggests less sexually risky behaviours.

However, only less than half of the intercourse occasions were condom protected and occurred with more partners than non-meth users. According to Wechsberg et al., (2008) the women in their study were more likely to have unprotected sex when they were under the influence of alcohol and other drugs including crystal methamphetamine. A study on Filipino methamphetamine users in San Francisco found that 44% of participants never used a condom during the preceding six months; while 21% used condoms less than half the time (Nemoto et al., 2002). In addition, Zule et al. (2007) found that more than half of methamphetamine users did not use a condom during vaginal sex (54%), and more than half did not use a condom during anal intercourse (52%). From the literature it is evident that the lack of condom use as contributing to risky sexual behaviours among drug users, especially methamphetamine addicts is a serious concern.

Corsi and Booth (2008) also emphasise that in some cases where there is a power struggle females cannot negotiate condom use in the face of a possible violent partner who is high on methamphetamine. In addition, when the female is high on methamphetamine herself she may not think to ask or desire that her partner use a condom (Corsi & Booth, 2008). However, due to methamphetamine producing pleasurable sexual effects for the user it may be difficult to expect risk behaviours to change in the context of methamphetamine use (Corsi & Booth, 2008). Issues such as condom use negotiation, and the possible lack of desire to negotiate condom use in the context of methamphetamine use by either or both sexual partners has not been explored in the methamphetamine population. However, Corsi and Booth (2008)

emphasise the importance of considering such factors in the light of risky sexual behaviours among methamphetamine users.

2.6.4 Anal intercourse

In a study among women who inject methamphetamine it was found that they have higher odds for anal intercourse and unprotected anal intercourse (Lorvick et al., 2006). Another study amongst injection drug users found that the use of methamphetamine by either or both partners increased the odds of having unprotected anal intercourse, protected anal intercourse, and vaginal and anal intercourse during the same encounter, with the exception of unprotected vaginal intercourse (Zule et al., 2007). Here, most encounters involving anal intercourse also involved vaginal intercourse (Zule et al., 2007). According to Zule et al. (2007) receptive anal intercourse increases the risk of HIV, which is likely to increase when vaginal and anal intercourse occur during the same encounter, because there is a greater likelihood of condom failure or improper condoms use.

2.7 Consequences of Risky Sexual Behaviours

2.7.1 Unplanned or unwanted pregnancy

An American study on high school students found that heavy crystal methamphetamine users were more than four times as likely to report having been or having gotten someone pregnant (Springer et al., 2007). Likewise, studies identify drug use as a risk factor for early initiation of sexual intercourse (French, 2003) as

well as sexual risk behaviours, which may lead to unplanned pregnancies (Cepeda & Valdez, 2003; Kaplan & Erickson, 2002).

2.7.2 Sexually transmitted infections

Sexually transmitted infections (STI's) are also identified as a consequence of risky sexual behaviours (Spittal et al., 2003; Tortu et al., 2000). In the U.S.A. two studies indicated self-reported prevalence of STI's among crystal methamphetamine users as 28% and 29% (Semple et al., 2004a, 2004b). A study on 83 Filipino methamphetamine users in San Francisco found that 7.2% of the total sample had been diagnosed with an STI of which 2.4% were vaginal candidiasis and 2.1% each with hepatitis B, gonorrhoea, Chlamydia, and trichomoniasis (Nemoto et al., 2002). In addition, Lorvick et al. (2006) emphasised that unprotected heterosexual anal sex puts women at a high risk for STI's that is more typically suffered by gay men, such as rectal gonorrhoea. Anal sex is a more efficient manner of HIV transmission than vaginal sex (Lorvick et al., 2006).

A study on 5745 adolescents found that alcohol and drug use before sex were associated with all STI/HIV risk behaviors including having multiple partners and unprotected sex (Yan et al., 2007). Likewise, another study on methamphetamine use and risky sexual behaviours during heterosexual encounters indicate that it involved sexual behaviours that placed the individuals at risk for HIV and other STIs (Zule et al., 2007). This was the case especially when both partners used methamphetamine

(Zule et al., 2007). Other studies which indicate an association between methamphetamine use and risky sexual behaviours include (Bolding, Hart & Elford, 2006; Brecht et al., 2004; Corsi & Booth, 2008; Mehrabadi et al., 2007; Morojele et al., 2006; Parry et al., 2008; Nemoto et al., 2002; Simbayi et al., 2006; Springer et al., 2007; Wechsberg et al., 2008), which is indicative of the high risk attached to crystal methamphetamine use and STI's.

2.7.3 HIV infections

According to Cepeda and Valdez (2003) risky sexual behaviour in the context of drug use may explain the increasing rates of HIV/AIDS. In recent years the increase of crystal methamphetamine has been closely tied to an increase in HIV infection, which is due to sexual risky behaviours associated with crystal methamphetamine use (Bolding et al., 2006; Parry et al., 2008; Simbayi et al., 2006; Wechsberg et al., 2008, Zule et al., 2007). A rapid assessment which was undertaken in the South African cities of Cape Town, Durban and Pretoria examined the links between drug use, high-risk sexual practices, and HIV in vulnerable drug using populations including sex-workers, men who have sex with men, injecting drug users and non-injecting drug users (Parry et al., 2008). In this study it was found that crystal methamphetamine was widely used in Cape Town where it was commonly used with sex (Parry et al., 2008). Here interviewees generally agreed that high-risk sexual behaviours were linked to drug use and that people were less cautious when using drugs (Parry et al., 2008). The study found that 28% of key informants tested HIV-positive, with sero-

positivity being highest among men who have sex with men and sex workers (Parry et al, 2008).

2.8 The prototype/willingness model of adolescent risk behaviour

According to Gerrard, Gibbons, Houlihan, Stock and Promery (2008) dual-process models agree that there are two different modes of information processing that takes place in decision making. One mode is based on heuristics and affect, and the other mode is a more deliberate, systematic reasoning (Gerrard et al., 2008). In general the prototype model assumes that to a great extent initial adolescent risk behaviour is not intended or planned, but is a response to circumstances that are risk conducive (Gerrard et al., 2008). It is related to other dual processing models, because it is based on the assumption that there are two types of decision making in health behaviour (Gerrard et al., 2008). For the prototype model the two modes of information processing is the reason path, which is similar to the theory of reasoned action; and the social reaction path (Gerrard et al., 2008). The reasoned path is more analytic in its processing and the social reaction path is image based and involves more heuristic processing (Gerrard et al., 2008, Sunstein, 2008). The social reaction path is assumed to explain adolescent unintended behaviour, especially in their decisions to start, continue, or stop behaviours that can put their health at risk (Gerrard et al., 2008). Therefore, the adolescent's risk behaviour may be a product of imaged-based decision making even in the case where the adolescent does not intend to engage in risk behaviour (Sunstein, 2008). This involves the constructs of risk prototypes,

which are images of people who engage in risk behaviours; and behavioural willingness, which indicates openness to engage in risky behaviour (Gerrard et al., 2008).

The reasoned path stems from positive attitudes towards performing a behaviour and supportive subjective norms, and then passes through intentions, which informs the intentional component of some adolescent risk behaviour (Gerrard et al., 2008; Hukkelberg & Dykstra, 2009). The reasoned path portrays the adolescent as a rational and reasoned individual who considers the positive and negative outcomes with its expected use to the adolescent (Hukkelberg & Dykstra, 2009). Therefore, the proximal antecedent to behaviour is intention, which is like theories of reasoned action and planned behaviour (Gerrard et al., 2008). The social reaction path's proximal antecedent is behavioural willingness, which acknowledges that many risk behaviours are not intentional and that adolescents often find themselves in situations that are conducive to risk behaviours (Gerrard et al., 2008). An example of this type of situation is an unsupervised party where substances are freely available. Here, social reaction is operationalised as behavioural willingness to risk opportunities, which indicates the adolescent's vulnerability to engage in risk behaviours when the opportunity is presented (Hukkelberg & Dykstra, 2009; Gerrard, Gibbons, Stock, Vande Lune & Cleveland, 2005). Therefore, it is often not a reasoned decision that takes place, but one that is determined by the adolescent's willingness to act out a certain behaviour (Gerrard et al., 2008), which is often brought about by situational influences that facilitate risk behaviours (Gerrard et al., 2005). For Gibbons, Gerrard

and Lane (2003) in Hukkelberg and Dykstra (2009) behavioural willingness involves little pre-contemplation, and has been found as a better predictor of behaviour in young people than intention.

2.8.1 Image-based decision making

According to Gerrard et al. (2008) a major assumption of the prototype model is that children and adolescents have clear social images (prototypes) of the type of individual who engages in specific risk behaviours, e.g., the typical substance user of their age. Therefore, instead of a physical representation of the individual, the image is a typology of the type of person who gets involved in risk behaviour (Gerrard et al., 2008). Following the imaging the adolescent will realise that if they get involved in the behaviours in public or with friends, they will acquire aspects of the image themselves (Gerrard et al., 2008). For example, if they perceive a drug user to be someone who is free of problems or socially more attractive, then they will gain that image should they engage in drug use. Therefore, the more favourable the image, the more likely the adolescent would be to adopt the behaviour and accept the consequences associated with it (Gerrard et al., 2008, Sunstein, 2008); and the less favourable the image the less willing they will be to engage in the risk behaviour (Gerrard et al., 2005). Evidence of the social reaction path has been demonstrated in literature on sexual risk behaviours (Gibbons & Gerrard, 1995 in Gerrard et al., 2008; Thornton, Gibbons, Gerrard & Gibbons, 2002); and smoking and drinking behaviour

(Gerrard et al., 2005; Spijkerman, van den Eijnden, Vitale & Engels, 2004; Spijkerman, van den Eijnden & Engels, 2005).

2.8.2 Perceived personal vulnerability

Conditional perception of vulnerability, which is another antecedent of willingness, is the perception of the extent to which the individual is vulnerable to the various risks associated with risk behaviour (Gerrard et al., 2008). In older adolescents Gibbons et al., 2002 in Gerrard et al. (2008) found that low conditional vulnerability can lead to higher willingness to engage in risk behaviours; and higher willingness can lead to lower perceived personal vulnerability. According to Gerrard et al. (2008) these are characteristics of high willingness in adolescents who are more likely to have an optimistic bias, and who process information in a more superficial manner in that they focus more on the immediate rewards instead of the long term risks. Therefore, the adolescent may not perceive her/himself as becoming susceptible to risky sexual behaviours in the context of crystal meth use, and consequently proceed in the drug use. Gerrard et al. (2008) contends that the more willing the individual is the more likely he/she will engage in risky behaviours.

2.8.3 Willingness and intentions

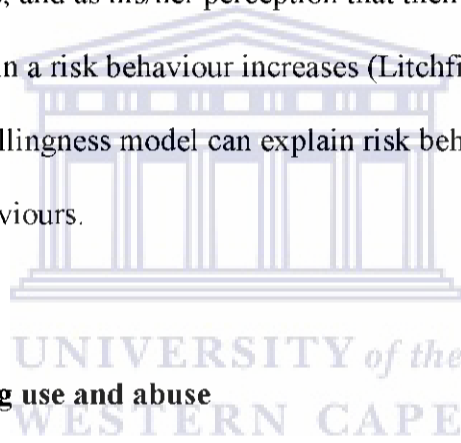
According to Gibbons et al., 2002 in Gerrard et al. (2008) subjective norms or perceptions, as in the theory of reasoned action, are linked to greater intention and greater willingness to engage in risk behaviour. Likewise, positive attitudes towards a

behaviour can also increase the chances of engaging in it (Gerrard et al., 2008).

However, unlike the theory of reasoned action, the prototype model includes prior behaviour as a precursor to favourable attitudes toward a behaviour (Bentler & Speckart, 1981 in Gerrard et al., 2008), positive subjective norms (Gerrard, Gibbons, Benthin, & Hessling, 1996 in Gerrard et al., 2008), and intention and willingness to engage in it. In addition Gerrard et al. (2008) indicates that primary factors associated with prototype favourability also include individual differences in self-control, parenting and parent behaviours, friends' behaviour, and media exposure. Gerrard et al. (2008) emphasised that as the behaviours associated with prototypes become more normative, it is logical that risks prototype become more favourable and non-risk prototypes become less favourable. There are also a number of contextual factors that moderate the influence of these variables on prototypes and willingness (Gerrard et al., 2008). Gibbons et al, 2002 in Gerrard et al. (2008) found that social influence factors such as 'friends' were significantly stronger predictors of willingness than intention. Whereas, parenting style and parent substance use were both antecedents to the adolescent's intention to use, but not their willingness to use (Gerrard et al., 2008). Here, Gerrard et al (2008) interpreted that parents activate reasoned or deliberate processing in their children through parent-child discussions or via modeling certain types of behaviours. Sunstein (2008) emphasise that due to the more analytic system some social influences seem to affect the adolescent's conscious intentions, but do not affect their actual behaviour.

2.8.4 Summarising the prototype/willingness model

In summary this model argues that model, attitude, subjective norms, and prototypes are described as influencing adolescent risk behaviour indirectly (Litchfield & White, 2006). An important aspect of this model is that the proposition that the adolescent's attitude towards engaging in risk behaviour is directly linked to his/her image of the typical person who performs this risk behaviour. Furthermore, the adolescent's willingness to engage in behaviour increases as his/her attitude towards a behaviour become more positive, and as his/her perception that their significant other would want them to engage in a risk behaviour increases (Litchfield & White, 2006). In this light the prototype/willingness model can explain risk behaviours such as drug use and risky sexual behaviours.



2.9 Stages of drug use and abuse

The MacDonald scale which outlines the stages of drug use and abuse propose five stages (Hogan, 2000 in Greydanus & Patel, 2005). During the initial stage 0 there is no obvious drug use, there is curiosity about drugs, low self-esteem, the need to be accepted by peers, and other factors that may predispose the adolescent to later drug use (Hogan, 2000 in Greydanus & Patel, 2005). Stage 1 is the experimental stage where the individual experience the euphoria accompanied by drug use, which is usually at weekend parties, without any obvious consequences of experimenting (Hogan, 2000 in Greydanus & Patel, 2005). During stage 2 the individual starts craving the euphoric experience, may start using other drugs, regularly buy or steal

drugs (Hogan, 2000 in Greydanus & Patel, 2005). At this stage life changes such as choosing different friends, change of clothing style, a drop in school performance and so forth may occur (Hogan, 2000 in Greydanus & Patel, 2005). This stage is also characterised by denial of drug dependence (Hogan, 2000 in Greydanus & Patel, 2005). During stage 3 the addict becomes preoccupied with experiencing the euphoria, and life becomes more out of control (Hogan, 2000 in Greydanus & Patel, 2005). Here, many of the severe consequences of drug abuse are experienced which may include depression, mood swings, acting out behaviour (Hogan, 2000 in Greydanus & Patel, 2005). Lastly, stage 4 is the 'burnout' stage where the addict seeks drugs to maintain the euphoria and to feel normal (Hogan, 2000 in Greydanus & Patel, 2005). Here, a variety of psychiatric reactions such as suicide, violence, and unpredictable behaviour can occur (Hogan, 2000 in Greydanus & Patel, 2005).



2.10 Theoretical framework

According to Giorgi (2010) phenomenology is a philosophy that was initiated by Edmund Husserl in 1900, and expanded throughout his life and after his death. Phenomenology is concerned with human existence and experience as well as the way in which phenomena are revealed in consciousness and lived experiences (Terreblanche et al., 2006). It is both a philosophic attitude and a research approach (Flood, 2010). Phenomenology's primary position is that the most basic human truths are accessible only through inner subjectivity (Thorne, 1991 in Flood, 2010), and that the individual is integral to the environment (Burns & Grove, 1999 in Flood, 2010).

Ontologically a common belief of phenomenologists as described by Boyd (2001, 96-97) in Donalek (2004) include: "Perception is original awareness of the appearance of phenomena in experience. It is defined as access to truth, the foundation of all knowledge. Perception gives one access to experience of the world as it is given prior to any analysis of it. Phenomenology recognises that meanings are given in perception and modified in analysis..." Therefore, the phenomenological approach in research aims to focus on people's perceptions of the world in which they live and what it means to them (Langdridge, 2007). According to Flood (2010) its epistemology focuses on revealing meaning instead of arguing a point or developing an abstract theory. Van Manen (1997) in Flood (2010) offers two types of meaning: (1) cognitive meaning that is concerned with the designative, informal, conceptual and expository aspects of a text, which is the semantic and linguistic meaning that makes social understanding possible, and (2) non-cognitive meaning of the text such as the evocative, expressive, transcendent, and the poetic elements, which results in the phenomenological information that enriches our understanding of everyday life. Together, both cognitive and non-cognitive meanings may be experienced as an epiphany or transformative effect, where one experiences an instinctive grasp of what is in the written text (van Manen, 1997 in Flood, 2010).

According to Cohen and Omery (1994) in Flood (2010) the two main phenomenological approaches is the descriptive approach and the interpretive approach. Husserl's philosophical ideas gave rise to the descriptive phenomenological approach to enquiry (Flood, 2010). According to Husserl (1970) in

Flood (2010) subjective information is important to scientists who seek to understand human motivation because human actions are influenced by what they perceive to be real. In describing a phenomenon, descriptive phenomenology clarifies other related ideas, and makes the reality, which these ideas are supposed to reflect understandable (Tillich in Lyons, 1963). The essential components of a lived experience are important. On the other hand for interpretative phenomenology, which has a hermeneutical foundation, Heidegger suggested that the exploration of the lived experiences or the situated meaning of a human in the world should be focused on instead of focusing on people or phenomena (Thompson, 1990 in Flood, 2010). Here, hermeneutics goes beyond the description of core concepts and essences, and looks for meanings embedded in what people experience instead of what they consciously know (Flood, 2010). Therefore, according to Heidegger in Flood (2010) this is representational of a move from an epistemological to an ontological project, which focuses on how interpretation is inherent to human existence. There are two fundamental assumptions of the interpretative approach (Parsons, 2010). The first is that humans are always relating to other people and things in the world (being-in-the-world). Therefore, people, places and all which is encountered during daily activities are not detached objects, but they are all meaningful and significant (Parsons, 2010). Following the first assumption, the second assumption is that meaning is always determined in the context of these relationships (Parsons, 2010). Therefore, Heidegger in Flood (2010) emphasised that humans are embedded in their world to the extent that their subjective experiences are linked to social, cultural, and political contexts. While individuals can make their own choices, this freedom is confined to

specific conditions of their daily lives (Flood, 2010). In this light the phenomenologist's focus will be on describing the meanings of the situated meaning of the human in the world and how these meanings influence the decisions they make, instead of merely bringing forth a purely descriptive category of the real, perceived world in the narratives of the participants (Flood, 2010).

In terms of the current study the research focus is on the sexual perceptions and the experiences of the participants in the context of their crystal meth. Therefore, in this study the participants gave meaning to their experiences and perceptions as they related it to me during their interviews. Phenomenology is interested in the "self-world" relation. It describes the meaning of lived experiences for several individuals about a concept or phenomena (Creswell, 1997). Here, researchers search for the essence or the central underlying meaning of the experiences and emphasise the intentionality of consciousness based on memory, image and meaning (Creswell, 1997). The focus is on people's lived experience (Langdridge, 2007). Therefore, the aim of the phenomenological approach is not merely to study experience and how the world appears to people (Langdridge, 2007), but to ascribe meaning to perceptions and experiences. In this study, female adolescents' experiences and perceptions in the context of crystal methamphetamine use is the core interest. These encompass their lived lives as well as their perceptions of others who experience or share this lived reality as they inevitably form part of these individuals' lives. Therefore, the phenomenological framework is deemed suitable for this research study.

2.11 Conclusion

The majority of the research that I consulted was quantitative in nature. It speaks of the need for more qualitative research in this area, because these studies do not fully represent the experiences of those for whom crystal meth use has become a reality. They lack in explaining the intricacies and dynamics at play in the life of the crystal meth addict. In relation to risky sexual behaviours of adolescents these studies present the reader with figures which is indicative of a link between risky sexual behaviours and crystal meth as well as the health consequences such as unplanned pregnancies, and STI and HIV infections. However, how do we understand such behaviours in the context of crystal meth addiction? How does the crystal meth addict make sense of his/her experiences and perceptions? In hindsight what do these experiences and their perceptions of their sexual behaviours in the context of crystal meth mean to them? My study is concerned with illuminating the participants' experiences and perceptions of their crystal meth addiction and how it fed into their sexual behaviours and their understanding thereof. In addition understanding how and why they initiated their crystal meth use, and their understating of risky sexual behaviours and the consequences thereof is also highlighted within this study. Therefore, understanding the information shared by the participants from a phenomenological perspective, and consequently analysing this information using interpretative phenomenological analysis (IPA) there is a deeper focus on the specific experiences and perceptions of the female adolescent crystal meth addict as they detailed their lived experiences and perceptions.

CHAPTER 3

METHODOLOGY:

3. Introduction

The methodological background of this study is discussed in this chapter, which includes the study design of phenomenology, detailed information of the sample, procedures, data collection, and interpretative phenomenological analysis, the credibility of the study, ethical considerations, and the significance of my study.

3.1. Research Design

As previously stated, the phenomenological framework is well suited for this research which is based on the sexual experiences and perceptions of adolescent females in the context of crystal methamphetamine use. The phenomenological approach uses research methods that allow the researcher to gain rich descriptions of concrete experiences and/or narratives of experiences (Langdridge, 2007). These methods are also known to study areas where little is known or to explore sensitive content (Donalek, 2004). This gives more credibility to phenomenology as a theoretical framework as well as a research method. This is primarily so because this study will be a valuable addition to the dearth of qualitative literature in this area as well as being a suitable method for exploring the sensitive nature of this study. In addition Donalek (2004) emphasised that research can only be truly phenomenological if the

researcher's beliefs are incorporated into the data. This refers to acknowledging the relationship that the researcher has with the research topic as well as acknowledging the researcher's thoughts, responses and decision-making throughout the entire research process.

This study employed interpretative phenomenological analysis (IPA). The aim of this specific analysis is to discover personal meanings that individuals assign to a specific experience, as it is perceived and re-constructed by them while they interact with the interviewer (Lemon & Taylor, 1997 in Tsartsara & Johnson, 2002). Influenced by phenomenology, IPA make sense of events and agree that how people talk about their experiences is unique as it is influenced by their personal cognitions (Smith, Flowers & Osborn, 1997 in Tsartsara & Johnson, 2002). According to Fade (2004) IPA is phenomenological because it seeks the insider's perspective of lived experience, and interpretative because it acknowledges the researcher's personal beliefs and standpoint and enforces the view that understanding needs interpretation.

IPA also recognises the interpretative role of the researcher during the interaction between the researcher and the participant (Smith, Osborn, Flowers & Jarman, 1998 in Tsartsara & Johnson, 2002). Traditionally this role has been subjected to the bracketing of preconceived notions or expectations of the research study (Colaizzi 1978 in Fade, 2004). However, Heidegger in Flood (2010) emphasised that it is not possible to clear one's mind of the background of understandings which has led the researcher to a specific research interest. Likewise, Smith, Jarman and Osborn (1999)

in Fade (2004) emphasised that the purpose of IPA is to attempt to gain an insider's perspective as far as possible, while acknowledging the researcher as the primary analytical tool. The researcher's beliefs are not seen as biases that should be removed but rather as being needed for gaining an understanding of the individuals' experience (Fade, 2004; Flood, 2010). In this light, reflexivity is viewed as an optional tool, which allows the researcher to acknowledge her/his interpretative role instead of being a technique for removing bias (Fade, 2004). In this study bracketing was enforced as far as not entering the interviews with a priori expectations. However, my own understanding of the phenomena aided me in understanding the participants better. In addition, reflexivity in this study had a two-fold purpose which was to help acknowledge my personal bias as well as to assist me in understanding the information shared by participants. Therefore, bringing forth a shared understanding of the participants' experiences and meaning making.

3.2. Participants

Participants were selected from drug rehabilitation centers in Mitchell's Plain and Lavender Hill, Cape Town. The sample consisted of six participants. The sampling method was purposive, which is a sample who fits specific criteria. The inclusion criteria for sampling in this study was that the participants were adolescent females ranging from 17 to 21 years who were addicted to crystal methamphetamine, and attending drug rehabilitation centers in Mitchells Plain and Lavender Hill. In addition I have also confirmed that all participants reside in these areas as it adds to the

context of this research. Consequently, this purposive sampling method characterised as a small, homogenous sample is in line with the general sampling strategy for interpretative phenomenological analysis (IPA) (Langdridge, 2007; Smith, 1995 in Tsartsara & Johnson, 2002).

3.2.1. The social context of Mitchell's Plain and Lavender Hill

The Mitchell's Plain as well as the Lavender Hill areas were products of the old Apartheid regime that was predominantly established in aid of providing housing for 'Coloureds' due to forced removals (McAlister, n.d.) from what we know today as more affluent residential areas. The social context in which residents of these areas live is that of poverty characterised by social concerns such as crime, domestic violence, drug abuse, and gangsterism (McAlister, n.d.). Therefore, the social context of both residential areas seems to be a breeding ground for social ills such as drug abuse and its by-products.

3.3. Procedures

Gaining access to drug rehabilitation centers in the Mitchell's Plain area was challenging. Initially an exhaustive list of drug rehabilitation centers were contacted telephonically. Some drug rehabilitation centers did not allow access due to their own privacy policy. At that time most of the remaining drug rehabilitation centers did not have individuals who fit the sampling criteria. In stark contrast I gained access almost immediately at the rehabilitation center in the Lavender Hill. Following this, I

provided each contact person at the various rehabilitation centres with the information sheet which informed them regarding the nature and goals of my research. In addition, I provided them with the sampling criteria for my study. This was done either via e-mail or I handed the information to them in person. Then, each contact person informed me about prospective participants who received the drug treatment through a programme which they ran at their center. Consequently, I met with the prospective participants at each center at a time and date which was convenient for them. During the meetings with the prospective participants I introduced myself to them and informed them regarding the nature and goals of the research as well as the role that they would play should they agree to participate in the study. As a further means of establishing good rapport with the prospective participants I explained to them why I have an interest in this particular research study. The prospective participants also received an information sheet (appendix A), which also explained the research study and their role as participants should they participate. At the end of all the initial meetings with the prospective participants all of them agreed to volunteer as participants. However, in the Lavender Hill area one participant was absent for the interview and another had to postpone her interview because she had to attend another interview for possible employment. It must be noted that this was during a period of extreme gang related violence in the Lavender Hill residential area, which could possibly be part reason for the two participants' absence.

At each rehabilitation center I was allowed to conduct the interviews in the privacy of an allocated office, which created an environment that was conducive to privacy as

well as freedom of speech. Before each interview commenced I briefly explained the nature and goals of the study as well as the role which they would play in the study with an emphasis on confidentiality and anonymity. In addition, I also informed them that provision for counseling was made should they feel a need for support after the interview. This was via the contact persons at each rehabilitation center, who informed me that they either had a registered counselor, a nurse or a social worker who will be available to do the counseling if needed. Subsequently, semi-structured individual interviews took place in a private office at each rehabilitation center.

3.4. Data Collection

Data collection took place in the context of the drug rehabilitation center. In keeping with IPA semi-structured interviews are usually considered when the topic is of a very sensitive nature (Welman & Kruger, 2004). Therefore, due to the sensitive nature of the participants' sexual experiences and perceptions in the context of crystal methamphetamine use, data collection proceeded by means of semi-structured individual interviews. This method of interviewing allows the interviewer to probe beyond specific questions as well as have free discussions with the interviewee (May, 2001). An interview guide (appendix C) was used as it involves a list of topics and aspects that have a bearing on the theme of the research (Welman & Kruger, 2004).

According to Welman and Kruger (2004) the order in which the interviewer brings these topics across may vary and depends on the way the interview develops.

Likewise, for this study it was found that each interview developed in a unique manner. This differed mostly per rehabilitation center as each center had its own approach to their drug rehabilitation programme. The various ways through which the interviews developed was predominantly influenced by the impression that some participants did not know what risky sexual behaviours are while others were well educated on risky sexual behaviours. On the other hand, some of the participants had an idea of what risky sexual behaviours are, but to prevent a lack of understanding or confusion I decided on defining the concept of risky sexual behaviours to most of the participants. Consequently, some received this definition as the question became more focused on risky sexual behaviours. On the other hand others received the definition closer to the end of the interview. I also established that two of the participants received thorough education on the concept of risky sexual behaviours during their drug rehabilitation, which canceled the need to provide a definition of risky sexual behaviours. Another two did not receive any education on risky sexual behaviours, which may be due the rehabilitation center being faith based.

3.4.1. Semi-structured interviews from a phenomenological perspective

According to Kvale (2007) the interviewees' lived experienced in terms of a specific phenomena is the topic of the qualitative research interview. The semi-structured interview is a sensitive and powerful method which enables the interviewees to convey their story from their own perspective (Kvale, 2007). It aids in understanding the meanings and facts of central themes of participants' lived world (Kvale, 2007).

During the semi-structured interview the interviewer encourages the participants to describe as accurate as possible what they experienced and felt (Kvale, 2007). These descriptions are also aimed at specific situations and events, which will help the participant to bring meaning to the situation (Kvale, 2007). Therefore, the aim of IPA is to facilitate the construction of the participants experience in a sensitive and empathic manner and recognising that the interview comprises a human-to-human relationship (Fontana & Frey 2000 in Denzin & Lincoln 2000). In this study such descriptions were encouraged with regards to the participants' sexual experiences in the context of crystal methamphetamine use as well as how they initially started using the drug. As the interviewer it was important for me to be sensitive, empathic and understanding to the participants lived experiences which aided in the interviewer's narratives. According to Kvale (2007) the interviewer should approach the interview with qualified naïveté and bracketing with regards to having pre-formulated questions which leads to prepared categories for analysis. This helps the interviewer to be open to new and unexpected phenomena, rather than already having categories and schemes of interpretation (Kvale, 2007). Eatough and Smith (2008) stressed that for IPA it is important that the participant is allowed a strong say in where the interview is going while asking them questions that will lead them to tell their own lived stories. Likewise, Kvale (2007) also refers to the semi-structured interview as being able to lead the participant towards certain themes, but not to specific opinions about these themes. Therefore, with this study having specific interests, the interviews were not leading but brought particular topics to the fore for discussion and exploration. In addition, the flexibility offered by semi-structured interviews as well as the ability of

the interviewer to guide the participant may serve to contain highly emotional nature of research interests' such as my study.

Kvale (2007) refers to possible ambiguity in the participants' answers where a statement can lead to more than one meaning or where contradictions may occur, which must be clarified by the interviewer. In the current studies ambiguities and contradictions were clarified by means of going back and forth during the discussions to gain clarity from the participants' side. Kvale (2007) also indicates that the participants' can change their description or meaning of a theme whereby they may discover new aspects of the themes that they are describing. Therefore, the interview may become a learning experience to the participants. This was also encountered in the current study; and was addressed in a similar manner that brings about clarity between the participant and me.

In essence semi-structured interviews was deemed an appropriate tool for data collection for this phenomenological study as it allows the participants to tell their own stories while being guided through it by the interviewer. As indicated by Kvale (2007) the researcher's interview skills plays a major role in constructing the participants' experiences and perceptions. Through good interview skills the interviews were able to proceed with the interviewer being empathic, sensitive and understanding of the participants' lived lives as well as counter any ambiguities, and an approach without any prior expectations.

3.5. Data Analysis

The method of analysis for this study was IPA (Langdrige, 2007). In this case, the researcher does not enter the research process with preconceived notions or a priori expectations (Langdrige, 2007; Potter, 1996). In essence the analyst is concerned with making sense of the participant's world (Langdrige, 2007). This leads the analyst to spend a large amount of time working through the transcripts to identify the major themes (Langdrige, 2007). The analyst reads and re-reads the transcripts and makes comments with regards to the meaning of certain sections (Langdrige, 2007). The analyst notes emerging themes, which should reflect broader and perhaps theoretically significant concerns (Langdrige, 2007).

The analytic process proceeded through a series of steps described by Smith et al. (1999) in Fade (2004). The first step is to read and re-read the transcripts several times. During this step important aspects of the each interview is noted (Tsartsara & Johnson, 2002); and an overall sense of the data should occur (Fade, 2004). During this step I was able to make notes, which indicated my thoughts on specific sections in the text. The second step involved the process of identifying themes per interview transcript. According to Tsartsara and Johnson (2002) these themes reflects the participants' view, which can be organised into groups of themes. An important aspect of this step was to compare and contrast themes that derived from each interview transcript against that of the other transcripts (Tsartsara & Johnson, 2002). Following this step, the third step entailed further development of the identified

themes into main themes. During this step coherent themes were clustered together and the super-ordinate themes were identified by looking at what the sub-themes had in common as suggested by Fade (2004). Here, themes were also dropped from the list of themes. This was dependent on whether I thought the identified themes were relevant or had enough or too little substance to form part of the identified themes. According to Tsartsara and Johnson (2002) this step aims to reveal the interviewees shared views. In the fourth step a separate table was drawn up for each super-ordinate theme which indicated where each sub-theme was linked to the raw data indicating the page and line number to which it was linked as suggested by Fade (2004). This can serve as a source of reference or to prevent confusion later in the research procedures.

For me the analysis process also entailed using my own initiative in terms of which data to include as sub-ordinate themes and sub-themes. Therefore, it was a process that required careful reflection on each individual interview. Immersing myself in the raw data, using my initiative in decision making called for a more subjective role as the researcher during this research process.

3.6. Ethical considerations

According to the codes of ethics, participants' identities and those of the research locations should be safeguarded (Creswell, 1997; Denzin & Lincoln, 2000). Due to the sensitive nature of this study ensuring the participants anonymity and enforcing

confidentiality was a very important aspect of my ethical considerations. It was also thought of as making them feel more comfortable and safe during the interviews. In addition the research locations, which were the rehabilitation centers were also safeguarded in terms of anonymity.

The participants were introduced to the study by means of providing them with information of the study. This information followed the format provided by Creswell (1997). I explained that the rights of the participants will be protected during data-collection; that they participate voluntarily and that they can withdraw at any time; the purpose of the study; the procedures of the study; that they have the right to ask questions; that they are not obligated to answer any questions which they do not want to answer; and that they can obtain a copy of the results. The information which I provided also ensured confidentiality and the means of ensuring anonymity. This information was provided to the participants verbatim as well as more detailed in the form of an information sheet (appendix A).

A consent sheet (appendix B) was developed and signed by me and the participants on the day of each interview. The consent sheet stated that the participants understand the nature of the study, that their participation was voluntarily, and that they agree to the recording of the interview.

3.7. Trustworthiness

Creswell (1998) proposed eight verification procedures to ensure trustworthiness. These include triangulation, negative case analysis, clarifying research bias, member checks and external audits (Creswell, 1998). Creswell (1998) recommends that a research study should at least use two of these methods to indicate the trustworthiness of a study. In my study the credibility of the study was ensured by employing strategies suggested by Creswell (1998). I used rich and thick descriptions to relate the research findings to the reader; self-reflection that helped clarify any bias that I may bring to the study; and the use of literature that is in opposition to or in line with the research findings. Apart from my supervisor I did not incorporate the help of others' to help check the quality of my data, transcriptions and analysis. However, the recorded interviews were checked against each transcribed interview a few times to ensure it was done without errors, and my themes were checked against the verbatim transcriptions a few times to minimise errors.

3.8. Reflexivity

I originate from and still reside in an impoverished community where crystal methamphetamine abuse is rife. Other social problems such as HIV infections, AIDS and teenage pregnancy are also highly prevalent in this area. These problems together with others such as alcohol abuse, sexual and physical abuse are social ills that I have been exposed to, and every day I am well aware of the consequences of many social problems as I see it unfold in my surrounding area. It was also important for me to

explain to the participants why I have such a keen interest in the research topic. This included providing them with more personal information about me, which stems from my own unplanned pregnancy, some family history, and my residential environment. I do believe that this created common grounds, which eased the perceived differences between me and the participants. Due to these factors I was constantly aware of my predisposition as the researcher and the impact that it may have on the outcome of this study. This knowledge and understanding made me constantly aware of the manner in which I received information from the participants as well as how I interpreted what they were saying. Therefore, during this research process I was aware of any personal bias which may have developed. However, I was also using my personal background which I believe aided me in understanding the research topic. This is in the light of coming from an impoverished area where substance abuse and other social ills, especially crystal meth, are rife. In this way I could relate to their circumstances and their experiences as I am exposed to these social ills and its consequences on a daily basis. In addition I had a very good understanding of the slang that the participants used, through mixing the English and Afrikaans languages and the use of certain terms, which helped them to express themselves. Therefore, this understanding aided in the interviews running smoothly with minimal explanation required from the participants. It also facilitated the process of analysis.

I feel that I was mostly affected by the participants' individual stories as I could identify with them on various levels. After more than one of the interviews I found myself thinking and processing the information that was shared with me for days on

end, empathising with their social backgrounds, having an idea of their vulnerabilities, but also acknowledging their individual strengths in attempting to break their cycle of their drug abuse.

3.9. Significance of the study

The literature identified people under the age of 20 years as well as the female population as at risk groups for risky sexual behaviour (Boskey, 2008; Yan et al. 2007), which can lead to HIV/AIDS, sexually transmitted infections and unplanned pregnancies. Research in recent years indicated the following: a lack of research that links substance abuse and sexual risk behaviours in the adolescent population (Yan et al., 2007); a lack of research regarding crystal methamphetamine use and sexual risk behaviours (Plüddemann et al., 2008; Springer et al., 2007); women are an understudied population with regards to rising trends of crystal methamphetamine use (Lorvick et al., 2006); females may have an increased risk to initiate methamphetamine use as literature indicates that their age of onset for methamphetamine is younger than that of males, which indicates that females may have an increase risk to initiate methamphetamine use (Hser et al., 2005; Wu, Pilowsky, Schlenger & Galvin, 2007; Brecht et al., 2004); the majority of studies on sexual risk behaviours in the context of methamphetamine focus on men who have sex with men and not heterosexuals (Corsi & Booth, 2008; Zule et al., 2007); in South Africa there have not been many studies that link HIV infections and crystal methamphetamine use (Parry et al., 2008); and lastly this study will address the lack,

highlighted by Degenhardt et al. (2010), of qualitative literature in terms of the contexts and risks in which crystal methamphetamine users engage. Identifying women and adolescents as at risk populations for risky sexual behaviours as well as populations in which an increase in crystal methamphetamine have occurred led to this proposed research study. Therefore, this study addressed the abovementioned research needs in terms of risky sexual behaviours amongst adolescent females recovering from crystal methamphetamine addiction.



CHAPTER 4

ANALYSIS AND DISCUSSION

4.1 Introduction

In this chapter I will be discussing the results of the interpretative phenomenological analysis of the conducted interviews for this study. A number of themes emerged from the data, which is indicative of the similarities and differences among the participants' experiences and perceptions of risky sexual behaviours in the context of their crystal meth addiction. In addition it is important to discuss the context of the lived world of the addict as described by the participants. Therefore, my discussion will reveal unanticipated themes. However, it is important to discuss these themes as it adds to the context of the lived world of the participants.

Apart from their sexual behaviours, the interviews depicted how the use of crystal meth affected the participants' lives in various aspects, which includes the effects that crystal meth had on them, the reasons why they initiated their crystal meth use, their relationships with significant others, the importance that they ascribe to everything other than crystal meth, and the rationale with which they approach their daily lives. Therefore, in essence the following themes portrays the power that crystal meth had over the participants lives especially their sexual risk behaviors.

4.2 Becoming the addict

The participants explained the ease with which they started out smoking crystal meth, and how that ease changed to the extent that they craved for it once they became addicted. Likewise, in outlining the MacDonald's scale of the stages of drug use and abuse Greydanus and Patel (2005) explains that seeking the euphoric experience that accompanies drug use takes place from stage two to stage four.

'I'd say a year after that. It was like we drank mos now. So it was more like that. that was just for the verbygan (an addition to the drinking). It was like we drank more most of the time, but as time went on it became worse. It became more aggressive, the smoking, and the need to keep up with the urge.' Jess

Elisabeth explained that at the beginning of her crystal meth use it was a nice experience, but that in later stages she became dependent on the drug. This is also in line with MacDonald's scale of drug use and abuse where the last stage is characterised by the need to feel normal and maintaining the euphoric experience (Greydanus & Patel, 2005).

'You know your first experiences or your first few years of doing it is lekker (nice), because I mean you know everything you can still maintain. Like you can still maintain your hygiene. You can still maintain your outer appearance

and whatever. But sooner or later then you need that so much. You become dependent on it so much, that you don't know any other way. ' Elisabeth

4.3 The effects of using crystal meth

The literature indicates the various effects that crystal meth has on the individual. These effects have included physical effects, emotional effects, social effects, medical effects and psychiatric side-effects (Batki & Harris, 2004; Brecht et al., 2004; Buxton & Dove, 2008; Corsi & Booth, 2008; Dawe et al., 2009 in Plüddeman, Flisher, Mcketin, Parry & Lombard, 2010; Degenhardt et al., 2010; Degenhardt & Topp, 2003; Hser et al., 2005; Klasser & Epstein, 2005; Marcelle, 1999 in Russell et al., 2008; Plüddeman et al., 2010; Saul, 2005 in Russel et al., 2008; Schifano et al., 2007; Slavin, 2004 in Russel et al., 2008; Wray, 2000 in Russel et al., 2008; Wechsberg et al., 2008; Zweben et al., 2004). The participants indicated various effects that it had on their lives throughout their interviews. The presented effects include their experiences as well as what they perceive the effects to be.

4.3.1 Physical effects of using crystal meth

The physical effects of using crystal methamphetamine as experienced and perceived by the participants in this study includes a higher sex drive or feelings of arousal, increased energy, loss of appetite, weight loss, insomnia, skin erosion, and medical problems.

4.3.1.1 Sexually related effects

The literature indicates that the use of crystal meth increases sexual encounters and results in heightened sexual arousal and experiences (Brecht et al., 2004; Buxton & Dove, 2008; Degenhardt et al., 2010; Degenhardt & Topp, 2003; Heckert, & Sanhces, in Degenhardt et al., 2010; Halkitis et al., 2005; Lorvick, Martinez, Gee & Kral, 2006; Marcelle, 1999 in Russel et al., 2008; McKirman et al., 2001 in Degenhardt et al., 2010; Rang & Dale, 2003 in Schifano et al., 2007; Ross et al., 2003; Wechsberg et al., 2008). Likewise Lorvick et al. (2006) found that the relationship between crystal meth and sexual disinhibition, and sexual pleasure is an important aspect of sexual risk behaviours. Another study found that men and women reported enhanced sexual thoughts, behaviours and activities when using crystal meth (Dluzen & Lui, 2008). All the participants except two detailed that they were sexually aroused and/or sexually more active. Two participants were specific in explaining the effect that crystal meth has on one's hormones:

'...for some females it enhance your sexual drive, hormones would drive wild, for others it wouldn't. With guys as well, their hormones would drive wild or it wouldn't. And being on tik and stuff your hormones drive wild and you don't care who you sleep with.' Mary

'... the symptoms of tik is that it messes with your hormones and when you get high, you feel like you, you just now. You see things that's not there man. When a guy is gonna hug you, or he's maybe gonna touch, where you know, no that's a softy, then you gonna give in eventually to him, because you at a high. So I was also a lot in that predicament when I, when I fell into any trap

man, because I thought at that moment that it wasn't because of the drugs, but then I realised afterwards that it is because of the drugs... If you drink also ganna feel like jy smaak nou die girlie (you feel like having sex) and that.'

Tessa

In contrast with the above findings that the participants experienced, two other participants indicated that they were not sexually aroused when they used crystal meth, which is in contrast with popular literature as stated above:

'No I didn't have a high sex drive. It was the same, it was normal. It didn't have that kind of effect on me.' Donna

Jess in particular expressed the dislike that she developed through her sexual experiences with her boyfriend who was also a crystal meth addict:

'Hy sal net se, 'kyk hiesa, ek is lis' (look here, I want to have sex), ne like so. So, on the bed mos now it will just be a matter of indruk en kla (putting in and finish). You understand. It wasn't still a matter of where people make love and you can actually say it was a nice experience, because it was never a nice experience for me. Because, I never enjoyed it.... It was just a matter of me laying there and him doing everything, you know, until it was done. And automatically if you on tik it boost your libido, so he was very, very, very (pause). So it would last long, like very long, so for an hour or something... For me, I developed a attitude where I didn't like sex, because I think my experiences was so crappy. So every time I had to sleep with him it was like, 'oh jinne, I really don't want to'. You know, I really didn't want to, but then I just did it at the end of the day. Ja, I never ever felt so sexually driven that I was the one to say, 'look here, I want to sleep with you now, I'm feeling a bit horny'. Honestly, I didn't want to come (ejaculate).' Jess

4.3.1.2 Increased energy

Literature indicates that crystal methamphetamine can result in higher energy levels (Buxton and Dove, 2008; Degenhardt & Topp, 2003; Degenhardt et al., 2010; Marcelle, 1999 in Russel et al., 2008; Schifano et al., 2007). Likewise, three of the participants' indicated that they have experienced higher energy levels:

'So it was like I have all this energy ne and I just wanted to clean.... I always just needed a hit to clean my mommy's house.' Michelle

Tessa's quotation explains how the higher energy levels enabled her to study throughout the night. She explained that the sleeplessness was caused by the high energy that she experienced due to her crystal meth use. This can be perceived as an example of increased productivity. In line with this literature indicates that methamphetamine is also used to increase productivity (Cretzmeyer et al., 2003), and to work more hours (Brecht et al., 2004). One can also link the following theme, 'loss of sleep', as a result of the higher energy levels experienced by some crystal meth addicts.

'... it was like I had energy man, always that energy, energy, energy. And I could study whole night. I could've did my hours (pause) I mos on school and at college and whatever. So I could study and for me it was just like, it wasn't actually because of staying awake whatever it was just a feeling, because you

have energy, you clean the whole house you make the food and everything you do.’ Tessa

4.3.1.3 Loss of sleep

Bungay et al., 2006 in Buxton and Dove (2008) found that street children used crystal meth to stay awake at night. Other literature identifies loss of sleep as one of the effects of crystal meth use (Brecht et al., 2004; Dawe et al., 2009 in Plüddeman et al., 2010). Sleeplessness is further indicated as an effect of crystal meth use by two other participants in this study:

‘I would stop sleeping as much as I did.’ Elisabeth



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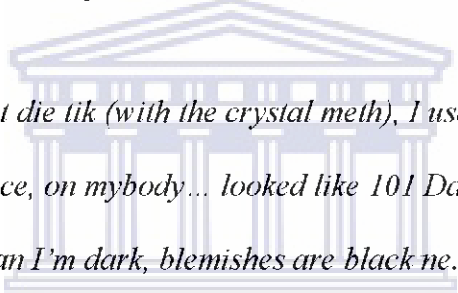
4.3.1.4 Weight loss

Four of the participants identified weight loss as a result of their crystal meth use. Likewise, literature indicates that decreased appetite (Buxton & Dove, 2008; Degenhardt et al., 2010, Schifano et al., 2007) and anorexia (Brecht et al., 2004; Buxton & Dove, 2008; Saul, 2005 in Russel et al., 2008; Slavin, 2004 in Russel et al., 2008; Wray, 2000 in Russel et al., 2008) are effects of methamphetamine use. Two of the participants indicated that their weight loss was extreme.

‘I picked up weight now, but I was, ek het gelyk soes iemand wat dood gaan (I looked like someone who is dying).’ Jess

4.3.1.5 Skin erosion

Only one of the participants indicated that she experienced skin problems due to her crystal meth use. This is in line with literature on the effects of crystal meth use (Brecht et al., 2004). While another participant detailed how the use of crystal meth affected the skin of other users, which is indicative of irritability and psychosis known as ‘tweaking’ (Buxton & Dove, 2008). Buxton and Dove (2008) explained that ‘tweaking may result from prolonged use leading to the user having many scabs from picking insects crawling on or under their skin.



‘You know, met die tik (with the crystal meth), I use to have a whole lot of marks in my face, on mybody... looked like 101 Dalmatians, let me put it like that. And I mean I’m dark, blemishes are black ne.’ Jess

Mary’s explanation of skin problems can be likened to the psychosis known as ‘tweaking’ explained by Buxton and Dove (2008):

‘Ok there is people that I know where it got to a stage where it’s so bad that tik used to eat at your skin and stuff, or say I would have a sore on my arm, it wouldn’t really heal, or you would scratch all the time and it would get infected and, stuff like that.’ Mary

4.3.1.6 Hair damage

Though literature does not indicate hair damage as an effect of crystal meth use, two of the participants indicated that the use of crystal meth led to hair damage for them:

'... my hair started to break off.' Jess

'You so beautiful and so nice and so cute and that and then it lets your hair fall out.' Tessa

4.3.2 Emotional effects

The participants explained that they have experienced a number of emotional effects after they have become addicted to crystal meth. These effects ranged from positive feelings when using crystal meth to more negative feelings reflected in their social lives as a result of their addiction.

4.3.2.1 Self-confidence

A low and high level of self-esteem was respectively experienced by two participants, which was indicative of both the positive and negative effects that crystal meth may have on the individual. In terms of the positive impact literature indicates that the individual may experience a sense of invincibility and lowered inhibitions (Buxton & Dove, 2008; Degenhardt et al., 2010; Marcelle, 1999 in Russel et al., 2008). Likewise Jess experienced a higher self-esteem and a sense of invincibility. On the other hand, Tessa indicated that crystal meth use takes away your self-esteem and at the same

time she indicates that she would think that she looks nice, which indicates a mixture of both the negative and positive effect that crystal meth can have on the individual.

'I was someone who had a very low self-esteem. For a minute when I had my fix, I didn't worry about how I looked. It's like it went away... You know you got your first hit in you, you He-Man.' Jess

'It take away your self-esteem, it takes away everything, your values that you have. You you you will soema, you will think you look nice also and you won't...' Tessa

4.3.2.2 Aggression

The literature indicates that aggression is an effect of methamphetamine use (Degenhardt et al., 2010; Plüddeman et al., 2010; Saul, 2005 in Russel et al., 2008; Slavin, 2004 in Russel et al., 2008; Wray, 2000 in Russel et al., 2008). However, two participants' experience of aggression gives more understanding on how it may be experienced by the crystal meth addict. For Donna the aggressiveness resulted from the denial that she was a crystal meth addict. She indicated that it is not her normal state, which is indicative of the change in personality that she went through. She experienced a sense of invincibility, which was discussed earlier. On the other hand Tessa indicated that she became aggressive when she did not have crystal meth. In Tessa's case the aggression was a withdrawal symptom. Tessa's aggression

developed into violence, which was also recorded in the literature as an effect of crystal meth use (Brecht et al., 2004; Buxton & Dove, 2008). Studies also indicated that violent behaviour is more characteristic in female methamphetamine users rather than males (Hser et al., 2005; Zweben et al., 2004). In both Donna and Tessa's cases the aggression that they experienced was an effect of their crystal meth addiction.

'...it wasn't really who I am, it wasn't me, because I'm not the type of person who will get all rude and go on. No that's not me. Normally I would just leave you, I will keep my mouth, but that wasn't me, because of influence and whatever you tend to keep you strong.' Donna

'... the moment I didn't have tik, then I would get aggressive and I would be moody, I would be all the all the negative moods. And that's also the reason why, if I didn't have it then I would just be rebellious... I came to a point where I actually hit my mommy. In a sense of, jy vertel nie vir my nie (you don't tell me). I became rebellious because I couldn't get my way.' Tessa

4.3.3 Psychological effects of using crystal meth

Some of the effects as experienced by the participants were indicative of psychological outcomes of crystal meth use, which are suggestive of the psychological effects as indicated in the literature (Brecht et al., 2004; Buxton & Dove, 2008; Degenhardt & Topp, 2003; Klasser & Epstein, 2005; Plüddeman et al.,

2010; Saul, 2005 in Russel et al., 2008; Slavin, 2004 in Russel et al., 2008; Wray, 2000 in Russel et al., 2008).

4.3.3.1 Becoming emotionally distant

The participants spoke about how the use of crystal meth affected their emotional states. Their narratives ranged from being emotionally distant, to being emotionally detached, to being emotionally confused. Research indicates mental confusion as a side effect of crystal meth use (Buxton & Dove, 2008; Degenhardt & Topp, 2003; Saul, 2005 in Russel et al., 2008; Slavin, 2004 in Russel et al., 2008; Wray, 2000 in Russel et al., 2008). Therefore, the emotional confusion experienced by Elisabeth can be suggestive of mental confusion or linked to it. The emotional distance and detachment can be indicative of depression among the participants in my study. However, they were not assessed for depression. In this light, literature indicates that depression is an effect of crystal meth use (Buxton & Dove, 2008; Degenhardt & Topp, 2003).

Michelle's account of being emotionally distant spoke of the direct effect that crystal meth had on her emotions, but she also indicated that she became emotionally distant because of the guilt she attached to her addiction:

'I always wanted to be alone, because I knew that what I was doing wasn't right. I always wanted to be in my, in my room, but then at all times my

mommy would come into the room and she would lay there by me and I just didn't want that man... I wanted to be alone, which wasn't like me, because I always use to go lay by my mommy, and she couldn't understand that.'

Michelle

Mary indicated that she became emotionally detached:

'...for me after using, I had no emotions. Ummm, didn't care about anything.'

Mary

On the other hand, Elisabeth's narrative spoke of the confusion that she experienced in not knowing when she was happy or when she was sad. In addition, she indicated that she experienced being emotionally detached when she was very sad:

'So yeah, emotionally it really fucked me up. I didn't know whether I was coming or whether I was going. I didn't know when I was happy or when I was sad. I didn't (pause). Like when I was really sad I wouldn't be able to cry because I was just numb so yeah it numbens you emotions.' Elisabeth

Michelle further explains the emotional distance that she experienced by contrasting how she interacted with people during the time that she was using crystal meth with relations in her sobriety:

*'I can interact more with people now, which I never had when I was on tik...
I've got that joy back in me where I can deal with people, and I can tell
people stuff... I can deal with other people, which means that when I get out
into the world I will be able to deal with people more easier than what I did
when I was on tik.'* Michelle

4.3.3.2 Psychosis

The literature indicates that symptoms of psychosis such as hallucinations and paranoia are some of the effects of prolonged crystal meth use (Brecht et al., 2004; Buxton & Dove, 2008; Degenhardt & Topp, 2003; Plüddeman et al., 2010; Saul, 2005 in Russel et al., 2008; Slavin, 2004 in Russel et al., 2008; Wray, 2000 in Russel et al., 2008). Likewise, the participants indicated that they have experienced altered ways of thinking. Mary and Jess's narratives indicate that they have experienced paranoia. While Tessa indicated the false impression she had about how she presented herself.

*'...and in your own head, your imagination probably runs wild with you.
Uhhh, there's people that I know of that does crazy things. Uhhh, like I ran
away from the house without thinking twice about it.'* Mary

*'Yes, and there was a time where I thought that I had a STD or something, but
it wasn't.. there was nothing wrong with us. We've been paranoid because of*

the drugs.' Jess

'You will think you look nice ne, you will think you look so kwaai (nice) but then you won't man. And, and you will see quickly when somebody uses drugs, because you will just see by the way they uhmm, they uhmm dresses themselves and that.' Tessa

4.3.3.3 Suicide

The literature indicated that prolonged use of crystal meth can lead to suicidal ideation (Klasser & Epstein, 2005). Likewise Brecht et al. (2004) found that 27% of methamphetamine users in their study have had suicide attempts. In my study only Tessa expressed that she had attempted suicide thrice. However, she did not explain her suicide attempts as an effect of her crystal meth use. Instead, she reasoned that it was due to the disappointment she had in an intimate relationship:

'Like I tried sieker (probably) about three or two, three times, but then I had a relationship, like last year, ja (yes). The year before I had a relationship with my ex boyfriend... And then he also ended up hurting me, but then I found out that he was just, hy't my net uit geslaap, en hy't my net gebruik (he just used me for sex). Because hy't 'n anne meisie gehet (he had another girl) and that. And that really just broke me down, because after that I, I, ek kanie mee nie man (I couldn't any more). It was like that was the worst thing that ever happened to me.' Tessa

4.3.4 The social effects of crystal meth use

Barton (2003) emphasised that social problems ranging from relationship difficulties to employment problems and household stresses are results of drug use. For the participants in my study the social changes that they have experienced were related to changing friends and changes related to their relationships with their families.

4.3.4.1 Getting involved with the wrong crowd

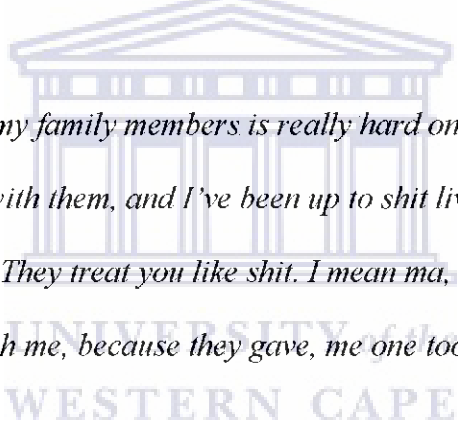
Greydanus and Patel (2005) emphasised that changing friends may be one of the identifiable life changes that the addict undergoes during stage two of their drug addiction. Associating with the wrong crowd was expressed by two of the participants as a result of crystal meth use. One can perceive this as socialising with people who have the same interest as them, which is using crystal meth.

'... you will get involved with all the wrong people because you will, in my situation, I didn't get love from my family so I always ran to boyfriends and to other people and they end up doing was hurting me.' Tessa

'...there's a lot of effects it has on people I'm going to use myself for instanceI was addicted to gangsters. I like gangsters as boyfriends... I was always, like for gangsters for boyfriends... it happened from smoking with this one and that one. And then, I ended up in the gang crowd.' Michelle

4.3.4.2 Family rejection

Family rejection is also linked to the social changes of crystal meth use. As an emerging theme, family rejection was not explored in my literature chapter. In this light, Coid et al. in Barton (2003) found that drug use has damaged their relationships, and either ended up in divorce or ending a relationship. In addition, Coid et al in Barton (2003) found that the participants in their study blamed drug use for the breakdown in family relationships. Likewise, in my study the participants experienced rejection from their families.



'Like some of my family members is really hard on my, especially my uncle. Uhmm, I live with them, and I've been up to shit living with them, because I'm a drug addict. They treat you like shit. I mean ma, I can't now expect them to sympathise with me, because they gave, me one too many chances and I threw it away.' Jess

'... my relationships with other people uhmm a lot of them I really hurt them and with a lot of them I lost them to my addiction. I chose my drugs over them so when it came to choosing whether I was going to keep to sort of promises that I made or arrangements that I made. I would end up disappointing them. I would hurt the people I love without even wanting to, but it was the smoke. I needed to lie to them and manipulate them and later when they found out then they weren't really impress with me to a point where a lot of them want nothing to do with me, so.' Elisabeth

4.3.4.3 Manipulation

According to the DSM-IV in Sussman and Ames (2001) one of the criteria for substance dependence is that the addict spends a lot of time on activities to obtain the drug, use the drug, and to recover from its effects. In this light, the participants' manipulation of their significant others was a means of obtaining crystal meth. Jess spoke about how she used her family to support and to hide her crystal meth addiction. Her addiction resulted in family conflict and hurting those closest to her. Likewise, Barton (2003) emphasised that relationship difficulties are one of the social problems resulting from drug use. Elisabeth indicated that she manipulated significant others in an attempt to hide or maintain crystal meth addiction.

'I was never negligent to my children, but I used them a lot as an excuse to get money. So at the end of the day I was stealing from them to.' Jess

'But here by my aunty them, I messed up a lot there. Because my uncle, the one that was so hard on me, he was a, on the army. He was a ex-captain or whatever. So I mean ma, hy wiet mos hoe lieg die mense en daa (so, I mean that he knows how the people tell lies). So he could see right through me.

Then I use my aunty, because my aunty would always cover up for me, but he was always right. He would say naci hy wiet ek praat kak man, 'julle kan mos sien, julle willie vi my glo nie' (no, he knows that I'm talking nonsense, 'you can see, you don't want to believe me'). And I caused trouble, I was between the two. And then they skel (argue). And then he's right right, but then she is

*covering up for me. At the end of the day the truth came out and he was right.
Then you see, then I caused all that conflict.' Jess*

*'I would hurt the people I love without even wanting to, but it was the smoke.
I needed to lie to them and manipulate them and later when they found out
then they weren't really impress with me to a point where a lot of them want
nothing to do with me, so.' Elisabeth*

4.4 The reasons for initial crystal meth use

The participants identified a number of reasons for initiating crystal meth use. These can be viewed as risk factors as it made them vulnerable to drug use. The reasons given by the participants included curiosity, experimenting, being mischievous, peer pressure, wanting a sense of belonging, escape from problems, family dynamics, and progressing from other drugs to crystal meth.

4.4.1 Curiosity and experimenting

Cretzmeyer et al., (2003) found that the second most common reason for using methamphetamine for women was increased productivity and for males it was curiosity. However, in this study the participants noted increased energy levels, which led to increased productivity as an effect and not a reason for crystal meth use. Instead, the female participants in this study indicated that curiosity and experimenting were the initial reasons for their crystal meth use. Likewise, the

literature indicated that experimenting and having fun were some of the reasons for initial crystal meth use (Brecht et al., 2004).

'...the girl I was friends with, it with was her brother's matric ball after party and it was at their house and most of the people was using... I didn't use that night but I was like curious and I was like what's that? What does it do to you? and all of that. Then a few of us, a week or two later decided ok we gonna try this and find out why everybody's using it.' Mary

'The thing is like in the beginning there wasn't really outside pressure. It was just like part of experimenting I suppose.' Elisabeth

4.4.2 Peer pressure

In addition to curiosity and experimenting I found that peer pressure and wanting to belong played a major role in the participants initial drug use. However, wanting to belong can also be linked to family dynamics which will be discussed later. Likewise, Morojele et al., (2006) found that peer pressure and peer behaviour contributed to drug use. The literature also indicated that the influence of friends play an important role in initial crystal meth use (Brecht et al., 2004; Sattah et al., 2002 in Russell et al., 2008) In addition Brecht et al. (2004) emphasised that females were more likely than males to be introduced to methamphetamine and continue to gain access to it via their spouses or boyfriends. However, though two of the participants in my study were

accompanied by their boyfriends when they first used crystal meth they did not indicate that their boyfriends introduced them to it.

'Firstly I got involved with the wrong friends. I use to go to game shops, and use to hang out there all the time. And uhhh, one night I was just sitting outside, outside our door. And then uhhh, this boy just came to me, and in the outside he gave me the thing and said, 'just try here'. In the cold cold, and I thought yor, with a lighter outside and then he said uhm (pause). And then I tried it... I did it out of my own. Just to be part of the group.' Michelle

'Look, she came and call me, and told us about it all the time. So ja, I think peer pressure also played a role. It wasn't as if I just decided on my own to try it. It was peer pressure in a nice way ja.' Donna

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The need to belong was expressed by Jess as well as Tessa as part of the reason for initiating crystal meth use in the presence of friends:

'...for me it was like, if I'm not gonna do it I'm not gonna belong to a certain crowd. I'm not gonna belong...' Jess

'... throughout the years there was a sense of belonging, that I wanted to fit in. Like uhhh, I don't wanna be out and I also wanna fit in to whatever group. Not whatever group, but to fit in. So I can be pressurised also because

I actually did it to fit in at that point in time, that time when I tried it first.

That's what happened.' Tessa

4.4.3 Willingness to initiate crystal meth use

The prototype/willingness model argues that model, attitude, subjective norms, and prototypes are described as influencing adolescent risk behaviour indirectly (Gerrard et al., 2008; Litchfield & White, 2006). An important aspect of this model is that the proposition that the adolescent's attitude towards engaging in risk behaviour is directly linked to his/her positive or negative image of the typical person who performs this risk behaviour. Furthermore, the adolescent's willingness to engage in behaviour increases as his/her attitude towards a behaviour become more positive (Gerrard et al., 2008; Lichtfield & white, 2006). Here, the construct of behavioural willingness is not always a reasoned decision, but one that is determined by the adolescent's willingness to act out a certain behaviour (Gerrard et al., 2008), which is often brought about by situational influences that facilitate risk behaviours (Gerrard et al., 2005). Therefore, in the light of the prototype model some of the participants in my study indicated that they were willing to initiate crystal meth use and acted on it due to a positive image that they had of the typical crystal meth user or due to the fact that the situation was conducive for risk taking.

Mary's account of how she became interested in crystal meth involves seeing people using it and becoming curious about it. In questioning those who used it she most

likely developed an image of the typical person who uses crystal meth. This is in line with the prototype model's explanation of willingness to pursue a risk behaviour, which is due to the individual's perception of the typical person who gets involved in a risk behaviour.

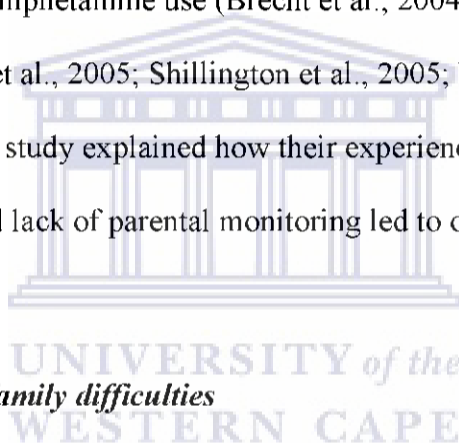
'First it was uhmm, the girl I was friends with, it with was her brother's matric ball after party and it was at their house and most of the people was using. And so uhmm, I didn't use that night but I was like curious and I was like what's that? What does it do to you? and all of that. Then a few of us, a week or two later decided ok we gonna try this and find out why everybody's using it.' Mary

In Michelle's case she was in a situation which was conducive to crystal meth use, because there were no authority figures such as parents in the environment, and her crystal meth use was facilitated by the presence of her friends. Therefore, though Michelle was willing to use crystal meth, the presence of an authoritative figure and/or the absence of her friends might have deterred her to act on her willingness.

'Uhm, I was on high school...and I went to my friends, that was at school. I went with them to a friend of that guy, his house, because he was alone at home. That time it was still a big globes that was in.' Tessa

4.4.4 Family dynamics

Family dynamics plays an important role in risk factors for drug use. Cardoso and Verner (2007) emphasised that the impact of the family background and the occurrence and timing of family events are important factors to consider in youth risk-behaviour. In this regard the literature indicates that the family environment can present both risk and protective factors for substance use in general (Benjet et al., 2007; Corsi et al., 2007; Greydanus & Patel, 2005; Kliwer et al., 2006), and more specifically for methamphetamine use (Brecht et al., 2004; Embry et al., 2009; Miura, et al., 2006; Rawson et al., 2005; Shillington et al., 2005; Yen et al., 2006). Likewise, the participants in my study explained how their experience of family discord, lack of parental attention, and lack of parental monitoring led to ongoing crystal meth use.



4.4.4.1 Coping with family difficulties

Two participants indicated that they used crystal meth to cope with family difficulties. The literature indicated that crystal meth is sometimes used, because it creates a sense of escape (Diaz et al., 2005; Halkitis et al., 2005; McKirnan et al., 2001 in Degenhardt et al., 2010; and Ross et al., 2003). Likewise, a study among “black” and “coloured” women in the Western Cape, South Africa found that methamphetamine was one of the drugs used as a coping strategy for interpersonal conflicts, and physical, sexual and emotional abuse (Wechsberg et al., 2008). In addition family violence (Cardoso & Venter, 2007; Kliwer et al., 2006), family dysfunction (Greydanus & Patel, 2005), and family instability (Benjet et al., 2007)

was also identified in literature as contributing factors to initial substance use among adolescents. Both Jess's parents passed away in a three year time span, and Tessa lost her father at a young age. In addition Tessa experienced family discord, which led to her family rejecting her.

'And not only that, in the past three years I lost both my parents. Ja, so it's got a lot to do with that also, because I don't speak about my feelings, I don't express my feelings. So tik was my scape goat. If I smoke, I've got no problems.' Jess

'I am the youngest but I, I had the most responsibilities on me that you can ever imagine, because even my oldest sister comes to me when she has a problem and she speaks to me, and my mother speaks to me about the stuff. So I was also in the middle. Even if they had a fight and I was also in the middle. I had to carry everything on me. That's all the reason why I also, uhmm, ran to drugs also in the first place.' Tessa

4.4.4.2 Lack of parental attention

Michelle blames her mother for her sexual behaviours and crystal meth addiction. She explained the relationship between herself and her mother as not being a parent-child relationship. She explains that she modeled her mother's behaviour in terms of going from one boyfriend to another; and that she didn't see the need to sit in the house if

her mother does not take note of her. One can link Michelle's crystal meth addiction and her subsequent sexual behaviours to a lack of family cohesion and the prototype/willingness model. According to Kliewer et al. (2006) family cohesion entails an environment where there is mutual care among the members and they enjoy spending time together. Kliewer et al. (2006) emphasise that adolescents who have a sense of family connectedness may be less likely to use substances. According to Kliewer et al. (2006) family cohesion creates a sense of mattering to the parent(s), and the adolescent's needs for safety and security tends to be met more than youth with a lesser sense of family cohesion, which may reduce the need for stress reduction via substances, and parents in cohesive families are more likely to monitor their children. However, according to Michelle's experience this was not the case. Therefore, she was vulnerable to crystal meth use. With regards to the prototype/willingness model, the social reaction path's proximal antecedent, behavioural willingness, acknowledges that many risk behaviours are not intentional and that adolescents often find themselves in situations that are conducive to risk behaviours (Gerrard et al., 2008). In this light Michelle was presented with a risk conducive situation, which is the lack of parental monitoring. The following section discusses how the lack of parental monitoring made Michelle's initial crystal meth use more accessible.

'It's almost like drugs was for me like, uhmm, how can I say. It was (pause). That was my way of getting revenge.... My mommy, she wasn't a good mother figure. She wasn't really a good mother, because why she was a mother at a

young age. So I just thought that I will also go from boyfriend to boyfriend... that's how I went into uhmm, into gangsters and having sex with them and then just leave them... We never really had a mother and daughter relationship. And uhmm, I always thought, 'why must I be inside. Why must I be in the house. Sy vat nie eens note van my nie (she doesn't even take note of me). She doesn't even look at me. She doesn't even care for me. Why must I sit here in the house. I can mos go out'. And uhmm, then I go drug and come back. And then, I would feel better, but my mommy was my main issue why.'

Michelle

4.4.4.3 Lack of parental monitoring

Parental monitoring refers to the extent that parents keep track of their adolescents, and know with whom and how they are spending their time (Kliewer et al., 2006). Therefore, parental monitoring can serve as a protective factor, because the adolescent will know that there are boundaries to his/her behaviour, and that their parent(s) will check up on them (Kliewer et al., 2006). Consequently, parental monitoring can reduce substance use. Likewise, the literature found that parental monitoring acts as a protective factor against substance use (Benjet et al., 2006; Kliewer et al., 2006), and the lack thereof served as a risk factor for drug use (Corsi et al., 2007). Research on adolescent methamphetamine use confirms this (Embry et al., 2009; Shillington et al., 2005). Jess and Donna indicated that the absence from home

by both their fathers facilitated their drug use. Donna specifically explained that her father did not know what she was doing while visiting with her friend:

'... my daddy was the manager of Caltex here in Bay View... then he lived with my aunty that I'm living by now here. That time they lived there, cos he lives closer to work. So I was alone with my granny. We had the house to ourselves. You can imagine all of the partying.' Jess

'Yes, my daddy would go to Joburg and he would leave me money. And then, I would think, 'this is a great opportunity, I'm going to my friend'. And then, he would sometimes drop me at my friends, and then I sleep there, but then him not knowing what we doing.' Donna

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4.4.4.4. Continued crystal meth use due to drug use in the household

The literature indicated that parental substance use may be associated with adolescent substance use (Rawson et al., 2005; Benjet et al., 2007; Yen et al., 2006). More so, a study among adolescent methamphetamine users in a juvenile home found that family history of drug use was significantly associated with methamphetamine use (Miura et al., 2006). Though Michelle did not indicate that any of her parents used any substance before she started using crystal meth, she indicated that she continued using it, because her mother's partner also used it in their household:

'...but she's got this boyfriend now. He's also on drugs, he's also using tik. And uhmm, in the household. That's why I also continued, cause he also use it, like in the house. And that's why I went on with it.' Michelle

4.4.5 Crystal meth as a progression from other drugs

The literature indicates that some individuals progress from gateway drugs such as cigarettes, alcohol and marijuana to other illicit drugs (Greydanus & Patel, 2005; Kandel & Logan, 1984 in Greydanus & Patel, 2005). According to Greydanus (2005) the gateway model indicates that youth start with easily accessible and affordable substances and progress to other substances that are socially acceptable as opportunities change from early to middle and late adolescence. Likewise, the literature indicates that the use of gateway drugs usually occur from early adolescence, and the initiation into methamphetamine use during late adolescence (Brecht et al., 2007; Rawson et al., 2005). Four of the participants indicated that they smoked either cigarettes, or they drank alcohol, or they smoked dagga or they used pills; or they used a combination of some of the aforementioned. Two of these participants agreed that their crystal meth use was a progression from other substances. Elisabeth was very frank about this progression:

'I was introduced to tik when I was in high school. Yeah I just started out partying. I did the other drugs before I eventually found my drug of choice which was tik. So I first started experimenting with dagga, first with alcohol.'

and dagga, then I started doing pills and that's more affiliated with the club scene and then eventually I blew with some friends... Everyone with their drug of choice uses what they like. Everyone find different things in their drug of choice and for me like with dagga people could see that you smoke. People could smell that you smoked or you laugh a lot or whatever. With pills it will also physically do a lot of things to you. And with tik is one of the things that you could appear to be normal sit in a crowd where (pause). You know, you obviously be high out of your mind, but at the end of the day I would be still appear normal... So it was a kwaai (nice) way for me to be able to do it like whenever, however, at home, when I went out with my parents.' Elizabeth

4.5 An ongoing cycle: Wanting the first hit back

Two participants explained how they kept on doing crystal meth, because they wanted the same effect of the first time that they used. Therefore, for the addict this feeling leads the unending cycle of drug abuse. Jess and Tessa's words, 'I went on, and on, and on' and 'want to get your first hit back, your first hit back, your first hit back, and you never get your first hit back', is indicative of how these two participants felt compelled and urged to constantly use crystal meth. Melis and Argiolas, 1995 in Corsi and Booth (2008) explains this in biological terms where the excess dopamine production and feeling of great pleasure is the reason why individuals crave the drug when they do not have it, because they want to attempt to reach that state of pleasure again. Corsi and Booth (2008) emphasised that methamphetamine creates a rapid high, which is followed by an immediate low,

which is caused by a rapid tolerance that develops within minutes of using the methamphetamine. Therefore, the crystal meth addict is constantly in need of achieving the euphoric feeling. Greydanus and Patel (2005) also emphasised that there is a need to achieve this euphoric feeling throughout the stages of MacDonald's scale which outlines the stages of drug use and abuse.

'... the first time that I tried it, that was my biggest mistake because the first time I went on and on and on but the reason I kept on was, because of the feeling that I had the first time I tried it and what effect it brought to me and that was actually the reason why I used it every time, because I never got that first hit again back. For all the times that I want to, I want to smoke. And then I don't get the hit that I got firstly, the first try. I don't get that. It's that feeling and that sense of (pause). How can I say man? I don't get that feeling I got that first time I tried it. I tried it every time, I did it every time. It was an ongoing thing for years and years.' Jess

'Now, it's almost like it makes you keep coming back for more because you won't get the satisfaction that you had the first time. You will go back to it every time every time, and you will never get back the feeling of the first hit that you got. And that's how it brings you down, and how it sucks you in, because it will make you think that you must smoke now a lot.' Tessa

4.6 The priority that crystal meth has in the life of the addict

Schneider (2010) describes addiction as becoming the individual's top priority, eventually suffocating the relationships with friends and family. With addiction the individual becomes preoccupied with the drug and other activities must give way for the individual's drug use and the need to obtain the drug (Schneider, 2010). This preoccupation is also mirrored in MacDonald's scale which outlined the stages of drug use and abuse (Greydanus & Patel, 2005). Stage 3 is characterised with the preoccupation of experiencing the euphoria, and the addict's life become more out of control (Greydanus & Patel, 2005). During stage 4 experience a heightened need to maintain the euphoria and to feel normal (Greydanus & Patel, 2005). Therefore, the addict's preoccupation with the drug leads to it becoming a priority in his/her life. Likewise, the individual interviews were threaded with an emphasis on how crystal meth took priority in the participants' lives. This explains the power that crystal meth attained as the participants became addicted to it. They explained this power on different levels including their relationships with significant others, their personal hygiene as well as their personal safety:

'I mean ma, if I had to have a scale, and I have drugs and my children then drugs would've overpowered it any day, any time of the week. Ok, now I can say differently, but at that time you just don't care. And I mean ma, I wasn't even thinking about what kind of mother I was being, about (pause) shit!'

Jess

'You'd get up like on a day and before you could even brush your teeth or before you could even like wash yourself or bath and stuff, you would go out looking to score, so yeah.' Elisabeth

'Even if something is dangerous to me there or wherever, I didn't care. I used to think that so long as I am using nothing would happen to me. So then uhmm, there was stages where I used, and uhmm, like I could have gotten raped and stuff like that, because of using and not caring about anything.'

Mary

The priority that crystal meth had in the participants' lives is also explained in the sense of 'losing everything' as an effect that it had in their lives.

'It's just something you want and want and want and want, until you've got nothing left.' Tessa

'Ja, basically the consequences of it all is that I lost everything.' Mary

4.6.1 Not wanting to face reality

The participants' denial about having a crystal meth addiction can also be linked to the priority that crystal meth has in their lives, because it took priority over their well-being as well as those closest to them. Likewise, Greydanus and Patel (2005)

emphasised that one of the characteristics of stage 2 in Macdonald's scale of drug use and abuse is denial of drug dependence.

'...you don't want to acknowledge it, because you don't see anything wrong with yourself. And then, you get angry and whatever ... You don't see yourself for what you were doing to yourself... You just aim for that one thing man, and that's what you want, but you don't see how you ruining yourself, and what you doing to yourself. You don't see that, but unfortunately other people do see and they. You get some people who wants to bring you back, but you don't want that. Ok, because life for you is nice, you don't want that.' Donna

'As far as my experience with tik is that its nothing to try it, but you going to do it over and over and over until you are so heavy into it. You will be so in denial. You will say that you don't have a problem, but then you have a serious problem ... And that's how it took over my mind... And, it gave me a heart of stone man, because I didn't care about my mother's feelings or my sister's feelings, nobody's feelings.' Tessa

4.7 Defining risky sexual behaviours and the consequences thereof

Not all the participants indicated a clear understanding of risky sexual behaviours, which compelled me to give a definition to most of the participants. However, they indicated a perception of the consequences of risky sexual behaviours. They named

the consequences as pregnancy, AIDS and STI's. However, they also identified TB (tuberculosis) and loosing self respect as consequences of risky sexual behaviours, which is not prevalent in the literature.

'And a lot of girls are young and pregnant... And a lot of girls are young and have AIDS. They're dying. There's people who have died already. They have TB also from drugs.' Tessa

'Children and sicknesses. Illnesses that you can't get rid of like AIDS. Uhhh, ja STD's and crabs and stuff. Ja, whole lot of those things. Also uhhh, loosing self respect.' Jess

Some of the participants spoke about their own experiences, which indicate that they are fairly aware of the risks of having unprotected sex. They indicated that the consequences they have experienced resulted from having unprotected sex. They noted that they have had unplanned pregnancies and STI's as a result of unprotected sex.

'I think that people (pause) STD's are there and I think there's a lot of us that don't know what the signs are of having STD's. I think, I know of once I did sleep with someone and sought of that gave me STD that's because I wasn't being safe... I was pregnant twice, and but that was with someone that I was

in a relationship with, but I wasn't safe about it, because I wasn't on anything. We wouldn't use protection. So, I would fall pregnant.' Elisabeth

These findings are in line with the literature. Cepeda and Valdez (2003) and Kaplan and Erickson (2002) identify drug use as a risk factor for sexual risk behaviours, which can lead to pregnancy. Likewise, Springer et al., (2007) found that high school learners who were heavy crystal meth users were more than four times likely to have been or having gotten someone pregnant. Research also identifies STI's as a consequence of risky sexual behaviours (Spittal et al., 2003; Tortu et al., 2000). The STI prevalence rate in two American studies among crystal meth users were 28% and 29% (Semple et al., 2004a, 2004b). While, another study on 83 Filipino methamphetamine users in San Francisco found that 7.2% of the total sample had been diagnosed with a STI's including vaginal candidiasis, hepatitis B, gonorrhoea, chlamydia, and trichomoniasis (Nemoto et al., 2002). In recent years the increase of crystal methamphetamine has been closely tied to an increase in HIV infection, which is due to sexual risky behaviours associated with crystal methamphetamine use (Bolding et al., 2006; Parry et al., 2008; Simbayi et al., 2006; Wechsberg et al., 2008). In addition, an assessment which was undertaken in the South African cities of Cape Town, Durban and Pretoria found that crystal methamphetamine was widely used in Cape Town where it was accompanied with sex, and 28% of participants were tested HIV-positive (Parry et al, 2008). Another study on 5745 adolescents found that substance use before sex were associated with STI and HIV risk behaviours including

sex with multiple partners and unprotected sex (Yan et al., 2007). More specifically, research associate crystal methamphetamine use with sexual risk behaviours (Lorvick et al., 2006; Nemoto et al., 2002; Zule et al., 2007). Zule et al. (2007) found this to be the case especially when both partners were using methamphetamine.

4.8 Sexual risk behaviours of crystal meth addicted teenage girls

Through their own experiences, perceptions and examples of their lived worlds the participants identified a number of risky sexual behaviours that crystal meth addicted teenage girls get involved with. These include sexual behaviours such as having multiple sex partners, lack of condom use, oral and anal sex.

4.8.1 Multiple sex partners

Two of the participants explained that they only had one sexual partner while they were addicted to crystal meth. However, the rest of the participants indicated that at some point they had multiple sex partners. The latter finding is in line with the literature. A study on adolescence found that those who had multiple sex partners were three and a half times more likely to use a substance before their most recent sexual intercourse (Yan et al., 2007). More specifically, Simbayi et al., (2006) found that meth users reported having a greater number of sex partners in comparison to non-meth users. Likewise, another study found that female meth users were more likely to have more than 5 sexual partners over a period of six months than females who did not use meth (Lorvick et al., 2006). In their study Nemoto et al. (2002) found

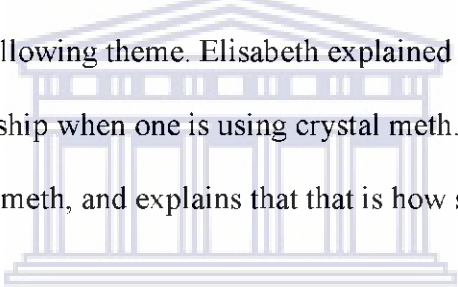
that of the 85% of Fillipino meth users in San Francisco who engaged in sex in the preceding 6 months, 53% had sex with more than one partner, and 83% of sexually active participants had sex at least once a week (Nemoto et al., 2002). For German et al. (2008) barriers to safer sex may occur for women who use methamphetamine and have multiple sexual partners, because they are likely to have a partner who uses methamphetamine, and are likely to receive less emotional support from their partners. In addition methamphetamine by either or both partners also increased the odds of having sex with a new partner, and increased the likelihood that individuals will have more than one sexual partner (Zule et al., 2007). In this study all of the participants' male partners were also crystal meth users and at least one of the participants indicated that her partner at that time had multiple sex partners.

'I got involved with a lot of gangsters, and a gangster broke my virgin. He 's carrying my virgin. And uhmm, I had a boyfriend after these two guys that I was with. They were both gangsters.... He loved me unconditionally and then I hurt him. I use to go sleep around with other guys because that was in me already. That was in me, but for gangsters.' Michelle

'... when I used to drug or whatever I was always between, I was always between boys... I got involved with a lot of guys... and I just, ek het net gou afgegee (I just gave in quick for sex)man. Ek het nie nog lank gedink oor 'n saak nie, net afgegee. And in a sense, at the time I was thinking for myself that I'm, I'm, I'm, soos hulle se, sleg (like they say, a whore.') Tessa

4.8.1.1 The challenge in maintaining long-term relationships

As an emerging theme, the challenge in maintaining a long-term relationship is an important factor for understanding why many crystal meth addicts have multiple sex partners. The participants' linked having multiple sex partners to the difficulty in maintaining an intimate relationship when one is using crystal meth. This can be linked to the priority that the addiction has over the addict's life where it eventually breaks down relationships with significant others (Schneider, 2010). Another explanation for this challenge is the constant need for sexual gratification as discussed under the following theme. Elisabeth explained the difficulty of maintaining a relationship when one is using crystal meth. She links the need to have sex with using crystal meth, and explains that that is how she experienced it.



'The thing is the multiple partners thing hey, like it's hard for you to maintain anything when you using drugs, especially with tik. It's hard for you to maintain a relationship. So there's a lot of people that don't stay in a relationship really long. And if you single and if you not a virgin you've had it before, you gonna want it at some point or another. If you don't have a boyfriend, I mean girls are not that open to the masturbation thing as much as guys are. So we don't do the whole masturbation thing regularly. We wanna have sex and if we don't have a boyfriend we gonna go and find someone to have sex with and that's the thing, it's not always one person it might be someone today, next week it might be someone else. It's just, that's how it is

when you use drugs, especially tik, so, cause that's how it was for me, so.'

Elisabeth

Tessa never experienced a relationship that lasted more than 6 months and she characterises these relationships as being more like friendships. She explained that she kept having sex with males even though they hurt her. Tessa lost her father to death at a young age and experienced rejection from her family even before she started using crystal meth. Therefore, Tessa's experience of having multiple sex partners can be perceived as a result of the need to be loved and belong together with the effect that crystal meth had in her sexual encounters with males.

'The longest relationship that I had was six months... It wasn't like relationships, because I got too quickly attached and I got too much hurt. And no matter how much people hurt me, I still, ek het nog altyd aan gegee, af gegee, af gegee... It was just, like I said, in the sense of like, father figure and uhm, ja, looking for love and looking for a sense of belongingness or whatever, because your family pushed you away and you go look for that elsewhere.' Tessa

4.8.1.2 Enslavement to sex

The literature indicates that the use of crystal meth increases sexual encounters and results in heightened sexual arousal and experiences (Brecht et al., 2004; Buxton & Dove, 2008; Degenhardt et al., 2010; Degenhardt & Topp, 2003; Diaz et al., 2005;

Halkitis et al., 2005; Lorvick, Martinez, Gee & Kral, 2006; Marcelle, 1999 in Russel et al., 2008; McKirnan et al., 2001 in Degenhardt et al., 2010; Rang & Dale, 2003 in Schifano et al., 2007; Ross et al., 2003; Wechsberg et al., 2008). In a previous section, under the effects of crystal meth the participants explained how it affected their hormones, which is indicative that they did not think that they had a choice in their sexual-decision making as they viewed their sexual behaviour as a result of the pharmacological effect that crystal meth had on them. In this light Corsi & Booth (2008) emphasised that methamphetamine use may leave an individual helpless to protect themselves against risk behaviours due to the nature of the drug and the influence it has over the individual's brain. The constant craving for sexual satisfaction was an explanation that the participants provided for getting involved with multiple sex partners. They explain it as though it is an addiction that is a product of their crystal meth addiction:

'... if you use you don't care who you sleep with. Uhhh like, I can sleep with this one guy today, tomorrow I go to another partner and sleep with him and it can go on and on and on. So, without thinking that don't care attitude is there. Just so long you can be fulfilled and you sexual desires is fulfilled it's like you don't care.' Mary

'Like a lot of people don't have to do it, but because like I've said like tik especially increases your sex drive so it's lekker (nice) at the time. And the thing is that lekker (nice) feeling is something that you also can't control at.

that time. So it would also be that, you know, you can't control how lekker (nice) you feel. So you just want it automatically. You don't have any control.'
Elisabeth

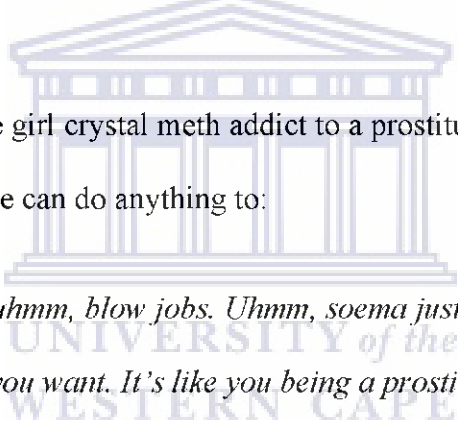
In Michelle's explanation of what she experienced the effects of drugs were her initial answer was 'sex'. She also provides an explanation for having multiple sex partners, which is based on her own experiences. She explains that she had multiple partners, because she had an insatiable craving for sex. She explained her sexual appetite as though it was an addiction, because she always craved for more sexual satisfaction. She also explained that the STI that her boyfriend had was due to her having had multiple sex partners. Therefore, Michelle's experience of multiple sex partners can be perceived as an effect that crystal meth had in the addict's sexuality.

'... while I had him I was still having sex with gangsters... It was never enough for me man. It was like I always had to have somebody more to fill another place for me. So I was. Like I always had to have more. And uhmm, I think that he picked it up. He picked the STI up. There was like stuff coming out by him... he would also do drugs with me. We use to do it together and whatever, but I would always like go the extra mile. I would go and look for another boyfriend to do it with. So uhmm, I never got enough. I was a bit sexual active in my active days.' Michelle

4.8.2 Oral sex, anal sex and orgies

The participants listed oral sex, anal sex and sexual orgies as risky behaviours that they perceive teenage girls get involved with when they use crystal meth. Only one of the participants linked her perceptions to her actual experience of anal sex. Likewise, a study on female methamphetamine users found that they had higher odds of having protected and unprotected anal intercourse (Lorvick et al., 2006). Another study found that methamphetamine use by either or both partners increased the odds of having unprotected or protected anal intercourse (Zule et al., 2007).

Jess likens the teenage girl crystal meth addict to a prostitute where the male treats you like a toy which he can do anything to:



'Threesomes, uhmm, blow jobs. Uhmm, soema just anything. Anal sex, anything that you want. It's like you being a prostitute. You know. You are a guy's toy thing. He can do anything to you.' Jess

Michelle experienced anal sex with her current partner who was also a crystal meth addict. She explains that she only started having anal sex when she was using crystal meth. However, one can view this as obligated sex in a relationship between two crystal meth users.

'Like one girl had sex with three guys at one time ... a lot of girls and one guy. Having sex with him and having blow jobs and everything with him. And uhm,

anal sex. That was for me. I have experienced anal sex and it was just gross for me man, because why I experienced it with my boyfriend that I am now with. Uhmm, I never use to do it. So it was only when I was using tik that I started doing it.' Michelle

4.8.3 Condom use

Research indicated that methamphetamine users were prone to not using condoms when they have sex (Nemoto et al., 2002; Simbayi et al., 2006; Wechsberg et al., 2008; Zule et al., 2007). In addition, according to Corsi and Booth (2008) condom use negotiation, and the possible lack of desire to negotiate condom use in the context of methamphetamine use by either or both sexual partners may lead to not using a condom when having sex. All of the participants had unwanted pregnancies during the time that they were addicted to crystal meth. Therefore, this is an indication of having unprotected sex. Tessa indicates that her pregnancy while she was using crystal meth was due to the lack of condom use:

'And pregnancy also is one, because I also fell into that trap at one time in my life. Not thinking about the consequences, because jy moet voel vleis op vleis or this, ek willie die he nie, jy kanie kondom use nie (you must feel meat on meat, or you can't use a condom) because is irritating. Then afterwards you have to sit with the consequences.' Tessa

4.8.4 Sex in exchange for drugs

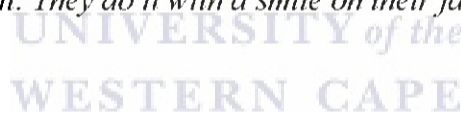
Various literature indicates that methamphetamine users often trade sex for drugs or money (Brecht et al, 2004; Mehradi et al., 2007; Morojele et al., 2006; Nemoto et al., 2002; Parry et al., 2008; Simbayi et al., 2006), and some give money or drugs in exchange for sex (Nemoto et al., 2002). In addition Sawyer et al. (2006) also found that “coloured” women often trade sex for drugs. In explaining that female teenage crystal meth addicts have sex with men to support their drug habit the participants used examples from their environments. Therefore, though these examples does not stem from their personal experiences it is accounts of the world in which they live. Through these descriptions the participants left me with an understanding of the control that crystal meth yields over the addict’s life.

‘There’s a lot of things that I do know. Like, they will sleep with anybody, just so that the guy could give them drugs or stuff like that, because maybe they not by the means to have money or whatever. So, basically there’s a lot of females that I know that will sleep with any guy just to use, and from there it would become a norm.’ Mary

‘Most of the teenagers, they sleep with people for drugs. It’s risky. They do it without a condom or whatever. And they sleep with them to get the drugs. They go out with older guys. Look, soos hulle sal se (like they say), ‘sugar daddy’s.’ Tessa

Jess gave an interesting description of a house where females go to the extreme of prostituting themselves in exchange for crystal meth:

'In Overcome you've got a place where they come, rooms with different girls. You come there with your tik, that's the guy. You choose yourself a girl as long as she gets from that tik you can do anything you want to that girl. I'm serious. Anything.... Ja, you choose. You feel you want to sit there and stick a stick up her. I'm serious. She is your thing and I mean they got no respect for you. To them it's just about, 'jy's myne vi die aand, ek betaal vi jou, hiersa is jou tik, jy moet net doen (you are mine for the night, I paid for you, here is your crystal meth, you must just do it).... Then if you not happy with a girl you can choose yourself another one, whatever to your liking. And the girls do it man. They do it. They do it with a smile on their face.' Jess



4.8.4.1 Getting involved with gangs

Gang involvement is an emerging theme which proved to be important for the participants of the Mitchell's Plain area. According to Plüddemann et al. (2010) in South Africa the methamphetamine drug trade seems to be mostly controlled by highly organised criminal gangs who are based and has the largest membership in Cape Town. They also have a long history of drug trafficking and dealing (Plüddemann et al., 2010). More importantly Sawyer et al. (2006) found that "coloured" women who use drugs reported having relationships with men who belong to gangs. In addition the participants explained that proceeding to gang

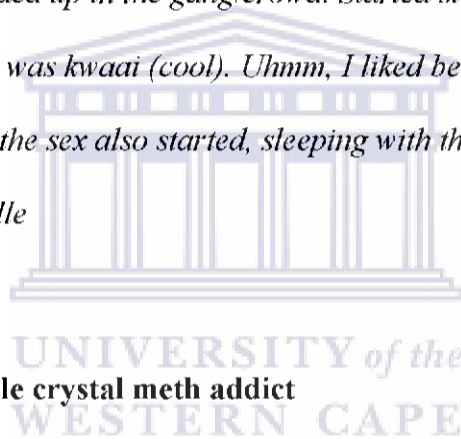
involvement is another means for female teenage crystal meth addicts of getting involved in risky sexual behaviours as a means of supporting their crystal meth addiction.

'Like there's a lot of females I do know that get involved with gangs, and stuff like that... In general. Ummm, cause I know that if I get involved in a gang then there's obviously drugs. There's obviously people who does sell, cause obviously the gangsters have money and whatever drugs they sell. So, when I get involved with a gang, I know there is drugs or whatever. So then automatically, if a female's with a gang, so automatically that female belongs to the entire gang. So if I sleep with you today or I sleep with a few of them today, that means that it's a gang thing. And tomorrow it will be the same. And I mean guys in gangs, I mean they sleep with anybody at any time and whenever they can get it. So, by me sleeping with him, that would mean that I slept with a whole lot of other people as well, and I don't know what they had or what they've got. So automatically the risk of me to getting whatever infection or HIV or AIDS, my risk is very high.' Mary

'They get involved with gangsterism. Sleep with the gangs like that. And they maybe just have sex with them, because the guy maybe tell them to show him how much she love him. Then they have sex with him, cause they will be so desperate for tik.' Tessa

Michelle explains that she became part of a gang through not caring with whom she smoked crystal meth. She further explained that she had multiple sex partners within the gang:

'Uhhh, I don't really know how it happened. I mean, one minute I'm just using tik and the next I'm almost, it's almost like I'm part of a gang. It happened so quick. But it happened from smoking with this one and that one. And then, I ended up in the gang crowd. Started sleeping with them and thinking that I was kwaai (cool). Uhhh, I liked being part of them I felt important. So the sex also started, sleeping with them, different guys of the gang.' Michelle



4.8.5 The vulnerable crystal meth addict

Through their experiences and perceptions the participants explained how the teenage crystal meth female is vulnerable to manipulation and to the effect that crystal meth had on their sexuality. In this light it may be important to consider the disease model of addiction's central idea that the addict experiences the absence of freedom of choice (West in Seear & Fraser, 2010). This implies that the addict's behaviour is impaired, which may lead to harmful consequences (West in Seear & Fraser, 2010). As an emerging concept the absence of freedom of choice has not been discussed in my literature chapter, but it is an important contributing factor to risky sexual behaviours in the context of crystal meth use.

4.8.5.1 Not having control over sexual decision making

The participants explained how the effect of crystal meth and the need to use crystal meth renders one powerless in sexual decision making. In this light the literature indicated that the use of crystal meth increases sexual encounters and results in heightened sexual arousal and experiences (Brecht et al., 2004; Buxton & Dove, 2008; Degenhardt et al., 2010; Degenhardt & Topp, 2003; Diaz et al., 2005; Halkitis et al., 2005; Lorvick, Martinez, Gee & Kral, 2006; Marcelle, 1999 in Russel et al., 2008; McKirnan et al., 2001 in Degenhardt et al., 2010; Rang & Dale, 2003 in Schifano et al., 2007; Ross et al., 2003; Wechsberg et al., 2008). The literature also indicated that drug use leads to impaired judgement (Morojele et al., 2006; George et al., 2005) and impaired decision making which can lead to risky sexual behaviours (Wechsberg et al., 2008). This can be perceived as part reason for the experience of powerlessness in sexual decision-making for the participants in my study. Likewise, Adrian (2006) emphasised that such impaired judgement may lead to unprotected sexual behaviours. Becker and Murphy, 1988 in Adrian (2006) further emphasised that this impaired judgement may be further compromised by poor decision making skills where the individual is more concerned with the immediate gratification of attaining a drug and not its long term effects. Therefore, the need to obtain the drug may override the rational thinking of having protected sex. In this light the need to use crystal meth and the sexual effects it has on the user may pose an increased vulnerability to risky sexual behaviours in the context of crystal meth use. Elisabeth explained that one gets into risky sexual situations due to the sexual effect that crystal

meth has on the individual. She explained that it's hard not to act on your sexual feelings when you are in the company of males. She also explained that one would do anything so that you can smoke crystal meth.

'... I think that, uhmm, tik in particular gives you, it increases your sex drive. It gives u like, you like, you might not even be feeling horny or sexual in any way but once you smoked it gives you that. So I think a lot of the times it's like hard not to act on, because there's males in the company. Then you would sort of start flirting or whatever. And sometimes to a point where you would end up having sex with him... And I think that it is a risk, because at that time you don't really worry about protection or whether you gonna be safe about it. Whether you are on, like any sort of birth control. It's just when it's there you have to smoke. So then you do whatever u need to do to smoke. If sleeping with someone is gonna give your drug of choice, then that's what some people do.' Elisabeth

Elisabeth gives a sense of being powerless when she explained how she did things that she did not want to do. She explained how one loses your power to the drug.

'I don't really think that's it's a choice that they have, because when you become, when you are an addict hey you are really powerless over a lot of the things, and that is especially the drug issue. And I think today a lot of the times it's just got to do with the drug that they are using, because a lot of the

times like with myself, I can only talk about my own experiences. I would do things that I didn't want to do. I would do things that's totally against all the morals and standards that I've set for myself, but because of the drugs that I was using I ended up doing it anyway. And that's just the affect the drugs have on you today. You no longer in control of anything... That's what they gonna have to do in order for them to score drugs.' Elisabeth

4.8.5.2 State of mind

Corsi and Booth (2008) emphasised that methamphetamine use may leave an individual helpless to protect themselves against risk behaviours due to the nature of the drug and the influence it has over the individual's brain. Likewise, the participants explained how their state of mind was affected as crystal meth addicts. In this way they also explained how they experienced the absence of rational thinking. This can also be linked to not being in control of their sexual decision making due to the experience of impaired judgement (Morojele et al., 2006; George et al., 2005), and impaired decision making (Adrian, 2006; Wechsberg et al., 2008). Therefore, through their perceptions and experiences the participants indicated how easy it is to get involved in risky sexual behaviors, because of their state of mind which was affected by their crystal meth use.

'I think that they are being taken advantage of, because why they are not in their normal state of mind. So guys will try, they will try their utmost best to get everything out of that girl in that time, because she is now in a other state.

So he will try to put all kinds of stuff in her head to do and try all kinds of things which she never did when she was sober. So tik has a major effect on your brain.' Michelle

'You are unable to think logically. That's why (pause). Because addiction it affects the brain. I can't recall the bio of it now. So, you like you confused man. Your thoughts are jumbled up. It's the drugs thinking for you, not you thinking. You conscious thoughts or whatever is at the back and the drug thoughts are in front. So, no matter how hard you gonna try, your addiction, the drugs are always going to speak until you get someone to help you and get that mindset properly again.' Jess

4.8.5.3 Preying on the crystal meth addict

The participants explained how people prey on crystal meth addicts due to the fact that they know that the addict has a weakness for crystal meth. Therefore, they use this knowledge in order to have sex with the crystal meth addict who does not acknowledge being used for other's sexual needs. Such manipulation has not been recorded in my literature chapter, but as an emerging theme it is important in understanding the risky sexual behaviours in the context of crystal meth use.

'Ok, some men and women, they tend to disrespect you and look down on you because of the situation you are in. And uhmm, like I said they tend to use you in such kind of way. (pause) . And you being used without you acknowledging

that you being used, because you having a good time, and you just see it as something that happened while you were having a good time, and tomorrow you may just be with that good time again.' Donna

Jess gave an example of how directly people approach crystal meth addicted females in order to have sex with in exchange for the payment of crystal meth:

'...if you know what people would do for tik then you'd use that. So if I know or I'm a sick person, you know, and I know that that girl is on tik I will be spiteful or something. I will go to the merchant, I will buy two packets. I tell you, 'kyk hiesa ek het twee pakkies ne, ma ek wil he jy moet die doen'. She's gonna say yes. You know what I'm saying. If she's at a point where she would do anything for it yes, she would.' Jess

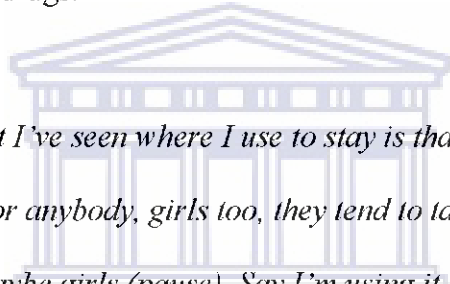
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According to the DSM-IV in Sussman and Ames (2001) one of the criteria for substance dependence is that the addict spends a lot of time on activities to obtain the drug, use the drug, and to recover from its effects. Therefore, the current sub-theme and the following one is indicative of the lengths that crystal meth addicts, especially the participants, went to maintain their drug use.

4.8.5.4 Manipulation: using other crystal meth addicts to score

Knowing the weaknesses of the crystal meth addict the participants explained how crystal meth addicts use fellow crystal meth addicts to maintain their drug habit. In

essence this is in a manner of selling them to someone who can supply them with crystal meth. However, they explained that the individual who is being used does not see it in that light. Sexual encounters are merely seen as something that happened while they were enjoying themselves. Research findings indicate that people trade sex for drugs or money to maintain a drug habit (Brecht et al, 2004; Mehradi et al., 2007; Morojele et al., 2006; Nemoto et al., 2002; Parry et al., 2008; Simbayi et al., 2006). However, the participants' knowledge and experiences adds another dimension to the idea of selling sex for drugs.



'Ok, from what I've seen where I use to stay is that some guy because you in that situation or anybody, girls too, they tend to take advantage of you. And then uhmm, maybe girls (pause). Say I'm using it and my friend, and then another girl comes along and then maybe somebody would say uhmm (pause) how do you say it in Afrikaans, like, "da is bait"... So, she go's to this guy. They know each other, but he's like a benefit or whatever. Now, she won't use herself to entertain him or whatever. She will come to me and this girl, and use us, but we won't see it in that way... It's all part of the plan. And then, the two of us gets used.' Donna

'... I would sort of sell my friends so that I could score my drugs. Then I wouldn't mind whether she would sleep with him or not.' Elisabeth

4.9 The addict, the teenager

In giving her view on why female crystal meth addicted adolescents get involved in risky sexual behaviours Tessa speaks from the perspective of the adolescent and not the crystal meth addict. She explained that having multiple partners is a means to 'try looking cool', and that because you are an adolescent you do not incorporate rational thinking. She further explains the adolescent's attitude to life as hedonistic and living in the moment. Here, 'wanting to look cool' is in relation to the adolescent's peers. Therefore, one way of explaining the risk of having multiple sex partners is an understanding of the prototype/willingness model. The prototype model assumes that there are two modes of information processing which include the reason path, which is similar to the theory of reasoned action; and the social reaction path (Gerrard et al., 2008). The social reaction path explains risk behaviour as often being unintentional (Gerrard et al., 2008) where adolescent risk behaviour may be a product of imaged-based decision making (Sunstein, 2008). A major assumption of the prototype model is that adolescents have clear social images (prototypes) of the type of individual who engages in specific risk behaviours (Gerrard et al., 2008) such as having multiple sex partners. Therefore, the typology of the adolescent's peers where they are considered as being 'cool' due to having multiple sex partners may lead to the adolescent's involvement in such risky behaviours. Here, the more favourable the typology, the more likely the adolescent would adopt the risk behaviour (Gerrard et al., 2008, Sunstein, 2008). Here, the social path and not the reason path take effect, which implies the absence of rational thinking as indicated by Tessa. In addition, Greydanus and Patel (2005) emphasised that a sense of invulnerability and immorality together

with an absence of concern about the adverse consequences of substance abuse are major developmental factors that influences drug abuse in adolescence. One can view this sense of invulnerability and immorality together with the absence of concern about the consequences of risk behaviours as contributing to the adolescent's attitude towards life as being hedonistic and 'living in the moment'. Likewise, Gibbons et al., 2002 in Gerrard et al. (2008) found that low conditional vulnerability can lead to higher willingness to engage in risk behaviours.

'It is like also maybe because they want to be kwaai (cool) maybe or to show their friends that they can be a player. They can have three boyfriends at one time and they can use or they can wrap them around their fingers. You see when you on high school you mos want to show your friends that you are cool and you can get any guy that you want. You mos still a teenager man, and don't think straight that time... And that time when you a teenager you don't take life seriously that time, because you young and you don't know what it is to have responsibilities, and to be a mother and to have to look after a house and that. So you will, just like, you will enjoy your life man. They mos say you only have one life to live. That's why many of them also just go into drugs, cause they think 'ek het net een lewe om te lewe en ek moet ma nou net een keer net mal doen' (I only have one life to live and I must live it crazy).'

Tessa

4.10 Power dynamics where both intimate partners used crystal meth

All six participants were involved in intimate relationships where both partners used crystal meth. All six participants had unplanned pregnancies during their crystal meth addiction. Out of these six only two claimed that crystal meth did not have an effect on their sexual experiences. However, Jess described the nature of her sexual relations with her partner as one which was a product of his crystal meth addiction. While, Donna described the nature of her relationship as one that became more aggressive. One in which she has become the more aggressive partner.

4.10.1 Aggression due to crystal meth use in an intimate relationship

As discussed under the section which discusses the effects that crystal meth had on the participants in my study, aggression (Plüddeman et al., 2010; Saul, 2005 in Russel et al., 2008; Slavin, 2004 in Russel et al., 2008; Wray, 2000 in Russel et al., 2008), and violence (Brecht et al., 2004; Buxton & Dove) were identified as some of the side effects among the participants as well as in literature. However, aggression was also experienced by the participants in their intimate relationships. Conflict resulted due to the effect that crystal meth had on one of the partners in both Donna and Jess's relationships. However, in Jess's relationship her partner became violent towards her, because she started buying her own crystal meth, which resulted in her not sharing it with him.

'Yes, there were so many times. I sit and I think, 'yor gosh, was I really like that, was it really me?' Cause I know that I'm not really that type of person or I think 'could I really have done that?' Donna

'Then it came to a point where I didn't care, I buy my own stuff you know. Then he also smoked, and then he started to get upset, cause I mean he hit me also, he started to hit me... but it's also because of the drugs you understand. Because, he wasn't such a person, I also. When we started we weren't such people, but it just goes to show how drugs change comes and how we put that first.' Jess

4.10.2 Sex in exchange for drugs

The literature indicates that methamphetamine users often trade sex for drugs or money (Brecht et al, 2004; Mehradi et al., 2007; Morojele et al., 2006; Nemoto et al., 2002; Parry et al., 2008; Simbayi et al., 2006), and some give money or drugs in exchange for sex (Nemoto et al., 2002). On talking about the sexual behaviours in an intimate relationship where both partners use crystal meth both Donna and Jess gave accounts of how the male partner can use the female where crystal meth is the reward. Donna gave an example of how the male partner uses the female in a sexual manner to gain crystal meth, which can be linked to the literature.

'I know about something, where the guy didn't work and the girl didn't work either. So then their come maybe friends that has money, and then the guy expects the girl to maybe flirt. Do you understand. So that the friend who have money can provide or whatever.' Donna

Though Jess did not have multiple sex partners or any other sexual partner other than her intimate partner at that time she explained that the fact that her partner provided crystal meth at times necessitated her to sleep with him in order to get some of the crystal meth. Therefore, she saw herself as being sold to him for crystal meth. Here, her partner was the supplier of crystal meth and to Jess having sex with him was symbolic or likened to her selling herself to maintain her crystal meth needs.

'For me it's just about the fact that you just don't care. I mean with me, I didn't sleep around. I mos just only slept with him. So I didn't care. You understand. To me it was just pleasing him. Doing what he wanted me to do, because I didn't want him to shout at me or not only that. He maybe worked the weekend so he could say that he's gonna make us a packet. So it was a matter of (pause) you can ma say that I've been selling myself to him.' Jess

Both Donna and Jess's narratives can be linked to 'manipulation' where the one individual use the other to support their crystal meth addiction as well as to the 'trading sex for drugs', which was discussed earlier:

4.10.3 Obligated sex

Jess spoke about her experience of painful unaffectionate sexual intercourse with her intimate partner. She explained her role as non-active. She explained the process as being almost an hour long in some cases, and dry painful vaginal intercourse. Therefore, the effect that crystal meth had on her partner and the consequent sexual act where she experienced painful and dry sexual intercourse and her partner had long sessions of intercourse with her is in line with findings that crystal meth causes an increased libido, delayed ejaculation, longer intercourse, and decreased humoral secretions causing raw genitalia, which may contribute to increased chances of sexual infections (Gay & Sheppard, 1972 in Schifano et al., 2007). According to Corsi and Booth (2008) it may be difficult for the female to negotiate condom use in some cases where there is a power struggle, and the female is faced with a possible violent partner who is high on methamphetamine. Therefore, in Jess's case, violence might have been the consequence if she denied her partner sexual intercourse.

'... my ex-boyfriend was the only one I ever slept with, but because of the drugs, it became more like I had to sleep with him... Hy sal net se, 'kyk hiesa, ek is lis' (look here, I want to have sex), ne like so. So, on the bed mos now it will just be a matter of indruk en kla (put in and finish). You understand. It wasn't still a matter of where people make love and you can actually say it was a nice experience, because it was never a nice experience for me. Because, I never enjoyed it. You understand. It was just a matter of me laying there and him doing everything, you know, until it was done. And

automatically if you on tik it boost your libido, so he was very, very, very (pause). So it would last long, like very long, so for an hour or something. And then sometimes it will be long and sometimes it will be just quick and it would be over. Ja, and I never ever used condoms, because he would always say that it's not the same thing. So I had to do everything his way... normally they always say that you must always have foreplay you know, but that was just a matter of dry you know. Putting the penis into a dry vagina. You know it's quite painful, ja.' Jess

The power dynamics in an intimate relationship where both partners use crystal meth was not discussed in my literature chapter. However, as an emerging theme it has proven to be an important dimension of risky sexual behaviours in the context of crystal meth use.

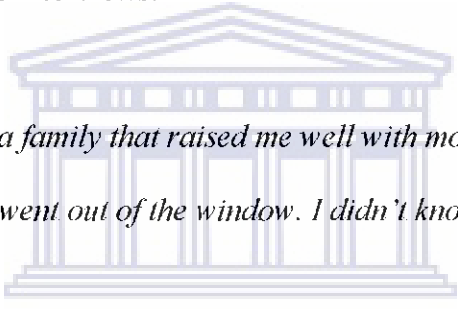
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4.11 Regret

As an emerging theme literature on 'regret' was not included in my literature chapter, but it is important as it indicates the regret that the participants had over their lives as crystal meth addicts, which is linked to their sexual activities at that time. A study which involved participants age 16 to 35 found that alcohol and drug use were associated with having had and regretted sex after substance use (Bellis et al., 2008).

'Like basically for it's just smoking on, like having sex with someone while I was on a substance. It's something that I can say today I wish that, I wish that I would never do ever in my life again, because of the mental and physical and emotional situation that I placed myself in and all of the consequences of that were all negative.' Elisabeth

Linked to regret, the expression of the absence of morals and values were also threaded through all the interviews:



'I come out of a family that raised me well with morals and stuff, but you know that just went out of the window. I didn't know who I was...' Jess

'... it takes away your values, your morals, everything man. You don't, it takes away actually your respect and everything.' Tessa

4.12 Putting the findings into perspective

Each of the participants' narratives spoke of the power that one loses to the crystal meth addiction. The identified themes outlined the reasons for the participants' initial crystal meth use, which included various psychosocial factors. The effects that crystal meth had on the participants, which included physical, psychological, and social effects were also identified. With regards to sexual behaviours, the participants emphasised the effects that crystal meth had on themselves and others, and they also

used examples from their social environments. These effects were mostly related to their experiences of heightened arousal, impaired judgement and decision-making, and other vulnerabilities that the female crystal meth addict is exposed to such as being manipulated into having sex, and selling sex for drugs. In this regard one of the key factors expressed in the interviews was how the individual loses power to crystal meth in relation to the effect that it has on their sexual experiences as well as how it facilitates the manipulation needed to maintain their drug addiction. In lieu of this, crystal meth left the participants vulnerable to risky sexual behaviours. This power that crystal meth has over people's lives is evident on various levels as indicated by the participants in my study, and reinforces the priority that it takes in the addict's life whereby it affects their relationships with significant others as well as their personal well-being.

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Phenomenology's aim is to find the core essence of experiences (Creswell, 1997; Flood, 2010) and perceptions (Parsons, 2010). In line with this aim, the essence of my findings with regards to the participants' experiences, and perceptions of their sexual behaviours lay in the power that they lost to their crystal meth addiction, which made them vulnerable to sexual risk behaviours.

CHAPTER 5

CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter will be including a summary of my findings, which will be followed by the limitations and recommendations for future research.

5.2 Summary of key findings

I will summarise the key findings of my study in terms of the objectives and overall aim of my study. Following this I will highlight other findings which have proven to be important to understanding the overall aim of the participants' experiences and perceptions of sexual behaviours in the context of crystal meth addiction.

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5.2.1 The objectives and overall aim

In gaining a deeper understanding regarding the reasons for initial crystal meth use the participants gave various reasons which include, curiosity, experimenting, peer pressure, the willingness to get involved in crystal meth use, the influence of family dynamics, and the progression from using gateway drugs to using crystal meth. In addition to family dynamics as factors that contributed to the participants initial crystal meth use, one of the participants explained that she did not stop using due to continued used by one of the members in her household. With regard to the second objective of the participants' perceptions of risky sexual behaviours and the

consequences thereof, it was evident that not all the participants clearly understood the concept of risky sexual behaviours, which necessitated me to define it to most of the participants. However, they indicated a good understanding of the consequences of risky sexual behaviours, and used their own experiences of falling pregnant and having an STI as a consequence of having unprotected sex. Using examples from their residential areas they acknowledged that unplanned pregnancies, HIV and STI infections, are consequences of risky sexual behaviors. Interestingly, losing self respect was also noted as a consequence of risky sexual behaviours, which adds an emotional context to the consequences. In the light of the third objective which sought a deeper understanding of the participants sexual behaviours in the context of crystal meth use I found that the participants were involved in risky sexual behaviours such as having multiple sex partners, having unprotected sex, having sex in exchange for crystal meth, and having anal sex.

The overall aim of gaining a deeper understanding about how and why adolescent female crystal methamphetamine recovering addicts experienced and perceive sexual behaviours in relation to their crystal methamphetamine addiction can be understood on various levels. First as a physical effect of their crystal meth use the participants experienced heightened sexual arousal as well as they became sexually more active. In this light some of the participants explained that their engagement in sexual risk taking was due to the need to fulfill their constant sexual desires. These sexual desires were expressed as though it was an addiction separate from their crystal meth addiction. Here, having multiple sex partners were also explained in the terms of the

difficulty of maintaining a long term relationship when using crystal meth in conjunction with the constant need for sexual gratification. Secondly, the constant need to achieve the euphoric feeling that they first experienced when using crystal meth left them vulnerable to sexual risk taking such as having unprotected sex, having multiple sex partners, and having sex in exchange for drugs. Here, the availability of crystal meth facilitated risky sexual behaviours. The participants explained that this need makes one vulnerable to being manipulated into risky sexual behaviours as well as manipulating others into engaging in such risk behaviours as a means to maintain their crystal meth addiction. One of the participants explained that she felt like she sold herself to her intimate partner, who also used crystal meth, because he supplied her with crystal meth. In addition to the context the participants also used examples of their residential areas to explain such vulnerabilities. Thirdly, the participants explained that the effect of crystal meth on one's sexuality and the need to use crystal meth renders one powerless in sexual decision making. In this light impaired judgement and decision-making in sexual decision making, which is due to the absence of freedom of choice, may lead to risky sexual behaviours.

5.2.2 Factors strengthening the experience of losing power to crystal meth

Throughout the interviews the participants expressed and detailed how the crystal meth addict loses her/his power to it. The participants experienced and explained that the constant need to achieve a state of euphoria via the use of crystal meth took priority over their relationships with significant others, their personal hygiene as well

as their personal safety, which explained the power that crystal meth gained as the participants became addicted to it. Likewise, the participants' denial about their drug addiction is also linked to the priority that crystal meth took over their well-being. One of the consequences of this priority was the rejection that the participants experienced from their families. In addition, the participants explained manipulation as a means of obtaining crystal meth in two ways. First, using crystal meth as a reward for having sex with an addict. Secondly, manipulating the crystal meth addict into sexual activities where sexual encounters are merely seen as something that happened while they were enjoying themselves. Here, the manipulator, who is also a crystal meth addict, uses a fellow addict to gain access to crystal meth. As discussed under the previous section, the participants' sexual experiences and the perceptions thereof also spoke of the power that crystal meth has over the user. Here, the need to maintain the addiction as well as the need for sexual gratification was influenced by the lack of judgement and rational decision-making in conjunction with the pharmacological effect that it has on the individual's sexuality, which often renders the individual helpless in their decision making.

The power dynamics where both intimate partners used crystal meth added another level to the power that crystal meth has over the female addict's life. One participant explained that sex with her partner was obligatory. Here, her partner and not she experienced the heightened sexual arousal and an increased libido, which is documented as an effect of crystal meth use. She also explained that she felt as if she was selling herself to him, because he supplied her with the crystal meth. Another

participant gave an example of how the male partner uses the female in a sexual manner so that she attracts the attention of someone who can supply him with crystal meth.

5.2.3 Regret

Throughout the interviews the participants expressed their regret over the lives they led as crystal meth addicts. This can also be linked to their sexual behaviours as addicts. Likewise, the absence of morals and values during their crystal meth addiction was also evident throughout the interviews. Through this, the now sober minded participants acknowledged that their behaviours, especially with regards to their sexual behaviours, would not have occurred if they were not addicted to crystal meth. Therefore, this regret and acknowledgement of the absence of morals and values in the context of crystal meth use is indicative of the power it had over the participants' lives.

5.2.3 Locating the adolescent in sexual risk behaviours

In understanding why crystal meth addicted adolescent females get involved in risky sexual behaviours the perspective of the teenager and not the crystal meth addict was also given. One participant explained that having multiple partners is a means of trying to look 'cool'. She also explained that most adolescents do not incorporate rational thinking; and further explained the teenager's attitude to life as hedonistic and living in the moment. Here, the typology of the adolescent's peers where they are

considered as being 'cool' due to having multiple sex partners may lead to the involvement in such risky behaviours. One can view the adolescent's sense of invulnerability and immorality, as identified in literature, together with the absence of concern about the consequences of risk behaviours as contributing to the adolescent's attitude towards life as being hedonistic and 'living in the moment'.

5.3 Limitations

My study focused on females who are identified as a risk population for both risky sexual behaviours and crystal meth addiction. Though IPA was good for exploring the participants' subjective experiences and perceptions, it does not fully explore the gendered nature of the participants' sexual experiences and perceptions in the context of their crystal meth addiction. Therefore, in the light of the gendered nature of my study, a feminist framework could have added another perspective to my study.

In addition, gaining access to rehabilitation centers that service the Mitchell's Plain area was extremely difficult and time consuming. The reasons for this include some rehabilitation centers policy not to expose their clients to any type of research; some rehabilitation centers not having individuals who fit the selection criteria for the sampling; as well as the fact that the rehabilitation centers indicated that their clientele for crystal meth addiction was only high during certain times of the year such as after a holiday period.

5.4 Recommendations for future research

With regards to crystal meth addiction recommendations for future research should include conducting more qualitative research that will explore the life of the crystal meth addict, especially in terms of risky sexual behaviours, conducting more research with a focus on females and adolescents who are risk populations for risky sexual behaviours and crystal meth addiction. Future research should also include a feminist framework which will aid in understanding the gendered nature of crystal meth use as well as substance use in general, and risky sexual behaviours. A feminist approach can also explore gender power imbalances in sexual decision making as well as focus more on the power imbalances where both intimate partners are using crystal meth. Such research can help identify and gain a deeper insight to the risk and protective factors of the life of the crystal meth addict, which in turn will inform the development of appropriate primary prevention strategies such as decision-making skills to help deter risky sexual behaviours in the context of crystal meth addiction as well as substance use in general. In addition, I recommend that future research should also obtain a deeper understanding of the consequences of crystal meth addiction and risky sexual behaviours in its context via qualitative research. Here, a deeper understanding of the context of crystal meth use can aid with secondary prevention strategies, which would enable more positive outcomes for rehabilitation.

5.5 Conclusion

In conclusion my thesis illuminates the participants' experiences and perceptions of their crystal meth addiction and how it fed into their sexual behaviours and their understanding thereof. My study was based on a phenomenological theoretical framework, which is concerned about people's lived experiences and the perceptions they have of their lived world. The data collection for my study utilised semi-structured interviews, which was analysed using interpretative phenomenological analysis. Through the analysis a number of themes were identified, which gave a more in-depth understanding of the participants' experiences and perceptions of the world that they lived in as crystal meth addicts. With regards to the objectives of my study, the participants gave various psychosocial reasons for their initial crystal meth use; not all of the participants indicated a clear understanding of the concept of risky sexual behaviours, but through their experiences and perceptions they indicated a clear understanding of the consequences of risky sexual behaviours in the context of crystal meth use. Speaking to the third objective with regards to their sexual behaviours in the context of crystal meth use the participants indicated that they were involved in risky sexual behaviours, which included having multiple sex partners, having unprotected sex, having sex in exchange for crystal meth, and having anal sex. In light of the overall aim the participants explained that the effect of crystal meth on one's sexuality and the constant need to use crystal meth renders one powerless in sexual decision making. In general, the participants' narratives spoke of how and why they lost power to crystal meth, and consequently were vulnerable to risky sexual behaviours. Therefore, my study illuminated the participants' experiences and

perceptions of their crystal meth addiction and how it fed into their sexual behaviours and their understanding thereof.

5.6 Reflection

My reflections span from my collection of resources to the analysis and discussion of my data. With regards to past literature, I found it difficult to retrieve information that focused on the experiences of crystal methamphetamine use. Consequently, I also used literature on methamphetamine in general as it includes crystal methamphetamine. Furthermore, my literature review covered appropriate focal areas, which led to it being concise with regards to the literature deemed necessary to assist in executing my research with its particular aims and objectives

Due to my personal background and knowledge attained from my residential area I selected data collection areas that are currently experiencing high levels of drug abuse. Like my own residential area these areas are labeled as disadvantaged with characteristics which include social concerns such as crime, domestic violence, substance abuse, and gangsterism. With the high levels of drug abuse in these areas I thought that I would gain access to potential participants easily. However, access was achieved with great difficulty due to the fact that many of the potential participants did not fit the selection criteria. At times I felt that I have exhausted the available resources, which led to long intervals between interviews.

The interviews proceeded smoothly. I met with the potential participants on a day separate from the interview day in order to establish a good rapport. This initial meeting was important as the participants received information regarding the nature and the background of the study. Part of my introduction included explaining why I have an interest in the research topic, which necessitated me to share information of my residential area as well as my personal background. I strongly feel that the interviews proceeded smoothly because the participants felt at ease with me as the interviewer, which is partly due to their knowledge of my background. Thus, I could relate to their circumstances and their experiences as I am exposed to such social ills and its consequences on a daily basis. In this way I was always aware of the manner in which I received information from the participants as well as how I interpreted it. I was constantly aware of any personal bias which may have developed, but I was also conscious that my own background aided me in understanding the research topic. In addition, the participants' language was that of a slang which mixes the English and Afrikaans languages with the addition of certain slang phrases which helped them to express themselves. Once again, my own background facilitated the interview as well as the analysis process. This is due to my own understanding of the slang used by the participants as well as my ability to use such slang, which led to the interviews running smoothly with minimal explanation required from the participants. This understanding also aided me with the data analysis. Therefore, having empathy with the participants' individual stories and social backgrounds, and having an idea of the vulnerabilities that they experienced assisted me throughout the data collection, analysis and discussion of my thesis.

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Appendix A

PARTICIPANT INFORMATION SHEET

Title of Study: Experiences and perceptions of risky sexual behaviours in the context of crystal meth use among female adolescents at rehabilitation centers in Cape Town.

I am Jessica Paulse. I am a Master's Research student at the University of the Western Cape. I am undertaking a research study as part of my curriculum. Conducting one-on-one interviews forms a critical part of this research project. You are being invited to participate in this research study, which will be conducted by me, because you have been identified as an ideal participant.

This is a student research study conducted under the supervision of Ms M. Andipatin. The study will help me learn more about the topic area and develop skills in research design, data collection, analysis of data, and writing a research paper.

In order to decide whether or not you want to be a part of this research study, you should understand what is involved and the benefits. This form gives detailed information about the research study, which will be discussed with you. Once you understand the study, you will be asked to sign a form if you wish to participate. Please take your time to make your decision. Feel free to discuss it with your friends and family.

Why is this research being done?

In recent years South Africa has been experiencing high increased rates of crystal methamphetamine (tik) addiction. In addition, the use of "tik" has been associated with risky sexual behaviours, which can lead to unplanned pregnancies, sexually transmitted infection (STI's), and HIV infections. The Western Cape has been experiencing escalating rates of crystal methamphetamine addiction as well as HIV infections. Therefore, I am trying to gain a deeper understanding of teenage girl's perceptions and experiences in relation to "tik" use. You have been identified as an ideal individual to help in gaining a better understanding of this.

How many people will take part in this research?

In total, six participants will be interviewed.

What will happen if I take part in this research study?

- You will take part in an interview session, which will bring about a discussion of the research topic.
- Your name will be omitted or you will be given a pseudonym (false name), which assist in keeping your identity anonymous.
- With your permission, a tape recording of the interview will be made. After the interview this recording will be typed into a computer. The information will be kept, but any mention of names will be removed so that the information cannot be traced back to you.
- All interviews will take place at the rehabilitation centre.

Can I stop being in the study?

Yes. You can decide to withdraw at anytime from the study. You can inform the researcher if you plan to do so.

What risks can I expect from being in the study?

The study poses no physical harm to you, but it may happen that you feel uncomfortable or upset during the interview. You are free not to answer any questions that you do not wish to answer. Counselling will be made available to you should a need for counseling arise.

Are there benefits to taking part in the study?

There will be no monetary payment or any other direct benefit to you from participating in this study. However, it will help researchers to gain a deeper understanding of sexual behaviours in relation to “tik” use.

Will information about me be kept private?

Any personal information gathered from this study will be kept private. Your name and/or any identifying information will not be used on any documents or any presentations or publications. Only your consent form will be kept on record.

What are my rights if I take part in this study?

Taking part in this study is your choice. If you decide to take part in this study, you may leave the study at any time. You will not be penalized in any way if you decide to withdraw from this study.

Who can answer my questions about the study?

You can talk to the researcher (J. Paulse) if you have any questions or concerns about this study.



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Appendix B

Participant Consent Form

I,..... hereby give my consent to participate in this research project which is a study based on the perceptions and experiences of teenage girls' with regards to risky sexual behaviours in relation to crystal methamphetamine use. I understand that the project is being conducted under the auspices of the Psychology Department at the University of the Western Cape. I have not been unduly pressurised into granting this interview, and understand that I am free to terminate the interview at any stage without any consequences. I understand that any information will be treated with utmost confidentiality and that my identity will be kept anonymous. Furthermore, I agree that the data collected could be published in reports or publications.

Name of participant:

Signature of participant: Date:.....

Consent for taping/recording the discussion:

I agree that the researcher is allowed to tape/record the interview.

Signature of participant:.....

Interviewer's statement:

I, the undersigned, have defined and explained to the voluntary participant in a language that she understands the procedures to be followed and the obligations of the interviewer.

Interviewer:

Interviewer's Signature: Date:

Appendix: C

Interview schedule

Demographic Questions:

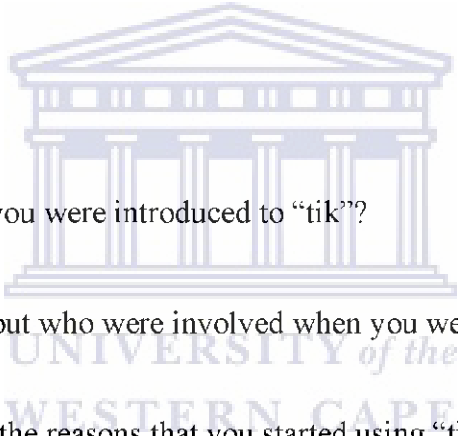
Pseudonym:

Age:

Dependents:

Home Language:

Interview Guide

- 
1. Tel me about how you were introduced to “tik”?
Probe:
 - a: Tell me more about who were involved when you were introduced to it.
 2. Tel me more about the reasons that you started using “tik”.
 3. What effect do you think “tik” has on someone?
Probes:
 - a: What do you think are the physical and emotional effects of “tik” use?
 - b: Please tell me more about your own experience when you used “tik”.
 4. What do you understand about risky sexual behaviours?
Probes:
 - a: How do you think risky sexual behaviours occurs?
 - b: Please tell me more about your sexual experiences?
 5. What do you think are the consequences of risky sexual behaviours?

6. How do you think HIV and STI infections are caused?
7. Have you ever had risky sex?
Probes:
 - a: Please tell me more about it.
 - b: Did your actions have any consequences?
8. What do you think are the reasons teenage “tik” addicted girls get involved in risky sexual behaviours?
9. From your knowledge, what kind of risky sexual behaviours do you know “tik” addicted girls get involved with?
Probe:

Can you tell me more about your own sexual experiences?
10. Do you think “tik” addicted teenage girls are at risk of being taken advantage of in a sexual manner/way?
Probe:

Please tell me more about it?
11. Is there anything more about your experiences or understanding about “tik” and risky sexual behaviours that you would like to share with me?

The interviewer will define “risky sexual behaviours” to the participant after question four.