

**EXPLORING PERCEIVED REASONS AND RISK FACTORS FOR
ILLCIT DRUG USE AMONG YOUTH IN THE WESTERN CAPE:
IMPLICATIONS FOR PRIMARY PREVENTION**

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The logo of the University of the Western Cape is a faint, light blue watermark in the background. It features a classical building with a pediment and columns, with the text 'UNIVERSITY of the WESTERN CAPE' written below it.

Thesis submitted in fulfillment of the requirements for the
PhD degree in the Department of Social Work
Faculty of Community and Health Sciences
University of the Western Cape

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Date: January 2017

ABSTRACT

Background: Globally, drug abuse among youth is recognised as one of our greatest health and social problems and, as in other countries, South Africa is battling with this phenomenon. Drug abuse among youth (including children and adolescents) is on the increase, and a National Youth Risk Behaviour Survey, conducted at High Schools in South Africa, reveals that overall, almost 50% of grade 8-11 learners had used alcohol, and 13% had indulged in cannabis use in their lifetime. Drug abuse at an early age has been associated with various problems, such as risky sexual behaviours, health problems, depression, crime, and ultimately drug addiction, which often occur at a later age. A better understanding of the perceived reasons and the risk factors that influence adolescent drug use is crucial for the development of effective prevention strategies.

Major aims: By examining the subjective life experiences and drug-taking pathways of young drug users, the researcher aimed to explore and analyse the perceived reasons and the contributing risk factors for drug use in adolescents. In addition, the researcher aimed to use the findings, emanating from the data, to inform the focus of primary prevention efforts.

Method: A mixed-method concurrent embedded research design, utilising both quantitative and qualitative methods of inquiry, was applied to gather in-depth data from a purposive sample of 41 young (14–19 years of age) drug users, at five drug treatment centres in the Western Cape. Multiple data collection techniques, including structured questionnaires (with close- and open-ended questions), semi-structured in-depth interviews with young drug users, as well as a school official, written life histories, and a focus group discussion were employed in this study. The quantitative data were analysed by means of the Statistical Programme for Social Science (SPSS) computer software, while a thematic data analysis method was applied to the qualitative data.

Bronfenbrenner's broad Ecological Systems Theory (EST) was utilised to explore the perceived reasons for drug-use. It was also applied to reveal and unravel the multiple, possible, inter-related contributing factors for this phenomenon, with the focus on the Microlevelsystem of EST, namely, the individual and his/her immediate social domains. Other theories were incorporated into the discussion of the findings to provide an integrated and deeper understanding of the findings, within the broader field of human development.

Results: The research findings of this study revealed clear associations between adolescent drug use and negative family functioning, such as substance abuse by parental/care-givers, absent fathers, domestic violence, physical abuse and compromised parent-child relationships. Other risk factors that were identified included a lack of adult after-school supervision, association with drug-using peers, school dropout, and easy access to drugs within the neighbourhood/community.

Conclusion: The results support prevention initiatives that strengthen family functioning (particularly the parent/care-giver-child relationship), encourage live-in and non-live-in fathers to be involved in the lives of their children, reduce parental/caregiver substance abuse, and focus on adolescents' resilience development and their ability to resist peer pressure. The extent to which these familial factors are defining features and characteristics of drug abuse among youth, in general, should be subject to further investigation, to inform more effective primary prevention approaches.



KEY WORDS

Adolescents

Drug/substance use

Ecological Systems Theory

Family

Parent/caregiver

Parent-child relationship

Precursors

Primary Prevention

Risk Factors

Substance abuse

Youth



ABBREVIATIONS

AOD	– Alcohol and other drugs
CJCP	– Centre for Justice and Crime Prevention
DSD	– Department of Social Development
EST	– Ecological Systems Theory
HSRC	– Human Sciences Research Council
MRC	– Medical Research Council
NDMP	– National Drug Master Plan
NIDA	– National Institute on Drug Abuse
NYLS	– National Youth Lifestyle Study
NYP	– National Youth Policy
SACENDU	– South African Community Epidemiology Network on Drug Use
SAIRR	– South African Institute of Race Relations
SAMHSA	– Substance Abuse and Mental Health Services Administration
SANYRBS	– South African National Youth Risk Behaviour Survey
SFP	– Strengthening Families Programme
StatsSA	– Statistics South Africa
UNODC	– United Nations Office on Drug and Crime
WHO	– World Health Organisation

DECLARATION

I declare that '*Exploring perceived reasons and risk factors for illicit drug use among youth in the Western Cape: Implications for primary prevention*', 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 by complete references.

Full names: Edna Grace Rich

Date: January 2017



Signed: 

DEDICATION

In dedication to my first grandchild, Anna Joy Schörger, and my children, Candida, Micaela, and Matthew, who serve as my inspiration to leave a legacy of life-long learning.

I also dedicate this work to all those people, who believe that the fight against drug abuse begins with primary prevention at the family level - which is the most powerful force in any child's life, and the bedrock of every society.



ACKNOWLEDGEMENTS

I would like to acknowledge my Heavenly Father, who provided me with strength and external supports to accomplish this God-sized project, and hereby express my sincere thanks to:

My husband, Trevor, and children, for your unwavering love and support and time sacrificed to enable me to complete;

My late Mom, for instilling in me a deep faith in God and resolute perseverance in all my endeavours;

My Dad, for inspiring me towards a life of service to God and His creation, and instilling in me a passion for reading and learning;

Prof. Lorna Holtman and Dr Marcel Londt, for their encouragement, direction and continual motivation, while supervising this study;

My friend and colleague, Prof Nicky Roman for her on-going support and belief in my work;

My editor, Mr Eddi Londt, for his competence and the professional manner in which he transformed my work into a thesis that I can be proud of;

All the participants, who shared their deepest feelings with me, without which, this thesis would not have been made possible;

My family for their loyal support and assistance in times of need, and to my friends for the encouragement along this journey;

Finally, to the National Research Foundation (NRF) for providing the much appreciated financial aid for this study, and to the Erasmus Mundus (EUSAID) scholarship that allowed me the opportunity to engage in my writing process at the Ruhr University in Bochum, Germany.

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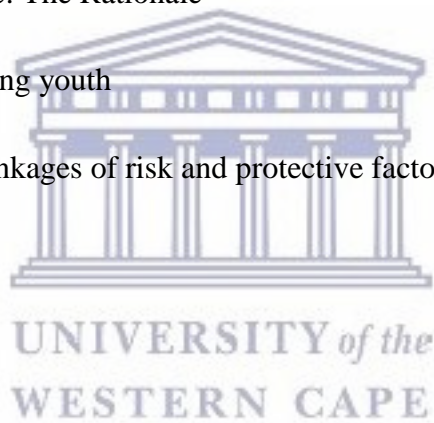
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CHAPTER ONE

CONTEXT OF THE STUDY

1.1. Introduction

South Africa has a high rate of substance abuse among youth, both in and out of school. Increasingly more young people, under the age of 20 years, are seeking treatment for substance abuse in the Western Cape, as well as other provinces in South Africa (Dada *et al.*, 2014). Consequently, it has been established that adolescents, engaging in illicit drug abuse, are also more likely to become involved in other risky behaviours, including school drop-out, unsafe sexual practises, as well as other anti-social and criminal activities that encumber their optimal developmental outcomes and overall well-being. What the reasons are, and which personal and external/environmental factors put young people in the Western Cape at risk for illicit drug using behaviours, are questions that summon responses and intervention.

Young children are primarily socialized through family processes and parenting/caregiver practices, while later in their development, other social environments, such as the peer/school/neighbourhood factors, may influence their decision-making behaviours, including the decision to abuse drugs and other substances. The researcher acknowledges and comprehends the critical role of family environments and childhood experiences. The purpose of this dissertation, therefore, is to explore the perceived reasons for drug use/abuse, from the perspective of the young drug user, and to explore the potential inter-related internal and external/environmental factors that put young people (aged between 14-19 years) at risk for drug-taking behaviours.

The contribution of this thesis is varied, as it –

- provides a voice to the young drug user and focuses on their reasons for drug use, from their own perspective;
- explores the demographic, individual, familial, and contextual factors at play in their lives;
- highlights the precursors and unravels the inter-related environmental factors that put them at risk for drug-using behaviours;

- highlights the identified areas of risks that could inform the focus of primary prevention efforts; and
- highlights the areas of need for further research on the reasons and risk factors of drug use among youth.

This introductory chapter presents the background information and rationale for this research study. In addition, the research questions, aims and objectives, as well as the research methodology and design are introduced. The significance of the study is discussed and the key concepts of the study are defined. Finally, a brief summation of the content of all the chapters in this research study is presented.

1.2. Background

South Africa is overburdened with widespread poverty, social and income inequalities, which pose immense challenges for its entire population and, more specifically, for its young people from previously disadvantaged communities (South Africa [SA] Department of Social Development [DSD], 2013d). Due to the discriminatory injustices of past practices and policies, a substantial portion of the population (39%), aged between 14 and 35 years, have experienced limited opportunities. Consequently, they have not fully developed to their maximum potential (South Africa, National Youth Commission & the Youth Desk in the Presidency, 2009: 1). Therefore, this lack of opportunities, as well as the high unemployment rate, contributes to the high incidence of drug use among youth.

Globally, substance abuse among youth is recognised as one of the paramount health and social problems (United Nations Office on Drugs and Crime [UNODC], (2012); World Health Organisation (WHO), 2002; 2014). As is the case in other countries, South Africa is also battling with this phenomenon (Reddy *et al.*, 2003; Reddy *et al.*, 2010; South Africa, Department of Social Development [DSD], 2006; 2013a). According to WHO (2014), the South African statistics for drug dependency and substance consumption, such as cannabis, cocaine, and methamphetamine, is twice that of the global average. A recent literature review on substance abuse among youth revealed that drug use is rampant among school-going youth. Many learners reported being offered, using, or being sold illicit drugs, including alcohol and other drugs (AOD), on their school's premises (Ndondo, 2016). A study conducted in Mitchell's Plain, Cape Town, indicated that 50% of all students had consumed

alcohol in their lifetime, 30% had used cannabis, and 9% had used methamphetamine (Hamdulay & Mash, 2011).

These statistics have dire consequences for the youth population (aged between 15-24 years old) of South Africa that totals about 13 million. Associated social, mental and physical health problems for drug using youth include, family dysfunction, psychiatric disorders, and increased risks of injury and death (Chesang, 2013; McDowell & Futris, 2004; Parry *et al.*, 2005; Plüddemann, Parry & Bhana, 2008). These consequences and others threaten the very fabric of the young people's social well-being and, very often, their lives, creating huge challenges for the future of human society, as a whole.

Researchers argue that the escalation in the cultivation, trafficking and consumption of drugs, has greatly fuelled the existing phenomena of gangsterism and crime (Kibble, 1997; United Nations Office for Drug Control & Crime Prevention [UNODC], 2002). In the Western Cape of South Africa, the most convictions for drug and gang-related crimes have been reported by previous studies, predominantly in the 'Coloured' townships, compared to the other provinces (Kinnes, 2000; Standing, 2003). According to Statistics South Africa [StatsSA] (2011), about half of the inhabitants of the Western Cape are historically referred to (attributable to the Apartheid Regime's racial classification) as "Coloured" people, or people of mixed descent. The problem, therefore, is overwhelming and the need for intervention, well overdue. The Drug use/abuse, not only exposes young people to poor school achievement, possible school drop-out and potential involvement in gangsterism and crime, but also to other risky behaviours, such as unprotected sex with multiple partners, unwanted pregnancies, and possibly, Human Immunodeficiency Virus (HIV) infection (Reddy *et al.*, 2003; Reddy *et al.*, 2010).

Recently, researchers of the Medical Research Council [MRC] researched treatment intake trends for alcohol and drug abuse (Dada *et al.*, 2014; Parry *et al.*, 2005). These researchers obtained data from various drug treatment sites, in all nine provinces of South Africa. Through this longitudinal monitoring study, entitled the South African Community Epidemiology Network on Drug Use (SACENDU) project, scientists were able to publish a bi-annual report that provided an overview of the scale of the problem (Dada *et al.*, 2014). The study further highlighted issues, such as the increase in intake at treatment facilities, changes in the ages in-patient admissions, as well as changes in the trends of drug abuse.

They, therefore, could draw attention to an increase in the abuse of the harmful methamphetamine drug (commonly known as ‘tik’) in Cape Town, especially among the youth from the Cape Flats area (Parry *et al.*, 2005; Dada *et al.*, 2014). In the latest SACENDU report (Dada *et al.*, 2016), cannabis was reportedly the most common illicit drug used across the country, however, in the Western Cape, methamphetamine (MA) remained the second substance of choice among users 20 years and younger. The same report revealed that during the first half of 2015, there was an overall increase in the number of users seeking treatment across the 75 centres/programmes under review (Dada *et al.*, 2016).

Clearly, the high prevalence of drug abuse among South African youth cannot be denied. According to the researchers of the Medical Research Council (MRC), there is a concern that the current statistics only represent a ‘drop in the ocean’ of the true prevalence rates. It is purported that the majority of drug-abusers do not seek, or have easy access to, treatment and, therefore, are not included in the figures provided (Parry *et al.*, 2005). In addition, it is significant that much of the South African data are usually obtained through school surveys (Reddy *et al.*, 2003; Reddy *et al.*, 2010). Although these school surveys target a major portion of the adolescent population, they, nonetheless, portray only a partial picture of the overall problem, as they neglect a segment of the group, namely, the ‘out of school and the unemployed youth’. These vulnerable groups, who are often marginalised by society, may have problems and needs that differ significantly from the youth, who still attend school.

A review of substance abuse studies, conducted in the Western Cape between 2000 and 2008 (Harker, Kader, Myers *et al.*, 2008), also revealed that the majority of South African studies focus on the trends and prevalence of substance abuse. A review of studies executed between the mid-1970s and mid 1990s (Rocha-Silva, 2001) reveal that the majority of South African studies have undertaken quantitative assessments of drug prevalence and trends involving youth, but have largely neglected to investigate the reasons for the drug abuse. In this review, only one qualitative study (Rocha-Silva, de Miranda & Erasmus, 1996) was identified and reported on. Rocha-Silva (1998: p. 1) noted, “...drug use was generally investigated, giving scant attention to the context of and the *reasons* for drug use” (*italics* - own emphasis). The researcher, therefore, realised that little attention was being paid to the internal and external risk factors, as well as the perceived reasons that, as claimed by young people, had influenced their drug-using pathways in the first place. This stark realisation was the motivating factor of this research project.

This study, therefore, aims to explore the perceived reasons for drug use, as well as the contributing environmental factors that put young people at risk of substance abuse. The experiences, perspectives, and views of ‘at risk’ youth in the Western Cape will be explored, unravelled and described, using various data collection tools, including questionnaires, interviews, and life-histories accounts. The researcher contends that the views and findings could provide the basis for informed future practices, which contribute to the development of need-centred and integrative, prevention strategies. The outcomes of this study could also influence future research on youth and substance abuse that would further contribute to credible knowledge development in the research arena of substance abuse among youth.

1.3. Problem statement

The United Nations Office on Drug and Crime (UNODC, 2012) reported that, during 2010, at least 5% of the global adult population participated, at least once, in illicit drug use. Subsequently, substance abuse among adolescents has become a global public health concern (Patrick, Schulenberg, O’Malley, Johnston & Bachman, 2011). It has been determined that substance abuse contributes to health and social implications for adolescents in the following areas: criminal activities, poor academic performance, exposure to risky sexual behaviours, and deterioration in mental and physical well-being (Morojele, London *et al.*, 2009; Pierce, *et al.*, 2015; Plüddemann *et al.*, 2013; Plüddemann, Flisher, McKetin, Parry & Lombard, 2012).

Although there is significant concern about the drug abuse of adolescents, few studies have focused on the perceived reasons that explain why they become involved, as well as the contributing factors that put them at risk of starting the abuse of drugs (Kaiser Family Foundation, 2002; Leoschut, 2009a). After reviewing the South African literature, the researcher discovered that, although youth are central to understanding delinquent behaviour, such as drug use/abuse, research on their life experiences, and their views on the factors that affect their behavioural pathways, remain limited. The lack of understanding ‘*why*’ youth get involved in illegal drug use, limits the ability to plan appropriate prevention/intervention skills and support programmes that could strengthen the protective factors and lead to the rehabilitation of young lives (Snedker, Herting & Walton, 2009).

This study set out to explore the perceived reasons and interrelated risk-factors for drug use, as perceived by young drug users (aged 14-19 years), who started using drugs in their

pre/adolescent years, and were currently being treated for substance abuse dependencies. The purpose of the study is to explore and identify challenges, as well as risks, in order to inform the focus of appropriate primary prevention strategies that will help to prevent and reduce the prevalence of adolescent substance abuse.

1.4. Research Questions

The research questions for this study are as follows:

- What are the main perceived reasons for drug use among youth?
- What are the contributing risk factors for drug use among youth?

1.5. Aim of the study

The aim of the study is to establish the main perceived reasons for drug use from the perspective of the young drug abuser, as well as to explore and identify the inter-related intrapersonal, familial, and environmental risk factors present in the lives of young drug abusers, and to use these findings to inform the focus of primary drug prevention efforts.

1.6. Objectives of the study

The following are the main objectives of the study:

- Identify and describe the demographic and contextual profiles of young drug users;
- Establish and describe the perceived reasons for the use of illicit drugs by young drug abusers;
- Discover areas of risk by exploring the childhood experiences and family contexts and inter-relationships;
- Explore and analyse precursors to their drug-taking pathways, in order to identify the contributing risk-factors in their lives;
- Identify and describe the perceived forms of support that young drug users had available to them at home and at school after they became involved in drug-using behaviour;

- Explore the perceived reasons for drug use and its implications for primary prevention from the perspective of a school official at an at-risk school community;
- Use the identified areas of risks emanating from the data to inform the focus of primary prevention efforts and programmes.

1.7. Research Methodology

This study employed an embedded mixed methods design, in which the researcher first collected the quantitative data, which was “embedded within a qualitatively phenomenological design to help describe the broader context of a qualitative study” (De Vos, Strydom, Fouche & Delport, 2011: p. 443). Tashakkori and Teddlie (2003: p. 711) define mixed methods research as ‘a type of research design, in which qualitative and quantitative approaches are used in types of questions, research methods, data collection and analysis procedures, or inferences’. There are, however, many types of mixed-methods research designs specified in literature, namely, the explanatory, the exploratory, triangulation and the embedded design (De Vos *et al.*, 2011; Maree, 2007). According to Creswell (2009), the concurrent embedded strategy of mixed methods, selected for this study, allows for the use of one data collection phase, during which both quantitative and qualitative data are collected at the same time.

Creswell (2009) asserts that the embedded approach has a primary method, guiding the project, with the secondary data providing a supporting role in the research process. In this study, the primary method was the qualitative approach, while the secondary method was the quantitative approach, which is given less priority, and, therefore, embedded within the qualitative method (Creswell, 2009). The rationale for this approach was that the quantitative data provided a demographical and biological profile of the participants, and, consequently, a general understanding of the research problem. The qualitative data and its analysis were able to refine and explain the statistical results, by exploring the participants’ views more comprehensively.

1.8. Research Design

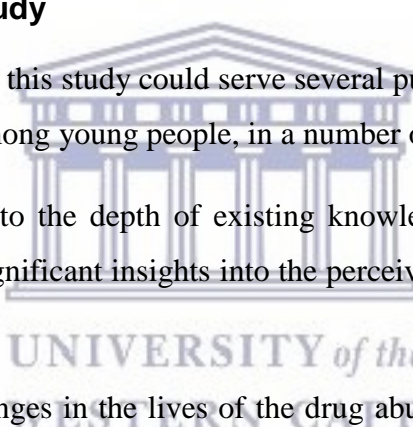
As previously mentioned, the concurrent embedded design employed in this study consisted of quantitative and qualitative data collection methods (De Vos *et al.*, 2011). The strengths

and weaknesses of this mixed-methods design have been widely discussed in literature (De Vos *et al.*, 2011; Maree, 2007). The advantages of this design are that both types of data (quantitative and qualitative) can be collected concurrently (Ivankova *et al.*, 2007, cited in De Vos *et al.*, 2011), while it can also “enhance a study with a supplemental data set, either quantitative or qualitative” (Maree, 2007: p. 288). For example, in this study, the quantitative data from the questionnaire is embedded within the dominant qualitative design, to provide and “help describe the broader context” of the qualitative data findings (De Vos *et al.*, 2011: p. 443).

The limitations of this design are that it could be time consuming to conduct the study, while the feasibility of the resources required for the collecting and analysing of both types of data, needs to be considered.

1.9. Significance of the study

The insights to be gained from this study could serve several purposes and contribute towards the reduction of drug abuse among young people, in a number of ways:

- 
- The study contributes to the depth of existing knowledge on drug abuse by young people and provides significant insights into the perceived reasons and risk factors for the abuse;
 - It highlights the challenges in the lives of the drug abusers, as well as their families, and allows for a greater understanding of the complexities of the risk factors;
 - These identified risk factors could inform the focus of preventative measures to reduce drug use among youth;
 - It serves as a pilot study to illuminate needs and factors, to inform policy makers, programme developers, service providers, parents, teachers, and others, in the design and implementation of more effective and needs-based intervention services;
 - The findings of this study inform parameters for future and unexplored research areas; and
 - The study could guide appropriate questions for surveys and questionnaires in future quantitative and other studies.

1.10. Definition of Key Terms of the study

Adolescence – A transitional period of human development ranging between the ages of 11 and 21 years, referred to as early, middle and late adolescence (Steinberg, 1993).

Youth – This study focuses on youth between the ages of 14 to 19 years, often referred to as adolescents (Arnett, 2002; Steinberg, 1993). In this study, the terms youth and adolescents will be used interchangeably.

Drugs or substances – The term encompasses drugs, alcohol, chemical or psychoactive substances. A *licit drug* refers to a drug that is legally available without medical prescription, and an *illicit drug* refers to a psychoactive substance, whose production, use, or sale, is prohibited (SA, DSD, 2006; 2013a).

Drug/substance use – Broadly refers to the use of licit or illicit substances that include, but are not limited to, cigarettes, alcohol, amphetamine, cocaine, marijuana (dagga), ecstasy, heroin, LSD, mandrax, methamphetamine. Although all the participants were undergoing treatment for illicit drug *abuse*, it should be noted that the focus of this study is on the perceived reasons that youth start to use drugs, in the first place.

Drug/substance abuse – The term refers to the misuse and abuse of *legal* substances, such as nicotine, alcohol, over-the-counter drugs, prescribed drugs, alcohol concoctions, indigenous plants, solvents and inhalants, as well as *illicit drugs* (SA DSD, 2006; 2013a).

Ecological Systems Theory (EST) – This is a developmental theory that views human development from a person-in-environment context and emphasises that all growth and development occurs within the contexts of the bi-directional relationships. This shows the interaction *in* and *between* various levels or systems, for example, a child must be studied in the context of the family system, and the family needs to be understood within the broader community, societal culture and values (Bronfenbrenner, 1979; 2005).

Family – This basic unit of society comprises a group of people, who love and care for each other, and is responsible for child-rearing functions (Seligman, 1992).

Family functioning – refers to the patterns in which family members relate, interact, react to and treat other members of the family, including communication styles, traditions, clear roles or boundaries, and family processes over time (Winek, 2010).

Family Resilience – refers to the family's ability to withstand and rebound from disruptive life challenges (Walsh, 2003).

Parent – The adult person(s) responsible for the primary caregiving of the young child – not restricted to the biological mother and father (Lezin, Roller, Bean & Taylor, 2004).

Parental monitoring – refers to a set of behaviours used to gain knowledge about an adolescent's whereabouts, friends, associates and activities (Bourdeau, Miller, Duke & Ames, 2011)

Parent-child relationship – refers to the quality of the emotional bond between child and parents (mother, father or significant parental figure) and the degree to which this bond is mutual and sustained over time (Lezin *et al.*, 2004).

Primary prevention – means any activity designed to prevent or delay the onset of substance use to reduce its health and social consequences". These include Universal programmes, selective and/ or indicated programmes (SA DSD, 2013).

Precursor(s) – something that comes before something else and that often leads to, or influences its development (Merriam-Webster's Learner's Dictionary) "Precursors of drug and alcohol problems have been described as risk factors for drug abuse" (Hawkins, Catalano & Miller, 1992: p. 65).

Phenomenology – "...the science of describing what one perceives, senses and knows in one's immediate awareness and experience" (Moustakas, 1994).

Reasons for use – refers to the perceived causes for the start of drug use, as described by drug-using youth.

Risk Factors – "Risk factors occur before drug abuse and are associated statistically with an increased probability of drug abuse" (Hawkins, *et al.*, 1992: p. 65). Healthy development is compromised when multiple risk factors occur that are not offset by compensating protective factors (Hawkins *et al.*, 1992).

"Youth at risk" - can be defined as young people, whose background places them 'at risk' of future anti-social behaviours, such as drug use, due to personal, environmental, social and family conditions that hinder their personal development, as well as successful integration into the economy and society (Kosterman, Hawkins, Haggerty, Spoth & Redmond, 2001).

1.11. Thesis chapter outline

In **Chapter One**, the background and rationale for the study is presented. The need for research that allows for a greater understanding of the interacting risk factors in the lives of

drug-using youth and their families is highlighted. Understanding to what extent family and social factors contribute to adolescent drug abuse, could serve to inform the *focus* of *preventative* and *eliminative* measures for drug use among youth.

In **Chapter Two**, the focus is on the theoretical framework of the study. In addition, the researcher presents and discusses some of the most widely accepted causation models of substance use. The researcher also discusses and justifies the conceptual/theoretical framework that was utilised to explore this phenomenon. These theoretical underpinnings aim to substantiate the significance and relevance of this thesis.

In **Chapter Three**, the literature review of the findings of previous studies that investigated this phenomenon is explored. The literature review encompasses scholarly works related to the prevalence of drug use among youth, both the global and local context. The literature review also explores the notions of adolescent development and its associated risk-taking behaviour, as well as the reviewed causes/reasons and risk factors for drug use among youth.

In **Chapter Four**, the rationale for the research methodology used in this study is outlined. A description of the research process, which includes the research setting, participants, data collection procedure and tools used in the study, is presented. The data analysis process and issues of ethical considerations are explained in detail. Reflexivity is clarified, and the study limitations are critically discussed.

In **Chapter Five**, the results of the study are presented in three sections namely Section A, Section B, and Section C. Section A presents the findings of the quantitative data, collected by means of the questionnaire. This section includes a descriptive presentation of the demographical findings, and provides a summary of the reasons for drug use, as provided by an open-ended question on the questionnaire. This section concludes with a presentation of the internal factors (individual/psychological or person factors) for drug use, as described by the young drug users. Section B provides the results of the study, in terms of the qualitative data, collected by means of the interviews, and life histories and field notes collected by means of the focus group discussion. This section includes the external factors, such as family and social factors, including the peer/school/neighbourhood reasons and risk factors for drug use among youth. Finally, Section C provides the results of the in-depth interview conducted with a school official, which explored the perceived reasons for drug use and the ways in which drug use could be prevented.

In **Chapter Six**, the researcher draws together all the results of the various data collection tools, and provides a discussion of the main findings of the study based on the various systems, in terms of Bronfenbrenner's Bioecological systems theory. These research findings include the perceived reasons provided for drug use, as well as the identified risk factors in the lives of the youth. Selected life-history accounts are used in the discussion to provide the context of the participants' lives and drug using pathways. The findings are explained in relation to existing literature and relevant theories.

Finally, in **Chapter Seven**, the researcher provides conclusions and recommendations based on the main findings of this study and other empirical studies/literature review. In addition, based on the findings, guidelines for parents and practitioners/educators regarding the prevention and reduction of drug abuse among youth are also recommended. Reflections, and the extent to which the research aims were met, are rendered, while the methodological strengths and limitations of this thesis and directions for future research are outlined.



CHAPTER TWO

THEORETICAL FRAMEWORK

2.1. Introduction

This chapter focuses on the theoretical framework of the study. In addition, the researcher presents and discusses some of the most widely accepted causation models of substance use among youth. The researcher also discusses and justifies the main conceptual/theoretical framework, namely and Bio-ecological Systems Theory, utilised in this study to explore and understand the reasons and risk factors for adolescent substance abuse.

2.2. Theoretical perspectives

According to Petraitis, Flay and Miller (1995), theories are sets of inter-related concepts and ideas that have been scientifically tested and combined to magnify, clarify and expand the understanding of people, their behaviours and their societies.

It is noteworthy that the growing malady of substance abuse is as complex as the individuals who are affected thereby. Research in this field has produced a host of differing theoretical perspectives and a mix of viewpoints on complex issues, ranging from causation to influencing factors for adolescent drug use (Bandura, 1977; Hawkins *et al.*, 1992; Jessor & Jessor, 1977). It is clear, however, that no one model has yet been developed to explain the cause of substance abuse fully, and present theories seem to be bound by reductionist interpretations from different disciplines. For example, Biological theories provide insight into specific mechanisms, relevant for understanding a certain (rather small) segment of the population (Goode, 2007). Psychological theories tend to focus on the individual, rather than on environmental and cultural contributors to individual behaviour (McDonald & Towberman, 1993). Sociological theories tend to focus on external factors, which have the effect of ignoring individual differences (McDonald & Towberman, 1993). Some theories will explain experimental substance use, and others examine factors that may influence regular use, dependence, or problem use (Goode, 2007). As a result, the literature is often contradictory; however, a few models exist that seek to clarify substance abuse by youth. These are summarised in the following four sub-sections.

2.2.1. Jessor's Problem Behaviour Theory

Steinberg and Morris (2001, p. 85) claimed that Jessor and Jessor's (1977) Problem Behaviour Theory, is probably the most influential of over-arching frameworks, to explain dysfunction and maladaptation in adolescence, and "continue[s] to dominate research during the past decade". Problem Behaviour Theory contends that adolescent behaviour, including risk and protective behaviour, is the product of complex interactions between people and their environment, and usually occurs in a 'cluster' of problem-behaviours (Jessor & Jessor, 1977; Jessor, 1992). This theory is based on the relationships among three psychosocial variables:

- The personality system, which includes values, personal beliefs, expectations, attitudes, and orientations toward self and society;
- The perceived environment system, which addresses perceptions of parents' and friends' attitudes toward behaviours; and
- The behaviour system that concerns problem behaviour, such as illicit substance abuse, as well as 'conventional' (protective) behaviours, such as church attendance and health behaviour.

The interrelations between these variables represent either instigations or controls that result in proneness – the likelihood that a risk (or protective) behaviour will occur. Problem Behaviour Theory also contends that early dysfunctional behaviour is associated with drug misuse in adolescence. According to Hawkins, Catalano and Miller (1992), the following young people are the most vulnerable to substance misuse:

- Those who are alienated from the values and norms of their families, schools and communities;
- Those who have a high tolerance for deviance;
- Those who have low religiosity;
- Those who have a resistance to traditional authority;
- Those who are sensation seeking;
- Those who do not show concern for their own safety;
- Those who do not do well in school; and

- Those, who befriend drug-using peers (Hawkins, Catalano & Miller, 1992; Van Ryzina, Foscoa & Dishion, 2012).

In addition, Problem Behaviour Theory emphasises the importance of young people's parental or peer attitudes and behaviour, as determinants of their own behaviour. Weakening risk factors, or strengthening protective controls, help to decrease a child's overall proneness for problem behaviours (Jessor, 1992; Whitesell, Bachand, Peel, & Brown, 2013).

2.2.2. Social Control Theory

A further widely held social process theory is Hirschi's (1969, cited in Petraitis, Flay & Miller, 1995) Social Control Theory. The focus of this theory is, almost exclusively, on deviant behaviours, such as delinquent acts (theft, vandalism) and drug use. Hirschi pinpointed three institutions or entities, namely, families, peers, and schools, which have the most profound impact on an individual's life, such as the child or adolescent. He argued that close associations with parents and siblings, law-abiding peers, teachers or other school officials, for example, were required to control the individual's behaviour. Therefore, drug use would be a likely outcome of ineffective ties to these systems, for example, poor bonding with parents or unhealthy child-rearing practices (Hirschi, 1969, cited in Petraitis, Flay & Miller, 1995; Johnston, O'Malley, Bachman, & Schulenberg, 2009).

Various studies assert that the establishment of a strong moral bond between the juvenile and society, consisting of an attachment to others, commitment to conventional behaviour, involvement in conventional activities, and a belief in the moral order and law, promotes conformity, and prevents delinquency and drug use (Hawkins *et al.*, 1992; Johnston, O'Malley, Bachman & Schulenberg, 2009).

There is consensus is that all aspects of a child's environment, including home, school, and community, determines whether or not s/he will start using drugs. Almost two decades after apartheid and under privilege, new policies and legislation are in place to address the well-being of all South Africans. Albeit, the country is still plagued by communities with high levels of gangsterism, crime, unsafe neighbourhoods, elevated levels of unemployment and poverty, as well as other social issues, such as school

drop-out, teenage pregnancies and substance abuse by youth and their families (SA DSD, 2013d). Recent statistics further suggest that there is an increasing prevalence of children being raised in single-parent households, with absent fathers (Holborn & Eddy, 2011). Furthermore, the lack of family support networks, inadequate resources and services, severely affect children and families, and not only the socioeconomic and relational dimensions on family life, but also has severe implications on healthy childhood development and behavioural outcomes – including substance abuse.

2.2.3. Social Development theory

An important extension of Social Control Theory in the area of substance use and abuse is Hawkins and Weis' (1985) Social Development Theory. In addition to elaborating on weak bonds between children, families, and institutions, it also combines insights from Social Learning Theory (Bandura, 1977) and Differential Association Theory (Dull, 1983) to explain adolescent substance use. There is a large contingent of empirical literature that supports these authors (Hawkins *et al.*, 1992; Johnston, O'Malley, Bachman & Schulenberg, 2007a; Kumpfer, 1999; Lezin *et al.*, 2004).

Social Development Theory focuses on the bonds that youth develop with those around them, indicating strong ties to Social Control Theory. It is a process-based theory, noting the importance of understanding socialisation influences over time. In short, bonds develop between youth and socialising agents, for example, families and teachers, around them (Hawkins *et al.*, 1992). Social Development Theory, therefore, posits that youth, who bond with drug-using adults or peers, are more likely to start using drugs themselves.

Pinnock (2016: 200) argues that trauma, coupled with dangerous neighbourhoods and high levels of drug use, undermines any sense of security in young people. He states, "If you don't expect to live past 25, why have safe sex or stay in school or study or drive carefully or avoid drugs? Why listen to anyone beyond your circle if you don't see a future?" (Gabarino, 1999, cited in Pinnock, 2016: p. 200).

2.2.4. Social Learning theory

Social Learning Theory, developed by Bandura (1977), envisions social behaviour as acquired through direct conditioning, or through modelling of others' behaviour. The

theory perceives human behaviour as the product of continuous reciprocal interaction between cognitive, behavioural and environmental factors. Behaviour is shaped through the positive reinforcement of reward and the negative reinforcement of punishment. It is weakened by aversive stimuli and by loss of reward (Bandura, 1999).

The theory further posits that the interaction of inner forces and environmental stimuli determines how people will behave. Behaviour is learned and moulded by watching others' behaviour and by integrating how others respond (Bandura, 1977; 1999). Substance use and abuse, therefore, is regarded as socially learned behaviours. Some children will learn to use alcohol and other drugs to help cope with stress, if their parents, peers or other important people in their environment do so. For example, younger children could acquire healthy, versus unhealthy, habits through observing the behaviour of their parents. Though there are other possible mechanisms, evidence has shown correlations, for example, between parental substance use and children's smoking and alcohol use (Hawkins *et al.*, 1992), consistent with a modelling process. A notable feature of Social Learning Theory is the importance it places on self-regulating capacities. Individuals have the ability to anticipate the consequences of their own behaviours, as well as the reactions of others to those behaviours. Young people, therefore, learn from observing others' behaviour (referred to as modelled behaviour), as well as from direct experience.

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From a prevention perspective, this theory suggests that improvements in health-related behaviour could be achieved by altering the modelling influence, for example, by helping parents to stop smoking or adopt healthier diets. Many social learning theorists focus on peers, because of the significance adolescents place on friends, as they mature and gain autonomy. However, families also appear to be important for learning attitudes and behaviours about alcohol and other drugs. In order to have a more holistic and integrated approach to the complex interplay of personality, genetic, environmental, and cultural influences on adolescent drug use behaviour, a more comprehensive conceptual framework for understanding adolescent substance abuse is required. The following discussion is the focal theory that underpins this study.

2.3. Motivation for use of an Integrated Framework

The explorative and descriptive nature of the research questions presented in section 1.4 indicates the need of a theory that emphasises the importance of taking the lived experiences of young drug users into account. Although there are different philosophical viewpoints that provide a foundation for the organisation and interpretation of empirical data into models, this study will adopt the philosophical viewpoint on human behaviour based on Thomas's concept/dictum. According to Thomas's concepts "If men define situations as real, they are real in their consequences" (Thomas & Thomas, 1928, cited in Bronfenbrenner, 1979: p. 23). As a result, the data collection procedures will attempt to encourage the participants in this study to provide their perceived reasons for drug use, as well as an exposition of their life events, leading up to their drug-taking behaviour. This stance requires the use of a theory that will be able to encompass a wide array of possible perceived reasons, which young drug users may provide as the instigation of their drug-using behaviour.

Central to the choice of framework is the knowledge that family factors and peer pressure have been the most strongly associated with adolescent substance abuse (Lezin *et al.*, 2004; Resnick, Harris & Blum, 1993). In addition, the literature also alludes to a variety of other interrelated causes within the individual/family/peer/school/neighbourhood and societal domains - rather than a single factor, for the initiation of substance use (Lezin *et al.*, 2004; Resnick, Harris & Blum, 1993).

The phenomenological method of inquiry indicates the need for a practical theory that could inform, support and/or challenge policy and action (Van Manen, 1990). Some theories in the literature review on the understanding of adolescent substance use and specific family-based variables that influence adolescent substance use include, Family Systems Theory, Social Cognitive Theory, Social Control Theory, and Strain Theory (Vakalahi, 2001; Goode, 2007). McDonald and Towberman (1993) noted that relevant psychological theories tend to focus on the individual factors/behaviour, such as personal attitudes, while sociological theories tend to focus on external/environmental factors. It would seem that there are many ways of viewing adolescent substance use; however, it is clear from the reviewed studies that the path to drug use and abuse is based on a complex interaction of multi-dimensional influences in and between personal, family, peer, school, neighbourhood and community domains.

A broad systemic framework, the Ecological Systems Theory of Human Development, developed by Urie Bronfenbrenner (1979; 2005), bridges the gap between analysing small and larger settings, as it provides a theoretical framework for systematically examining social contexts on both micro and macro levels. The framework is, therefore, well suited and useful to unravel the perceived causes, and explain the various influences and interactions within the various social contexts of the developing drug user, while also offering the freedom for the integration of other approaches, where necessary (Bain, 2004). This model, therefore displayed the potential to incorporate all perceived and non-perceived aspects of the individual's life.

2.4. Bio-ecological Systems Theory

Well-known developmental theorist, Urie Bronfenbrenner's (1979) Ecological Systems Theory, recently re-named Bio-ecological Systems Theory (Bronfenbrenner, 2005), purports that human behaviour is best studied from a personal and individual perspective, within human social contexts. It also underscores a fundamental principal of human development, namely that the *individual is at the centre* of five major environmental contexts, structured as a network of systems. These systems are referred to as Micro-, Meso-, Exo-, Macro- and Chronosystems (Bronfenbrenner, 2005).

- **Microsystem:** This is the innermost system, which is the immediate and most powerful environment of the child, such as people and events in the family, school/peers, and neighbourhood/community. The child is at the centre of this level and is not a passive recipient of experiences in these settings, but reciprocally interacts with others, while helping to construct the settings.
- **Mesosystem:** This second system represents the connections and interactions between one or more microsystem settings, for example, the connections between family and school experiences, or between family and peers. Experiences in one microsystem can affect experiences in another microsystem, for example, children, whose parents have rejected them, might have difficulty developing positive relationships with teachers. The last sentence in Microsystem refers.
- **Exosystem:** This is the third system, which refers to social settings within the wider society that do not include the child, but indirectly affects the child, for example, the parents' workplace, mass media, local government and community-based family

resources. Policies at the parents' workplace, such as inflexible or long hours, could affect the quality of the parent-child relationship, and, therefore, helps or hinders a child's development (Bronfenbrenner, 2005).

- **Macrosystem:** This is the outermost system, referred to as a 'societal blueprint', where cultural, sub-cultural or broader social systems exist. Culture is a very broad term that includes the roles of ethnicity and socio-economic factors in children's development, as well as societal values, customs, laws, beliefs and resources. For example, some cultures emphasise traditional gender roles that may promote male dominance, while in other cultures, more varied gender roles are accepted, and individuals have become sensitive to endorsing the value of equal opportunities for females and males (Bronfenbrenner, 2005).
- **Chronosystem:** This time-related system reflects dynamic environmental (ecological) transitions, entries, milestones, or turning points in the child's life. The timing of these transitions, or socio-historical conditions, may affect the child's development. For example, the disruptive effects of the parents' divorce, or other critical events, may coincide with entry into the adolescent life-stage, and may negatively affect a young person's development (Bronfenbrenner, 2005).

The researcher subscribed to the Ecological Systems Theory, as it was best suited to examine the phenomenon of drug use, and views human development from a *person-in-environment* context. The theory posits that all growth and development transpire within the context of relationships, while an individual's biological disposition, as well as the quality and context of the individual's environmental forces, converge to shape (either *help* or *hinder*) the child's development. This perspective embraces culture, power, inter-personal relationships, group value systems and social norms that help to reveal and elucidate how the lives of individuals, families and societies are inter-dependently linked (Bronfenbrenner, 2005; Maseko, Ladikos & Prinsloo, 2003; Mohasoa & Fourie, 2012; Resnick *et al.*, 1993).

This theory could also be used to apply strengths-based approaches, such as strengthening family-systems, to promote positive development across the human life span. Bronfenbrenner (2005) articulates the following about the importance of the family, and the quality of the parent-child relationship on the developing child:

Of all the settings that make us human, the family provides the most important developmental conditions: the love and care that a child needs to thrive. A healthy child and future is one who has such devoted people actively engaged in its life – those who love it, spend time with it, challenge it, and are interested in what it does and wants to do; in what it accomplishes from day to day. Other settings, such as school, church, or day care, are important to a child's development, but none can replace this basic unit of our social system: *the family is the most humane, the most powerful, and by far the most economical system known for making and keeping human beings human* (p. 262).

In a systems perspective, the behaviour of family members is viewed as intertwined, but thinking 'systemic' does not mean that the larger context always has to be included when addressing an issue. Spronck and Compernelle (1997) argue that, although it is interesting to be aware of the interaction within the various levels of the interacting systems:

'Systemic' does not signify that one always deals with the larger context at the same time, e.g., the family, when one deals with an individual; or society when one deals with a family. Thinking 'systemic' means that one is willing to take into account information about the other levels, the higher, as well as the lower ones. Working with families, for example, one is ready to take into account information about the culture, as well as about the individual and the brain. Therapists, as well as researchers, however, cannot address all these levels together at the same time. They have to choose. The level you choose to study and intervene on, depends on your interest, your goal, your knowledge, your tools, capacities, power, and so on. (p. 153)

As mentioned before, authors have cited many reasons for drug taking behaviour, but there seems to be consensus that children are influenced, first and foremost, by their parents and immediate family structures, as well as other social domains, such as peers, school and neighbourhood influences (Bogensneider, Small & Riley, 1994; Pinnock, 2016; Steinberg, 2001). Other researchers also argue that behaviour, such as adolescent substance use, is best understood in the family context (Anderson, 1991; Kumpfer, Alvarado & Whiteside, 2003; Vakalahi, 2002; Whitesell, Bachand, Peel & Brown, 2013). Therefore, it should be noted that

the focus of this study, when exploring the risk factors, is on the young drug abuser's most direct social context in the microsystem, namely, the family context. This study is concerned with the interactions and quality of relationships within the family system, as well as the interactions in, and between, the other social systems, such as the peer/school/neighbourhood influences on the lives on young drug abusers (see figure 1).

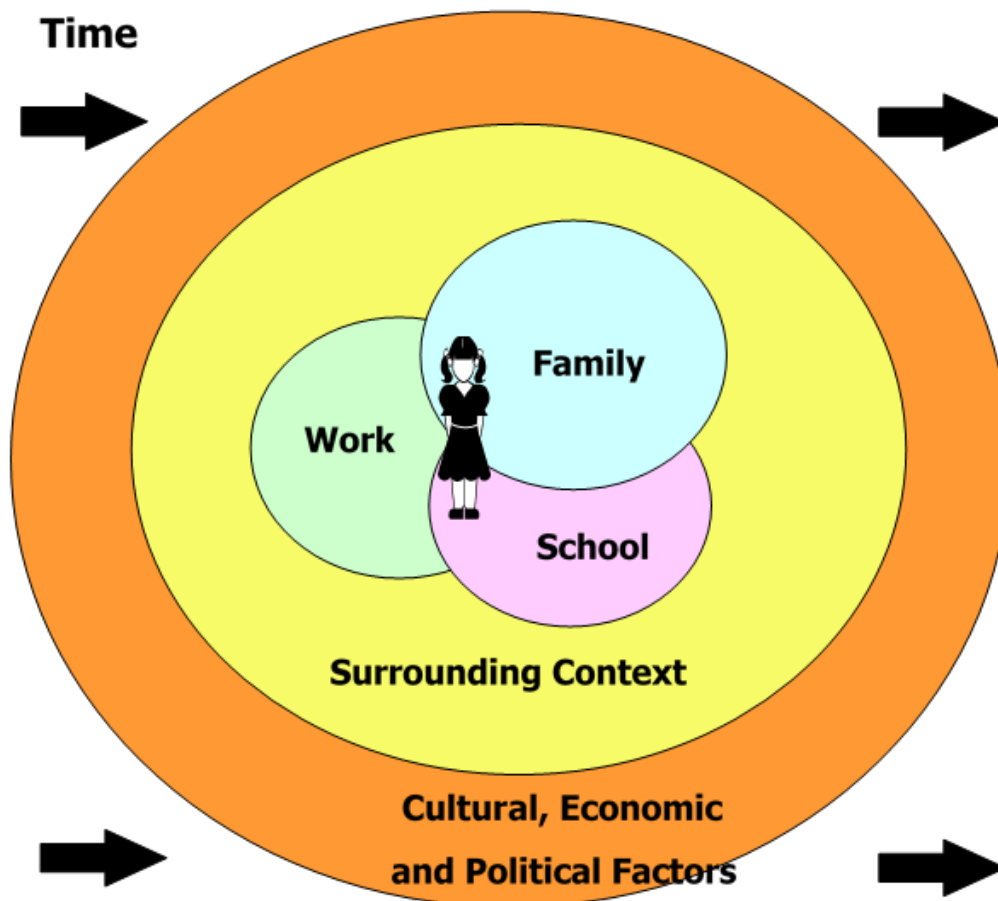


Figure 1: Bronfenbrenner's Ecological Model of Child Development

Source: Robertson (n.d).

The Ecological Systems framework is considered best suited to unravel and describe the perceived causes, as well as explain the numerous influences and interactions, within the various social contexts of the developing drug abuser (see Figure 2). This is due to the open-ended nature of the research question; "What are the perceived reasons and contributing risk

factors in the lives of young drug users?” This theory could also be utilised to discuss possible prevention/intervention strategies. It posits that in order to bring about change in the delinquent behaviour, the social systems within the family, school, community and society, which help to shape the behaviour, also have to change (see Figure 2 for an overview of interactions in, and between, various systems).

Huitt, W. (1999). Systems model of human behavior the context of development.
Retrieved February 18, 2001 from the World Wide Web:
<http://chiron.valdosta.edu/whuitt/materials/sysmdl.html>

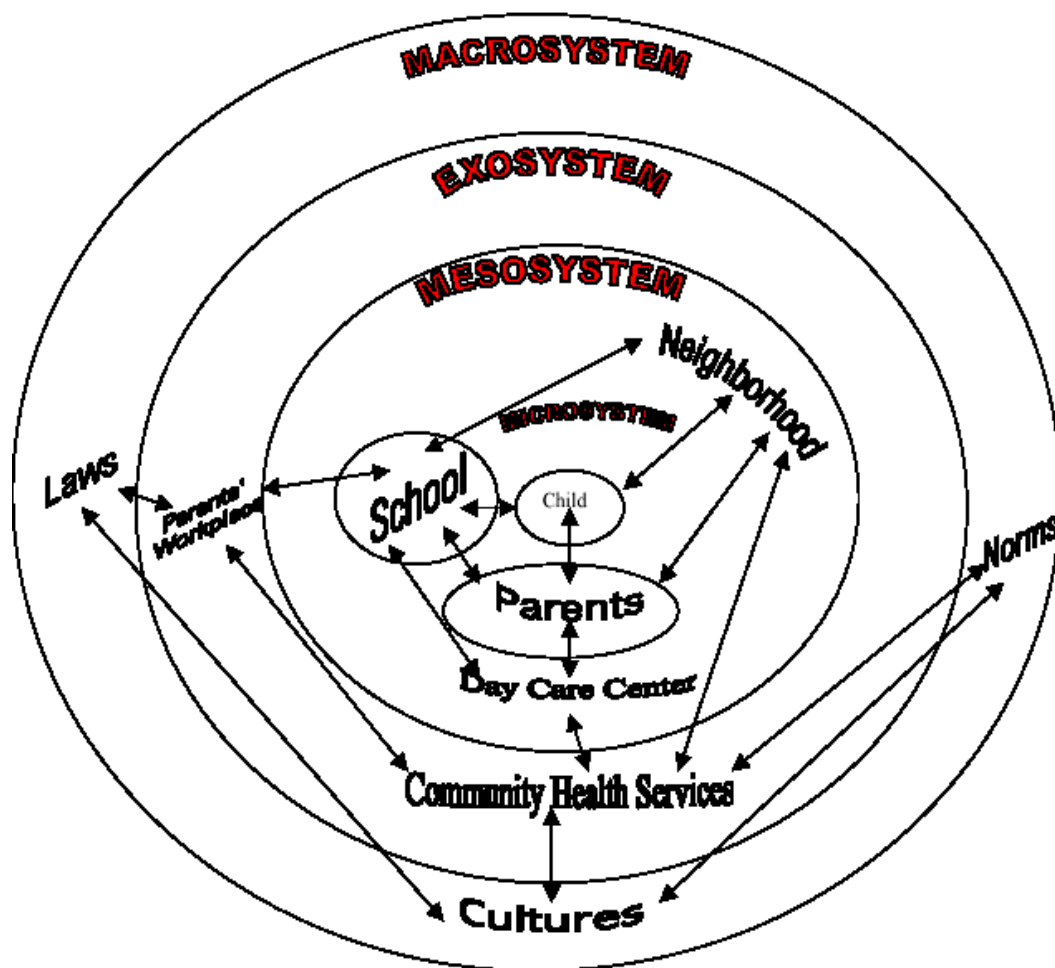


Figure 2: Systems model of human behaviour
Source: Huitt (1999; 2003).

Notwithstanding the above explanations, the researcher is aware that no theory is ‘all encompassing’, and critics of Bronfenbrenner’s theory assert that it gives too little attention to the biological and cognitive factors in children’s development (Boemmel & Briscoe, 2001; Ungar, 2001). However, Tudge, Mokrova, Hatfield and Karnik (2009) counter that, while the

criticism may have been true in Bronfenbrenner's earlier work (Bronfenbrenner, 1979), with a perceived focus on 'context', Bronfenbrenner later 'corrected' that shortcoming, by renaming it the 'Bio-ecological' Systems Theory. This stresses the importance of including the processes of human development (Bronfenbrenner, 2005). Bronfenbrenner further explains that the connection between some aspect of the context and some aspect of the individual could have implications for the outcomes. The revised theory engages the interaction among processes, person, context and time; it is labelled the Process-Person-Context-Time model [PPCT] (Bronfenbrenner, 2005; Bronfenbrenner & Morris, 1998). Critics of Bronfenbrenner's theory (Boemmel & Briscoe, 2001) also pointed out that the theory does not address the systematic developmental changes that are the focus of other theories, such as Erikson's (1950, 1968) Psychosocial Life Stage Development Theory. Therefore, where possible and relevant, other theories, such as Erikson's (1950, 1968) Psychosocial Life Stage Development Theory and/or Attachment Theory (Bowlby, 1980), will be utilised to provide a deeper understanding in the analysis and the discussion of results. Of notable importance, is the epistemology of the systemic framework, which emphasises interactions *within* and *between* systems, and does not attempt to provide one 'truth', but rather a truth in exploration of different realities (Bain, 2004).

2.5. Erikson's Psychosocial Life Stage Development Theory

Complementing Bronfenbrenner's analysis of the social contexts, in which children develop, as well as the individuals who are important in their lives, Erikson's Psychosocial Life Stage Development Theory (1968) captures some of life's key socio-emotional tasks, and places them in a developmental unfolding of life, in eight stages of development across the human lifespan. Each stage in the human life span consists of a developmental task that confronts individuals with a crisis. According to Erikson (1975), each crisis is not catastrophic, but a turning point of increased vulnerability and enhanced potential. The more successfully an individual resolves each crisis, the more psychologically healthy the individual will be. Each stage has both positive and negative sides. Success, or failure, in dealing with the conflicts at each stage could affect overall functioning.

Erikson's psychosocial theory was a critical force in forging the current view of human development as lifelong, rather than restricted only to childhood, and his concept of identity is especially helpful in understanding older adolescents (Santrock, 2000). During the

adolescent stage, for example, failure to develop an identity results in role confusion. This theory complements Bronfenbrenner's fifth system, the chronosystem, which refers to the importance of the timing of events in the developing individual's lifespan (see figure 3).

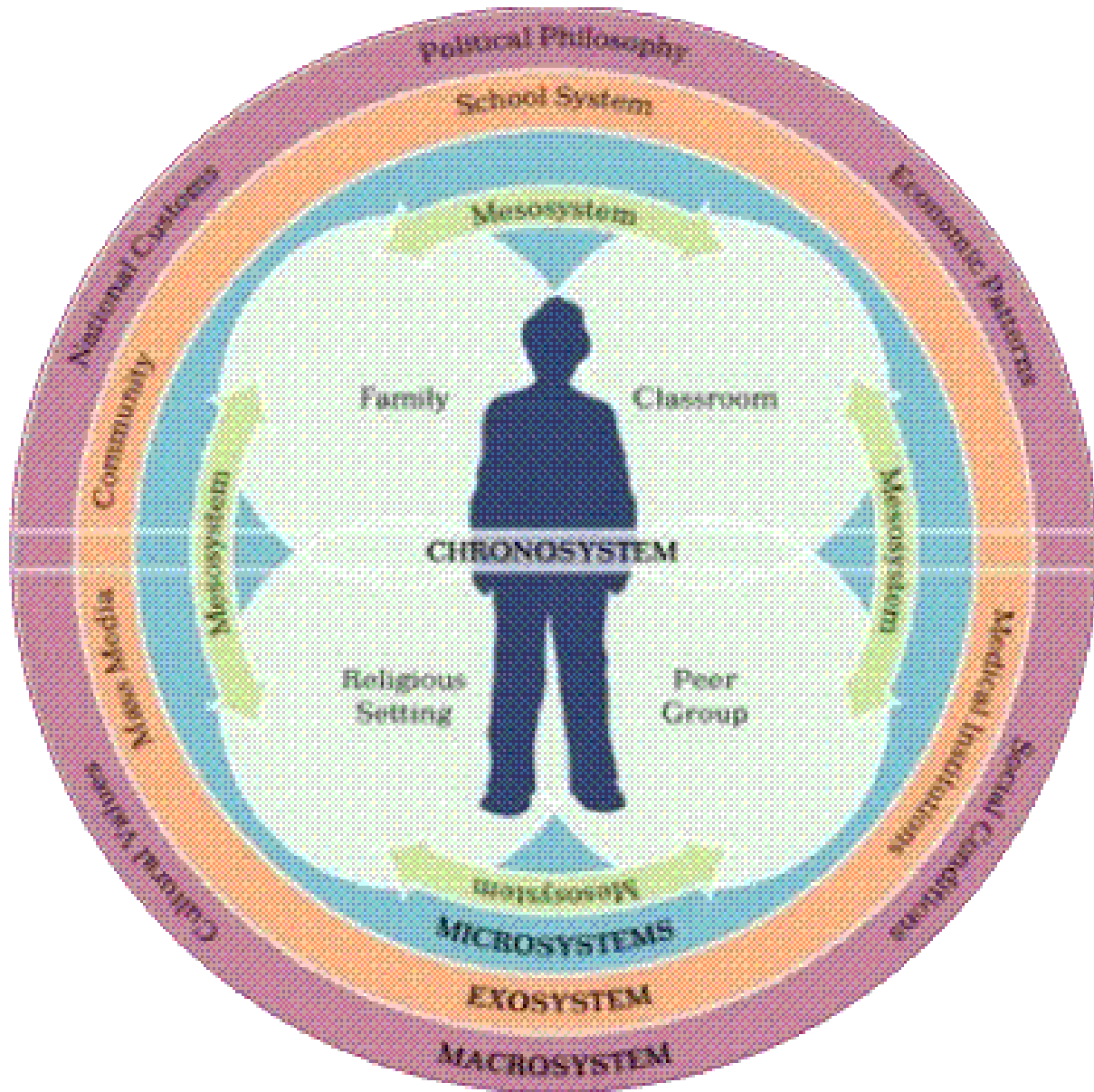


Figure 3: Bronfenbrenner's chronosystem: timing of events across the lifespan

Source: Metaphysical Ecology Reformulated (Nielsen, 2011).

Individuals are most likely to embark on abusing drugs, including tobacco, alcohol, and illegal or prescription drugs during adolescence and early adulthood. Adolescents have many reasons for using these substances including: the desire for new experiences; an attempt to

deal with problems; to perform better in school, or simple peer pressure. They are ‘biologically wired’ to seek new experiences and take risks, as well as carve out their own identity. Erikson (1975) describes the various stages of psychosocial developmental, through which human beings need to transition during their lifespan. During each stage, individuals face a core developmental conflict, and the extent to which they succeed in resolving this conflict, determines the likelihood of transitioning smoothly to subsequent developmental tasks. Experimenting with drugs may fulfil some of these normal developmental drives, but in an unhealthy way, that could have very serious long-term consequences. In the following section, the researcher summarises the first six stages of development, up to the early adult years, as described by Erikson (1968) and Santrock (2000), to reveal the links with future adolescent substance use, as well as other disorders.

- **Trust versus mistrust** is Erikson’s first psychosocial stage. It occurs in the first year of life. The development of trust requires warm and nurturing care giving. In the earliest stages of life, infants are entirely dependent on their caregivers. Caregivers provide infants with food, warmth, diaper changes, cuddling and response to calls of distress. The desired, positive outcome is a feeling of comfort and security, with minimal fear. As these initial experiences evolve over time, the quality of the caregiver-infant relationship becomes the infant’s first mental representation of the world. Mistrust develops when infants are treated negatively or are ignored.

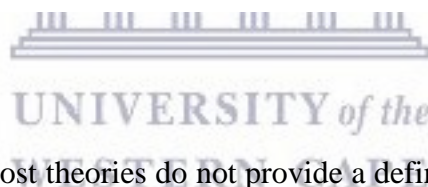
From this sense of mutuality, the infant gains its first understanding of ‘self’, providing it with a rudimentary sense of identity that is carefully honed through life’s experiences, and provides a foundation for social interactions, stored in memory, which will eventually guide the infant’s future. When caregivers respond to the infants’ vocalisations and provide the desired warmth, nourishment and physical contact, infants develop stable and positive representations of the world. These initial ‘cycles of learning’ provide the sense that the world can be trusted, and is safe. Conversely, infants, whose basic needs are not met with regularity and comfort, develop a sense of ‘mistrust’ that eventually fuels anxiety, fussiness and irritability. The lack of mutuality and the daily inconsistencies that abound between caregiver and infant, eventually give way to feelings of hopelessness.

- **Autonomy versus shame and doubt** occurs in late infancy and the toddler years. After developing trust in their caregivers, infants start to discover that their behaviour is their own. They assert their independence and realise their will; therefore, if infants

are restrained too much, or punished too harshly, they develop a sense of shame and doubt.

- **Initiative versus guilt** is Erikson's third psychosocial stage. It corresponds to early childhood, about 3 to 5 years of age. As young children experience a widening social world, they are challenged more than they were as infants. To cope with these challenges, they need to engage in active, purposeful behaviour. In this stage, adults expect children to become more responsible, and require them to assume some responsibility for taking care of their bodies and belongings. When children develop a sense of responsibility, it increases their initiative taking. Children develop uncomfortable feelings of guilt when they are irresponsible, or are made to feel too anxious.
- **Industry versus inferiority** is Erikson's fourth psychosocial stage. It corresponds approximately with the elementary school years, from 6 years of age until puberty or early adolescence. Children's initiative brings them into contact with a wealth of new experiences. As they move into the school years, they direct their energy toward mastering knowledge and intellectual skills. At no time are children more enthusiastic about learning, than at the end of early childhood, when their imagination is ripe. The danger in these primary school years is developing a sense of inferiority, unproductiveness and incompetence.
- **Identity versus identity confusion** is Erikson's fifth psychosocial stage. It corresponds to the adolescent years. Adolescents try to find out who they are, what they are all about, and where they are going in life. They are confronted with many new states and adult status, such as vocational and romantic transitions. Adolescents need to be allowed to explore different paths to attain a healthy identity. If adolescents do not adequately explore different roles, in order to carve out a positive future path, they could remain confused about their identity. Key to Erikson's theory is that each stage has both positive and negative sides, but the more successfully an individual resolves each crisis, the more psychologically healthy the individual will be. Although identity exploration is normative and considered part of healthy development, it may also represent a risk factor for experimentation with potentially risky behaviours, such as alcohol, or other drug use (Maggs, Frome, Eccles & Barber, 1997; Van Zyl, 2013).

- **Intimacy versus isolation** is Erikson's sixth psychosocial stage. It corresponds to the early adult years, the twenties and thirties. The developmental task is to form positive close relationships with others. Erikson describes intimacy as finding oneself, but then losing oneself in another person. The hazard of this stage is that one will fail to form an intimate relationship with a romantic partner or friend and become socially isolated. For such individuals, loneliness can become a dark cloud over their lives.
- Some experts believe that the overall scope of his theory has not been scientifically documented (Santrock, 2000). They argue that his stages are too rigid – that identity, intimacy, independence, and many other aspects of socio-emotional development in adolescents, do not always occur in the order he proposed, and that lifestyle differences influence the actual trajectory outcomes (Alsaker & Flammer, 1999; Brooks-Gunn, 1996, cited in Santrock, 2000). For example, for some individuals, especially females, intimacy concerns may precede identity or develop simultaneously. However, much research has been done on some of Erikson's stages, such as identity development (Santrock, 2000; Sokol, 2009), and this theory may be useful to highlight some aspects of the individual drug user's behaviour, not adequately attended to in Bronfenbrenner's Ecological model of human development.



2.6. Conclusion

This chapter concluded that most theories do not provide a definitive one-factor response that addresses the issue at hand. In fact, the theories revealed that behavioural outcomes are not driven by an individual's genetic make-up and biological characteristics alone, but result from interactions between biology, life experiences and the kinds of environments in which children and adolescents develop. Central among these environments are family, school/peer and neighbourhood groups. Broader social influences, such as the cultural values of the society (often mirrored through the media and political discourse), or those of the sub-culture in which the young person's family of origin is embedded, as well as the quality of the neighbourhoods, and the availability of, or access to, harmful substances, are also important. It is noted, however, that the family is a significant mediator of environmental influences (Lezin *et al.*, 2004).

Consistent with this, the literature on children exposed to family and social risks emphasise the importance of an ecological perspective for early intervention practices (Bronfenbrenner,

1989; Dishion & Kavanagh, 2000; SA DSD, 2013b; Garbarino & Abramowitz, 1992). For example, having an ecological perspective suggests that for school-aged children, attending to the school environment, as well as family factors, may be needed to bring about comprehensive improvements in children's behaviour. There is a dearth of qualitative studies into drug use among youth in the South African context. Even fewer studies have explored the perceptions of the individuals' reasons for drug use or taken the subjective life experiences of users into account.

This study, therefore, endeavours to explore the perceived reasons for drug use, the lived (home) experiences, as well as the perceived quality of the parent-child relationships, of the young drug users. In addition, this study aims to determine the nature of the support that young drug users perceived to be available for them, at home and at school, after they had started their drug use behaviour. It also aims to highlight the areas of need within the lives of drug users, as well as their families, and reveal a greater understanding of the interacting risk factors at work in their lives. These identified risk factors could serve to inform the focus of preventative and reduction measures (for example, promoting positive parenting practices as a prevention strategy), and could highlight the possible gaps in services and support to young people and their families. The following chapter will focus on the main literature that explores the reasons and risk factors for drug use among youth.

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CHAPTER THREE

LITERATURE REVIEW

3.1. Introduction

This chapter focuses on the literature and studies that address the causes and prevalence of drug use among youth. The risk factors, in both the global and local context, are defined and explored, in order to understand the challenges experienced by youth, who use substances. The researcher also provides a brief overview of adolescent development, in terms of general risk-taking behaviour, and explores the identified reasons and risk factors for drug use among youth. Additionally, an overview of some of the widely used theories that explain the etiology of drug use among adolescents is presented, and the theoretical underpinnings that substantiate the significance and relevance of this thesis are provided. The main threads identified in the literature are compared and contrasted in order to contextualise the significance to this study



3.2. A Global Context: Substance abuse and Youth

Substance use among young people appears to be a worldwide problem (World Health Organisation [WHO], 2002; United Nations Office on Drugs and Crime [UNODC], 2012), as there has been a global increase in adolescent substance abuse. In the United States, a survey, normally used with 8th graders, was conducted with 12th graders, and revealed an increase in the response to the questionnaire item, 'Have you ever used?'. An increase of 16.7 per cent for marijuana, 58.8 per cent for alcohol (26 per cent having been drunk), 46 per cent for cigarettes, and 20 per cent for inhalant use, was the outcome of the survey (Johnston, O'Malley & Bachman, 1995). This indicated that more 12th graders were abusing substances than 8th graders. In addition, the survey also indicated an escalation of drug abuse among young adolescents (primarily 8th graders) over a period of 4 years (1992 to 1996), since 8th graders were added to the high school seniors sampled in the 'Monitoring the Future' study' (Johnston *et al.*, 1995). The reported escalation over the 4-year period was substantial – 37 per cent increase for marijuana, 59 per cent increase for hallucinogens and 115 per cent increase for cocaine (Johnston *et al.*, 1995). According to Johnston, O'Malley, Bachman and Schulenberg (2007a; 2009) and Johnston, O'Malley, Bachman, Schulenberg and Bethesda

(2007b), these increases in prevalence trends of the ‘Monitoring the Future’ national survey results, continue to prevail.

Other researchers in the USA reported that by age fourteen, 35 per cent of youth had engaged in some form of illicit drug use, and by the time they graduate from high school, more than 50% had tried, at least, one illegal drug (McDowell & Futris, 2002; Resnick *et al.*, 1997; Van Ryzina, Foscoa & Dishion, 2012). Similar results for the use of illicit psychoactive substances were found among young people in the United Kingdom. The results of a British Crime Survey revealed that 50% of young people between the ages of 16 and 24 years had used an illicit drug on, at least, one occasion in their lives [lifetime prevalence] (Ramsay & Partridge, 1999). Among the 16-19 and 20-24 year olds, the most prevalent drug was cannabis (used by 40% of 16-19 year olds and 47% of 20-24 year olds), followed by amphetamine sulphate (18 and 24% of the two age groups respectively), LSD (10 and 13%) and ecstasy (8 and 12%). The lifetime prevalence for cocaine hydrochloride (powder cocaine) use between the two age groups was 3 and 9%, respectively. Collectively, these estimates were generally comparable with other European countries (European Monitoring Centre for Drugs and Drug Addiction, 1998) and the US (Johnston *et al.*, 2007a; 2007b; 2009).

The aforementioned researchers, as well as Lezin *et al.* (2004), McDowell and Futris (2002), Resnick *et al.* (1997), Van Ryzina, Foscoa and Dishion (2012) and Velleman, Templeton and Copello (2005), associate one, or more, of the following factors with the increased risk of drug use:

- poor parent-child relationships;
- family environments that model drug use;
- peer drug use;
- high-risk communities where drug use is prevalent;
- low self-esteem; and
- poor school achievement.

According to researchers, Robins and Przybeck (1987, cited in Bogenschneider, Small & Riley, 1994), and Marks, Miller, Schulz, Newcorn and Halperin (2007), various other factors in anti-social behaviour, such as childhood aggression, withdrawal or hypersensitivity, as well as early initiation, are great risks for developing future drug problems.

Using a functional approach to understand drug use among youth, researchers Boys, Marsden and Strang (2001) conducted a study to examine the reasons that young people allude to for the use of psychoactive substances. Their study sample comprised 364 young poly-drug users. Data on lifetime, recent frequency and intensity of use for alcohol, cannabis, amphetamines, ecstasy, LSD and cocaine were presented. The majority of the participants had used at least one of these six substances. The most popular reasons for using were: to relax [96.7%]; to become intoxicated [96.4%]; to keep awake at night, while socialising [95.9%]; to enhance an activity [88.5%]; and to alleviate a depressed mood [86.8%] (Boys, Marsden & Strang, 2001).

Hengelaar (1999) cites his previous studies to indicate that a combination of individual (anti-social attitudes), family (low warmth, high conflict, parental problems), peer (association with anti-social peers), school (low academic performance) and neighbourhood (disorganisation, criminal subculture) factors are all aligned to antisocial behaviour in adolescents (Hengelaar, 1991; 1997, cited in Hengelaar, 1999). Kumpfer (1999) argues that, although peer influence is the final pathway for use, the major predictor of whether youths will associate with anti-social peers is the quality of their family relationships and the amount of support and guidance they receive. Generally, nurturing or supportive parental behaviours are related to the positive adaptation of adolescents and have been evidenced to serve as a buffer against adolescent substance use (Barber, 1992; Barnes, 2000; Baumrind, 1991; Needle, Glynn & Needle, 1983; Peterson & Leigh, 1990). Different ways of expressing parental support of adolescents include, praising, encouraging, physical affection, showing approval, love and acceptance (Barnes, 1990, cited in Anderson, 1991; Resnick *et al.*, 1997). A meta-analysis of other studies have found that, when the ‘emotional climate’ of the family is one of affection, warmth and trust, combined with minimal conflict (or ‘cohesion’), individuals were “buffered” (protected) from many kinds of adversities, including drug use (Lezin *et al.*, 2004).

A growing body of international research studies indicate that there is no single cause for problem behaviours (Bogenschneider, Small & Riley, 1994; Patrick *et al.*, 2011; Pierce *et al.*, 2015; Sarah, 2006) and youth cannot be assessed in isolation of the social environments in which they live, work and play. Authors have cited many reasons for drug taking behaviour, but they concur that children are influenced, in the first instant, by their parents and immediate family, followed by other social domains, such as peers, school and

neighbourhood (Bogenschneider, Small, & Riley, 1994; Lezin *et al.*, 2004; Brook, Brook, Morojele & Pahl, 2006; Van Zyl, 2013).

3.3. South African Youth and Substance abuse

Two major national surveys, namely, Youth Risk Behaviour Surveys (YRBS), were conducted by the Medical Research Council in South Africa to determine risk behaviour, including substance abuse involvement, among adolescent learners (Reddy *et al.*, 2003; Reddy *et al.*, 2010). The first survey (in 2002) was a cross-sectional, national prevalence study among secondary school learners in South Africa, out of which 23 Government schools were selected in each of the nine (9) provinces in South Africa. In the survey, 14,766 students between grades 8, 9, 10 and 11 were sampled to complete a self-administered questionnaire. A total number of 10,699 completed questionnaires were returned, representing over 70 % of the total participants. These results revealed that, nationally, 1 in 2 learners (49.1%) had consumed at least one drink of alcohol in their lifetime. It also revealed that in the 30 days preceding the survey, 31.8% had used alcohol on one, or more, days, while 23.0% had consumed five or more drinks (referred to as binge-drinking) within the space of a few hours on one, or more days. In addition, some learners (approximately 12% of the participants) reported to have had their first drink before the age of 13 years (Reddy *et al.*, 2003). The percentage of learners, who reported not ever using dagga, was 12.8%, while 9.1% had used dagga in the month preceding the survey. Some learners (4.2%) had used dagga for the first time at the age of 13 years, or even younger. The findings regarding illicit and other drugs revealed that 11.1% reported not ever using inhalants, 6.0% had used mandrax, 6.4% cocaine, 11.5% heroin, 5.8% club drugs and 15.5% reported having used over-the-counter or prescription drugs (Reddy *et al.*, 2003).

The second YRBS (Youth Risk Behaviour Survey) was conducted in 2008 and was able to track changes in risk behaviours over time. Similar trends were reported, with a notable decrease in heroin use (down from 11.5% to 6.2%) and prescription drugs, but with increases in other illegal drugs, such as cocaine and club drugs. Significantly, more 'Coloured' learners reported not ever using methamphetamine ('tik'), while the Western Cape reported the highest rates, ever, of cannabis (dagga) use, as well as past-month-use, in the month prior to the survey (Reddy *et al.*, 2010). Additionally, in the month preceding the survey, 12.7% of the learners reported having used alcohol on school grounds and 7.8% reported having used

dagga at school. During the six months before the survey, 9.3% of the learners reported that they had been offered, sold or given an illegal drug, while at school (Reddy *et al.*, 2010). These figures pertain to school-going youth, and do not include the many young people, who had dropped out of school and, who were more likely to engage in drug-taking and other antisocial behaviours, such as drug-related crimes.

Van Heerden *et al.* (2009), therefore, argue that ‘harder drugs’ are being taken at a younger age, and children, as young as 14 or 16 years of age, could be fully addicted to heroin or crack (UNODC, 2012). This behaviour has serious health and social consequences for youth and has been associated with the increased risk for injury and death, academic difficulties, school dropout, poor peer and family relationships, and crime or gang-related activities (Kapp, 2008; Parry *et al.*, 2005). Leggett, Louw and Parry (2002) found that 66% of the arrestees under the age of 20 years in their study, had tested positive for drugs, and that males in the Western Cape formed a distinct group of persons arrested.

The Systems Research, Co-ordination and Epidemiology Research Update 5[2] (South Africa, Department of Health [DOH], 2003) reports that this behaviour is influenced by many factors, such as attitudes and behaviours; family dynamics; school, peer and work pressures or influences; community norms and expectations, as well as other social factors, namely, poverty, family disintegration and sexual exploitation. Caution should be exercised not to generalise the reasons cited by young people for their drug use and abuse, as research reveals that South African young people are introduced to drugs in various ways (Vakalahi, 2001; Van Zyl, 2013).

In a study conducted by Rocha-Silva, De Miranda and Erasmus (1996), the participants cited reasons, such as ‘enjoyment’, ‘to calm nerves’, ‘because my friends drink’, among the main reasons for substance using behaviour. The findings of a study conducted by Visser (2003) revealed that the perceived reasons for alcohol use among primary school learners were – ‘to forget our problems’; because they ‘like it’, ‘for fun’, ‘to feel good about ourselves’, ‘to be brave and happy’ and ‘do not care’ about themselves. It is apparent, therefore, that multiple risk factors, on individual, community and societal levels, have been found to be present in drug users lives. However, the aforementioned, seemingly ‘surface-level’ reasons suggest that a more in-depth inquiry is necessary to probe the possible underlying factors compelling young people to indulge in such self-destructive behaviour, as illegal drug use.

3.4. Cape Town: The regional hub for adolescent drug use

Drug abuse is widely viewed to be part of the erosion of social institutions in South Africa, and the poor, generally, seem to be particularly vulnerable in such circumstances (Wilson & Ramphele, 1989; Blum *et al.*, 2000; South Africa, National Youth Commission [NYC] & the Youth Desk in the Presidency [YDP], 2009). This is reflected in the steady growth of drug use of all kinds, particularly in the previously disadvantaged communities, such as Mitchells Plain, Athlone, Manenberg, Bonteheuwel and others (Parry *et al.*, 2005; Plüddemann *et al.*, 2008). The South African Community Epidemiology Network on Drug Use (SACENDU), a project co-ordinated by the Medical Research Council (MRC), measured trends for admission to treatment centres and showed a dramatic increase of drug abuse in Cape Town. These results confirmed that almost six out of ten patients were younger than 20 years of age, of whom 40% were using methamphetamine (commonly known as ‘Tik’) on a daily basis (Plüddemann *et al.*, 2008). The young people using this drug resided in 99 suburbs of Cape Town – two-thirds were male, and 91% were ‘Coloured’ (Parry *et al.*, 2005).

A senior scientist at the MRC, stated in the *Science in Africa Online Magazine* (2005, p. 1) that the use of methamphetamine is responsible for the fastest addiction rate ever seen in the Cape Flats communities (most notably Mitchells Plain, Manenberg, Elsies River and Hanover Park), and is associated with gangsterism and crime. Additionally, Plüdderman states: “Nowhere else in the world has ‘tik’ taken off in the way we are finding in these specific communities” (Science in Africa Online Magazine, 2005, p. 1). He also warns that the statistics from treatment centres are ‘just a drop in the ocean’, compared to the prevalence in these communities, as it is a minority of users, who actually seek treatment (Plüddemann *et al.*, 2008).

The findings from the first South African National Youth Risk Behaviour Survey (SAYRBS) in 2002 that was conducted by the Medical Research Council (MRC) confirmed drug use prevalence in Cape Town, as the worst in the country (Reddy *et al.*, 2003). A more recent study by the Centre for Justice and Crime Prevention [CJCP] also found that young school learners were engaging in various harmful practices, including substance abuse (Leoschut, 2009b). Of the different substances explored in this study, alcohol emerged as the primary substance of choice, with 31.4% of the sample having had a drink of alcohol in their lifetime. Of this number, one in three (34.8%) had been under the age of 15 years, when they had their

first drink of alcohol (Leoschut, 2009). The second SANYRBS, conducted in 2008, revealed that South African learners continued to engage in high risk behaviours, like the abuse of alcohol and other drugs, namely cannabis, methamphetamine, methadone and cocaine (Reddy *et al.*, 2010). These high risk behaviours are of concern, as literature confirms that adolescents, who initiate alcohol and other drug use (AOD) before the age of 15 years, are five times more likely to develop AOD dependence, than those, whose age of initiation was after the age of 21 years. These behaviours were also associated with alcohol-related violence (physical and sexual assault) among youth and adults (Davis, 1998, cited in Leoschut, 2009a), as well as the associated short- and long-term health and social consequences, including school drop-out, risky sexual behaviours (unprotected sex, teenage pregnancies, multiple partners), criminal activities, and even suicide (Leoschut, 2009a; Reddy *et al.*, 2010).

Maseko, Ladikos and Prinsloo (2003) propose that addressing the root causes of the conditions that put young people at risk for drug abuse should be considered as the best long-term solution to the problem. As drug use/abuse has no single cause, but rather a multiplicity of factors working together to influence behaviour, it becomes absolutely necessary to understand and uncover the underlying and interrelated reasons for this high risk behaviour, before effective intervention or risk reduction measures could be developed.

3.5. Risk taking behaviour in adolescence: An overview

Adolescence is the period of psychological and social transition between childhood and adulthood. The ages of adolescence vary by culture. The World Health Organisation (WHO) defines adolescence as the period of life between 10 and 19 years of age. Although there may be variations in the age bracket of adolescents, there is consensus that adolescence is a challenging developmental period, when young people go through many biological, cognitive, social and psychological transitions. Cognitive thinking, during adolescence, changes from concrete operational thinking, to abstract thinking, and, psychologically, adolescents develop a sense of identity and a self-concept (Erikson, 1950). Socially, adolescents spend more time with their peers and move away from their family and home environment, or try to develop their identity, while living in the same household with parents and grandparents. Adolescents also tend to be risk-takers and therefore, adolescence is the phase, during which most substance abuse is initiated. It is widely believed that substance

abuse is often part of a cluster of ‘problem-behaviour syndrome’ – many interrelated risk behaviours, including unprotected sexual intercourse, eating disorders, delinquency and conduct disorders that seem to share similar causes (Jessor, 1992). This is based on the concept of ‘proneness’ to engage in risk, or problem, behaviours. Problem behaviours serve as a common social or psychological development goal, such as separating from parents, achieving adult status, or gaining peer acceptance. These behaviours may serve to help an adolescent cope with failure, boredom, unhappiness, rejection, low esteem, social anxiety or isolation. For example, adolescents could use substances as a means of gaining social status and acceptance from peers, while counteracting feelings of low self-worth (Arnett, 2002).

3.6. Adolescent Substance Use: The Rationale

Young people use substances for many functional reasons, such as rebellion, sensation seeking, pleasure, curiosity, social bonding, attaining peer status, alleviating boredom, escaping or coping with reality. In addition, different substances tend to be used for different reasons by young people. For example, young illicit substance users reported that they drank alcohol for fun, but used heroin to deal with problems (Spooner, 1999; Steinberg, 2001).

Researchers have found that young people may also use substances for symbolic reasons, such as expression of solidarity, or to demarcate the boundaries of inclusion and exclusion in a social grouping (Paglia & Room, 1998, cited in the United Nations Office on Drugs and Crime [UNODC], 2003). According to Oetting and Donnermeyer (1998), drug use tends to be more related to peer and social factors, while substance abuse, or dependence, tends to be more associated with biological and psychological factors. The analyses of a study conducted by Reilly and Homel (1987, cited in Spooner, 1999) also identified that a relationship exists between the type of drugs used, and the reasons for the use thereof. The respondents in their study, who had used tranquillisers, barbiturates, opioids and/or inhalants, tended to use drugs to cope with negative feelings, boredom, or peer pressure, while the respondents, who had used amphetamines, claimed to have used it for social or psychological enjoyment.

Youth workers in Australia report that young people abuse substances for the following reasons: adolescent risk-taking behaviour, low self-esteem, pain suppressant (from sexual/emotional/physical abuse, or parental disapproval/rejection), recreational use and peer approval, as well as stress or anger management (Australia. Department of Human Services,

1998, cited in United Nations Office of Drugs and Crime [UNODC], 2003). Community factors, such as the availability of drugs, and the cultural norms, for example, tolerant attitudes, have also been associated with adolescent substance use (Hawkins *et al.*, 1992; Van Zyl, 2013). According to empirical studies, adolescents (and other individuals) learn to use drugs in small, informal groups (Petraitis *et al.*, 1995; Bahr, Hoffman & Yang, 2005), and through imitation and reinforcement, will hold attitudes that are favourable, or unfavourable, to drug use. In families where alcohol is used, adolescents may observe alcohol use, acquire favourable attitudes toward alcohol use, and start to use alcohol themselves (Bahr *et al.*, 2005). Similarly, if their friends drink alcohol, adolescents are likely to receive positive social reinforcement from their friends to start drinking alcohol (Petraitis *et al.*, 1995; Onya, Tessera, Myers & Flisher, 2012a).

Several authors (Brook *et al.*, 2001; Kumpfer, 1987; 1999; Spooner, 1999; Steinberg, 2001) have reviewed and found support for the growing body of knowledge on the biological correlates (such as genetic factors) of a predisposition to alcoholism and drug dependency. Inadequate social support, stressful life events, societal pressures, and physical or sexual abuse have been increasingly associated with heavy substance use by adolescents, especially young women. Research, however, consistently assert that, apart from biological predispositions and negative extraneous factors, family factors and peer associations could also be contributors to substance abuse in adolescence (Steinberg, 2001; Resnick *et al.*, 1993). Resnick *et al.* (1997) studied over 12,000 adolescents in grades 7 to 12. The key findings of their study revealed that being positively connected with their parents (feelings of warmth, love, and caring from parents), their families and their schools helped to protect teens against a wide array of health risk-behaviours, including substance abuse.

Reviews by the National Institute on Drug Abuse (NIDA, 2003; 2016) explored how causality is pre-determined, and concluded that social, environmental, intrapersonal, and behavioural factors are interacting determinants of adolescent drug use that are difficult to dissect, or treat as independent forces. Additionally, adolescent substance abusers often have co-existing problems with family, school or career; medical or emotional concerns; social relationships; or leisure, which may have been present before substance abuse, or may have originated from substance abuse (Roberts & Ogborne, 2005). The authors of NIDA (1997; 2003), therefore, argue that simple answers to the question, “What causes drug abuse?” do not exist. Additionally, researchers claim that it is the net effect of the combination of risk

factors and protective factors, rather than any individual risk factor, that predicts drug abuse (Bronfenbrenner, 2005; Reilly & Homel, 1987, cited in Spooner, 1999; Van Zyl, 2013).

3.7. Reasons for drug use among youth

Drug use is harmful to people of all ages, especially to young people, in whom dependency on substances develop quickly and easily (Barrett, 2011). The following studies show that there are many reasons that highlight why youth may use drugs, namely:

- vulnerability of youth (Mohasoa, 2010; Rocha-Silva, 1998; Ziervogel, Ahmed, Flisher & Robertson, 1997-1998);
- peer pressure (Ghuman, Meyer-Weitz & Knight, 2012; Hoberg, 2003; Ladikos & Naser, 2003; Mohasoa & Fourie, 2012; Naser, Ovens, Victor-Zietsman & Ladikos, 2001; Parry, Morojele, Saban & Flisher, 2004);
- poor role modelling by parents and significant others (Amoateng, Barber & Erickson, 2006; Brook, Brook, Morojele & Pahl, 2006; Meghdadpour, Curtis, Pettifor & MacPhail, 2012; Morojele, Brook & Kachieng'a, 2006);
- community tolerance (Morojele *et al.*, 2006; Onya, Tessera, Myers & Flisher, 2012b; Parry *et al.*, 2004);
- the availability of drugs (Mohasoa, 2010; Morojele *et al.*, 2006; Naser *et al.*, 2001); and
- factors within the family systems.

A study conducted by Florence and Koch (2011) in South Africa, explored the contextual factors that contribute to substance abuse. Their findings concur with others (Amato, 2005; Bahr, Hoffman & Yang, 2005; Brook *et al.*, 2006; Hawkins, Catalano & Miller, 1992; Kumpfer, 1999; Mudavanhu & Schenck, 2014; Resnick, Bearman *et al.*, 1997), revealing that the family contributes to both the risk/vulnerability and protective/resilience factors in the lives of young people.

3.8. Overview of contextual linkages of risk and protective factors

Hawkins, Catalano and Miller (1992), as well as Hawkins (1999) consider conflict in the family and peer substance-use to be significant risk factors for adolescent substance use. Some researchers also assert that risk and protective factors exist on several levels namely:

- On the *individual level*, life experiences play a more significant role in substance use than genetic traits. Important contributory factors are – the level of support and care from a parent or other adult at an early age; the quality of a child’s school experience; and general personal, as well as social competence, such as feeling in control and feelings about the future. In addition, adolescents, who have spiritual beliefs and who do not believe their friends use substances, are less likely to use substances themselves (Vakalahi, 2001).
- On the *peer level*, the selection of peers with whom young people associate, as well as the nature of peer support, is crucial. For example, associating with a problem behaviour peer, or a conventional behaviour peer, makes a difference (Hawkins *et al.*, 1992; Hawkins, 1999)
- On the *family level*, contributory factors include – a history or lack of substance use; the effectiveness of family management, including communication and discipline; the structure of coping strategies; the level of attachment between parents and children; the nature of rules and parental expectations; and the strength of the extended family network. Adolescents, who have a positive relationship with their parents and whose parents provide structure and boundaries, are less likely to use substances. However, adolescents in families where there is conflict are more likely to use substances (Brook *et al.*, 2006).
- On the *societal and community level*, contributory factors include the prevailing social norms and attitudes toward substance use; social-competency skills; communication; and resistance skills. At the school level, adolescents, who have a positive relationship with teachers, attend school regularly, and do well, are less likely to use substances (United Nations Office on Drugs and Crime [UNODC], 2003).

Johnston *et al.* (1995) describe three basic categories of risk factors: demographic, social and behavioural. An analysis of demographic risk factors suggests that age and gender can predict the course of substance abuse. Several studies have found that males have a higher rate of alcohol and/or illicit drugs use than do females (Johnston *et al.*, 1995; Johnston, O’Malley & Bachman, 1995; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). Other researchers report that the period of major risk for initiation into alcohol and marijuana use peaks between the ages of 16 and 18 years, and for the most part, ends by age

20 years (Griffin & Botvin, 2010). Social risk factors involve the influence of the family, peers and the environment. Many studies suggest that in families, where the use of alcohol and other drugs are high, the adolescent is also more likely to become involved in substance use (Johnson *et al.*, 1995; Lezin *et al.*, 2004). Other studies have found that adolescents from dysfunctional or disturbed families are also likely to become substance abusers (Oetting & Beauvais, 1987, cited in Kumpfer, 1999; UNODC, 2003). An adolescent, whose peer group abuses alcohol and other drugs, is also more likely to become involved in substance abuse (Hawkins, 1999).

According to Kumpfer, Trunnell and Whiteside (1990), the adolescents' choices of peers are as likely to affect their relationships at school, in the community and family. Similarly, the family environment could also affect the young person's relationship with the school and peer environments. Several environmental factors have also been implicated. A lack of appropriate law enforcement has been found to contribute to the prevalence of adolescent alcohol abuse (Kumpfer, 1999; UNODC, 2012). In addition, mixed messages received from society affect adolescents' attitude toward drinking and drug use (Griffiths & Botvin, 2010). Finally, behavioural risk factors could lead to adolescent substance abuse. Research has shown that the use of certain substances, such as alcohol and marijuana, could lead to increased use, as well as the use of 'harder' drugs (Johnston *et al.*, 1995; SA DSD, 2013b; Sarah, 2006).

Researchers have cited many reasons for drug taking behaviour; however, there appears to be consensus that children are influenced, first and foremost, by their parents and immediate family, and thereafter, by other social domains, namely peers, school and neighbourhood (Bogenschneider, Small & Riley, 1994; Brook, Brook, Morojele & Pahl, 2006; SA DSD, 2013a). Researchers have widely recognised the critical role that family influences, particularly poor parent-child relations, have on adolescent drug-using behaviour (Lezin *et al.*, 2004; Resnick *et al.*, 1997; SAMHSA, 1998). There is also consensus that no *one* risk factor, but a complex array of interacting factors influences adolescent drug-use behaviour. Hawkins *et al.* (1992) assert that the presence of more risk factors instigates a greater likelihood of adolescents engaging in substance use/abuse.

3.9. Conclusion

In this chapter the literature and studies that address the prevalence and causes of drug use among youth was surveyed and critically discussed. The risk factors for adolescent drug use were explored and defined, both globally and in the local context, to understand the challenges experienced by youth, who use substances. A discussion is presented of some widely used theories that explain the etiology of drug use among adolescents, and a motivation for the theoretical framework for this study was provided. In Chapter Four, the research methodology is justified and presented.



CHAPTER FOUR

RESEARCH METHODOLOGY

4.1. Introduction

In this chapter, the researcher presents an overview of different research methods, followed by the rationale for a mixed research methodology approach, as well as a discussion on the selected research design for this study – the (concurrent) Embedded Mixed Method Design, using both quantitative and qualitative research methods. A brief overview of the pilot study is provided, followed by a description of the research setting and a discussion on the research process for both the qualitative and quantitative research methods of data collection. The ethical considerations, validity/trustworthiness, credibility and reliability, reflexivity, as well as the limitations of the multi-method approach, are presented and explained. Finally, the conclusion provides a summary of this chapter.

4.2. Overview of Research Methods

According to Creswell (2009), a research method is a strategy of enquiry, which moves from the underlying assumptions, to the research design and data collection. Although there are other distinctions in the research modes, the most common classifications of research methods are qualitative and quantitative. On one level of discourse, qualitative and quantitative refer to distinctions about the nature of knowledge and how the world is perceived, as well as the ultimate purpose of the research. On another level, the terms refer to research methods (ways of collecting and analysing data) and the type of generalisations and representations derived from the data.

The quantitative research method was originally developed in the natural sciences, to study natural phenomena (Creswell, 2009). The qualitative research method was developed in the social sciences, to enable researchers to study social and cultural phenomena. Qualitative research is naturalistic and attempts to study the everyday life of different groups of people and communities, in their social and cultural contexts. According to Creswell (2009), qualitative research is designed to help researchers gain an understanding of people in their natural settings. Such studies allow for the complexities and differences of the worlds of the

participants being explored and represented.

Both quantitative and qualitative research studies are conducted in the social sciences. In qualitative research, different knowledge claims, enquiry strategies, and data collection methods and analysis are employed (Creswell, 2009). Qualitative data sources include interviews and questionnaires; documents and texts; observation and participant observation; and the researcher's impressions and reactions (Myers, 2009). Data is derived from interviews, written opinions or public documents, as well as from direct observation of behaviours (Creswell, 2009).

However, quantitative research studies measure variables on a sample of subjects and express the relationship between those variables, using effect statistics, such as correlations, relative frequencies, or differences between means. The focus, largely, being on the testing of theory thereof. An obvious basic distinction between qualitative and quantitative research is the form of data collection, analysis and presentation. For instance, quantitative research presents statistical results, which are represented by numerical or statistical data, qualitative research presents data as descriptive narration with words, and attempts to understand phenomena in 'natural settings'. Therefore, qualitative researchers study objects/entities in their natural settings, in an attempt to make sense of, or interpret, phenomena, in terms of the meanings ascribed to them (Creswell, 2009; De Vos *et al.*, 2011).

A major difference between the two methods is that qualitative research is inductive and quantitative research is deductive. In qualitative research, an inductive data analysis is employed to provide a better understanding of the interaction of mutually shaping influences, and to explicate the interacting realities and experiences of researcher and participant (Denzin & Lincoln, 2000; Maree, 2007). It allows for a design to evolve, instead of having a complete design to start with, as it is difficult, if not impossible, to predict the outcome of interactions. This is due to the diverse perspectives and values systems of the researcher and the participants, as well as their influence on the interpretation of reality, and the outcome of the study.

It is noteworthy to state that neither of these methods (qualitative and quantitative) is intrinsically better on its own, as each has strengths and weaknesses (Creswell, 2014). The suitability of the research design needs to be decided on by the context, purpose and nature of

the research study in question. Other considerations include the personal and impersonal role of the researcher, the knowledge discovered and the knowledge being constructed. Some researchers prefer to use a mixed methods approach, taking advantage of the differences between quantitative and qualitative methods and combining the two methods, for use in a single research project, depending on the kind of study and its methodological foundation (Creswell, 2009).

4.3. Rationale for a Mixed Research Methodology

There are fundamental differences between qualitative and quantitative methods. In addition, mixed-methods is a procedure for collecting, analysing and integrating both quantitative and qualitative data, at some stage of the research process into a single study, for the purpose of gaining a better understanding of the research problem (Creswell, 2009; De Vos *et al.*, 2011). The rationale for mixing both kinds of data into this one study is grounded in the fact that neither quantitative nor qualitative methods in isolation are sufficient to capture the intricate details of the phenomenon of drug use among youth. However, when used in combination, quantitative and qualitative methods complement each other by allowing for a more robust analysis, as well as a more comprehensive set of findings.

The aims of this study were to identify and explore the perceived reasons and contributing risk factors for drug-taking behaviour, as described by young drug-abusers. In order to best satisfy these aims, questionnaires with themed open-ended questions, as well as a close-ended questions, were employed to probe their reasons for drug use, as part of the quantitative method. As part of the qualitative method, semi-structured in-depth interviews were conducted with young drug users, as well as with a school official at an at-risk school community, and brief written accounts of life histories were gathered from young drug users. Additionally, to explore the drug pathways of young drug-abusers, as well as the risk factors in their lives, a focus group discussion was conducted with a group of participants to confirm the tentative findings for the reasons that young people use drugs and to ascertain whether any new insights could be obtained. Field notes and journal entries were employed to document the research process throughout the study. These field notes helped to clarify ‘meanings’, cross-check findings, record methodological issues, triangulate the data, and increase the validity of the interpretations of the data.

4.4. Research Design of this Study

It has become clear that no one particular research methodology is perfect or complete, and, therefore, researchers consider using data obtained through multiple methodologies to strengthen their findings. Mixed-methods have been described to “involve the collection, analysis, and integration of quantitative and qualitative data in a single or multiphase study” (Hanson, Creswell, Plano Clark, Petska & Creswell, 2005: p. 224). Given the interpretive and explorative stance adopted in this research study, coupled with the nature of the research questions, the researcher was of the opinion that the mixed methods approach was the most appropriate research strategy for this study. The advantages of revealing in detail, the unique perceptions and needs of individual participants in a real-world situation, would have been lost if only quantitative, or experimental strategies were adopted.

Many mixed-methods research designs are reported in the literature (Creswell 2009; Creswell, 2014; De Vos, Strydom, Fouche & Delpont, 2011; Hanson *et al.*, 2005). According to Creswell (2009), mixed methods research takes advantage of using multiple ways to explore a research problem. The basic characteristics of mixed methods are:

- The design can be based on either or both perspectives;
- Research problems can become research questions and/or hypotheses, based on prior literature, knowledge, experience, or the research process;
- Sample sizes vary based on methods used;
- Data collection can involve any technique available to researchers; and
- Interpretation is continual and can influence stages in the research process.

Creswell (2009) describes six mixed methods design strategies:

1. *Sequential Explanatory* is characterised by collection and analysis of quantitative data followed by a collection and analysis of qualitative data. The purpose thereof is to use qualitative results to assist in explaining and interpreting the findings of a quantitative study.
2. *Sequential Exploratory* is characterised by an initial phase of qualitative data collection and analysis followed by a phase of quantitative data collection and

analysis. The purpose thereof is to explore a phenomenon. Creswell asserts that this strategy may also be useful when developing and testing a new instrument.

3. *Sequential Transformative* is characterised by the collection and analysis of either quantitative or qualitative data first. The results are integrated in the interpretation phase. The purpose is to employ the methods that best serve a theoretical perspective.
4. *Concurrent Triangulation* is characterised by two or more methods used to confirm, cross-validate, or corroborate findings within a study. Data collection is concurrent. Generally, both methods are used to overcome a weakness in using one method with the strengths of another.
5. *Concurrent Embedded* is characterised by a 'nested' approach that gives priority to one of the methods, which guides the project, while another is embedded, or 'nested'. The purpose of the nested method is to address a different question than the dominant one, or to seek information from different levels.
6. *Concurrent Transformative* is characterised by the use of a theoretical perspective reflected in the purpose, or research questions, of the study, to guide all methodological choices. The purpose is to evaluate a theoretical perspective at different levels of analysis.

Creswell, (2014: p. 288) purports that researchers should:

...consider factors that play into your choice of a mixed methods design. These involve considering what outcomes you expect from the study, the integration of the databases, the timing of them, the emphasis placed on each database, the choice of design that matches your field, and the conduct of the project by either yourself, or a team of researchers.

After reviewing the different mixed method strategies, the Concurrent Embedded Design was selected for the purpose of this study. This approach best suited the exploratory aim of the study, which gives priority to one of the methods, namely the qualitative approach. Creswell (2009) posits that the concurrent embedded design is characteristic of one data collection phase, whereby both quantitative and qualitative data are collected with one being the dominant or primary research method. The primary method guides the project, while the secondary method "provides a supporting role in the procedures" (Creswell, 2009: 2014). According to Creswell (2009; 2014), the secondary method normally addresses a different

question, and is thereby embedded (or nested) within the predominant method. In this study, the structured questionnaire, consisting of both close-end and open-ended questions, was the secondary data source, which was used to elicit baseline information from selected respondents. The questionnaire employed in the quantitative stage allowed the demographic and contextual circumstances to be uncovered. It also created the opportunity to answer the first research question, “What are the main perceived reasons for drug use among youth?” and directly ask the respondents what they perceived to be the reason/s for the initiation of their drug use.

The qualitative data collection consists of in-depth interviews, written life histories, and a focus group discussion. The aim of these data collection tools was to uncover and answer the second research question, “What are the contributing risk factors for drug use among youth?” The rationale for this approach is that the quantitative data could provide a general overview of the research problem, as well as the demographical context of the participants. The qualitative data could refine and explain those statistical results, by exploring the participants’ views, in more detail (Creswell, 2009). The quantitative data collection was “embedded within a qualitatively phenomenological design to help describe the broader context of a qualitative study” (De Vos, Strydom, Fouche & Delport, 2011: p. 443).

Qualitative data is by nature exploratory, is inductive in nature and enables the researcher to make interpretations of the meaning of the data in order to develop theory, whereas quantitative data is confirmatory, and makes allowance for the testing of theory (Creswell, 2009). The reason for using both quantitative and qualitative data is to merge the two forms of data for greater insight, than would have been obtained by either qualitative or quantitative data, separately. Both the quantitative and qualitative instruments of this study are important for the research questions in this study, namely “to explore the perceived reasons and risk factors for drug use among youth”. The strengths and weaknesses of each approach complement each other, and allow the researcher the opportunity to triangulate data that is different, yet complementary (Mertens, 2003). The benefits of using a concurrent embedded mixed methods approach is that it is easy for a single researcher to implement and is useful in providing a fuller understanding of the quantitative results.

4.5. The Pilot Study

Before starting the main study's research process, the semi-structured questionnaires, themed in-depth schedule, and life-history guide were pre-tested on a convenient sample of in-patient drug abusers, at a rehabilitation centre. The aim was to identify any shortcomings or difficulties in the research process, instruments or analyses. The pilot study was conducted at a faith-based centre that houses about forty in-patient males, between the ages of 14 and 40 years from the Cape Flats area. The centre was approached telephonically, followed by an initial interview with the manager to ascertain the suitability of the candidates regarding literacy levels and language of choice. A second interview was arranged with the director of the centre where the nature and aims of the study were discussed, and verbal permission to collect data was requested and granted. The director of the centre explained that the in-patients had a daily routine, however, it was agreed that the researcher could spend about an hour per day at the centre, two days per week, for the duration of the data collection process. The researcher aimed to have all willing in-patient participants complete the questionnaires in one sitting, and to conduct at least two in-depth interviews and two or three written life-history accounts with willing participants. It was anticipated that the duration of the pilot-study-data-collection would take place over a period of about a month due to the limited time that the researcher was allowed access to the participants (two hours per week).

At the beginning of the process, the purpose of the study and the voluntary participation process was explained to the participants and informed consent was obtained, in writing, from willing participants. In cases where the participants were under the age of 18 years, the management of the centre (as their guardians), co-signed the consent forms. The consent forms made provision for the participants to indicate whether they were willing to participate and complete the questionnaire, participate in an audiotaped in-depth interview, or write about their life experiences prior to their drug-taking behaviour (see Appendix 1). The researcher explained beforehand that as this was only a pilot study, only a few interviews would be conducted and that there would be no preference criteria for participating in the interviews. It would just depend on the availability of the willing participants.

Twenty-seven self-administered questionnaires were completed in one sitting at the centre, where the researcher was available to answer any questions, or provide any necessary clarifications. In addition, two in-depth interviews, two written life histories, as well as

informal interviews with staff members were conducted during the data collection process. The informal interviews with staff members were valuable in providing a wider range of viewpoints on the phenomenon of drug use among youth. This facilitated the building of a fuller picture of the issues at hand.

Some difficulties were encountered in the production of the written life histories at the in-patient centre. Initially, about ten participants indicated their willingness to do the written life history accounts. However, only one participant was willing to do the writing, while the researcher was present at the centre. The others opted to write it, in their own time, and hand it to the researcher at the next visit. At the next visit, many of the participants claimed that they either had forgotten to do it, or had not found the time to do it. This happened time after time, and after more than a month the researcher was only able to obtain two written life histories from the participants (one wrote while the researcher waited one it, and another one returned it after a few weeks). The researcher then realised that she would have to find new ways of collecting the written life history account data in the main study.

Obstacles in the data collection process, such as the limited time allowed at the centre and the difficulties encountered with the wording of the research instruments were highlighted and discussed with this study's supervisors. The necessary adaptations were brought about. At that stage, it was also decided that the researcher would focus on one in-patient centre, when collecting the written life histories data and that arrangements had to be made for the participants to write it in one sitting, under the supervision of the researcher, to ensure that the process was completed successfully. Since the level of writing skills could not be predetermined, another lesson learnt through the pilot study, was that the researcher would read the written piece back to the participant, in order to clarify illegible or unclear wording, or phrases.

4.6. Main Study: Research Setting

Permission was granted by the Senate for Higher Degrees at the University of the Western Cape to conduct the research. The researcher then set out to obtain permission from rehabilitation centres to gain access to their premises, in order to access young drug users, who would be willing to participate in the study.

At the outset, many drug treatment centres in the Western Cape were contacted, both telephonically and in writing, regarding possible participation in the study. All the relevant information, as well as an abbreviated proposal, was submitted for their scrutiny. Repeated attempts to follow-up, telephonically, on the written requests enabled the researcher to secure permission to conduct research at an outpatient rehabilitation organisation with a number of branches in the Western Cape. The researcher decided to collect data at three of the branches. The centres offered group, individual, and family counselling to young male and female drug abusers. Most of the young people were referred to the centres by the various schools that they attended, while some were brought to the centres by concerned parents and family members. Most of the patients at these centres resided in the Cape Flats area, in the Western Cape.

Additionally, another faith-based outpatient rehabilitation centre, located on the Cape Flats, granted permission for data to be collected at their site. This centre catered for out-of-school youth. The young people (under the age of 18) were granted the opportunity to attend the centre on a daily basis, where they were offered counselling, as well as participation in other group activities and skills training. This service was offered free of charge and included both males and females. The overall idea was to keep these young people off the streets during the day and, in doing so, lower the risk of them participating in drug abuse and other related anti-social behaviours.

The Western Cape has the largest Coloured population than any other province in South Africa (StatsSA, 2011). It is also known to have some of the highest incidence of gangsterism and gang-related crime (Leggett *et al.*, 2002; Pinnock, 2016). The Cape Flats is an area located within the Western Cape that was established through the ‘forced removals’ of the Group Areas Act (No. 41 of 1950) during the apartheid era. People from widely divergent backgrounds and experiences, were uprooted from their communities and thrown together in a wasteland that has become known as the Cape Flats. With the standard of living being low and the unemployment rates being high, communities on the Cape Flats have been plagued with violence and substance abuse issues (Leggett *et al.*, 2002; Standing, 2003).

Several schools on the Cape Flats are surrounded by a number of gangs. In some instances, school fences marked the borders of gangland territories. In addition to the often impoverished state of the Coloured population in South Africa, the constant lower-class

status drug use (methamphetamine, dagga and mandrax, being some of the most common) is also most prevalent in these communities (Parry *et al.*, 2005; Reddy *et al.*, 2010; Dada, 2016).

Apart from the four outpatient centres, an inpatient, drug rehabilitation centre on the Cape Flats was also identified and approached as a possible data collection site. The centre is a faith-based organisation that housed young males under the age of 18 years. This centre offered users a four-month period, in-patient treatment regimen for their drug use. Most of the young in-patients were school dropouts and the treatment included drug counselling, individual and family therapy sessions, and skills training programmes, which comprised carpentry and other training. To ensure anonymity, the exact locations of the data collection sites are not mentioned in this document.

4.7. Research Process

Creswell (2009) asserts that the concurrent embedded design may be used when qualitative data are required to explain significant (or non-significant) or surprising results. It may also be used when first-phase quantitative results guide the selection of sub-samples for follow-up in-depth qualitative investigation in the second phase. In order to answer the research questions adequately, both quantitative (structured questionnaires) and qualitative research methods (in-depth interviews and written life histories) were used to collect data from young drug abusers. The following data were collected from five treatment centres with forty-one questionnaires (37 males, 4 females), fourteen in-depth interviews (10 males, 4 females), and eight life histories (males only). Additionally, an in-depth interview was conducted with a school official at a high school situated on the Cape Flats area and a focus group discussion with six young drug users. The data collection process was concurrently conducted as explained in the following sections below.

According to Creswell (2009), the concurrent embedded strategy of mixed methods allows for the use of one data collection phase, during which both quantitative and qualitative data are collected at the same time. Creswell (2009) also asserts that the embedded approach has a primary method that guides the project and the secondary data can provide a supporting role in the research process. This secondary method (which can be either quantitative or qualitative) is given less priority, and, therefore, is embedded within the dominant method

(qualitative or quantitative). This embedding can also mean that the secondary method may address a different question than the primary method, and can reside alongside each other as two different pictures that provide an overall multifactorial range of viewpoints that places the data into context, and is, therefore, able to provide a fuller understanding or assessment of the research problem. In this approach, a researcher is able to collect the two types of data concurrently, during a single data collection phase, where each data collection tool had a particular aim and addressed different research questions and concerns (Creswell, 2009).

In the case of this study, the concurrent qualitative methods of data collection depended upon the quantitative (structured questionnaire), in order to guide the researcher in exploring the information provided. The questionnaires provided the biographical and contextual information that guided the line of questioning in the in-depth semi-structured interviews. The quantitative data (structured questionnaire), therefore, were embedded in the qualitative methods. These mixed methodologies allow for the collecting, analyzing, and interpreting of both the qualitative and quantitative data in a single study, and integrating (or mixing) the data findings/interpretations (Creswell, 2009; 2014; De Vos *et al.*, 2011). The layout of the various data collection processes follows hereafter and will introduce the different instruments used to meet certain objectives of the study.

4.7.1. Quantitative method

Quantitative research makes use of questionnaires, surveys and experiments to gather data that can be revised and tabulated in numbers, allowing the data to be characterised using numerical or statistical analysis (Creswell, 2009). The research design for this study is of a descriptive and interpretive nature, which is analysed largely through qualitative methods (in-depth interviews, written life histories and a focus group discussion), with a small quantitative component in the form of a questionnaire with open-ended, as well as closed ended questions (see Appendix 2). The purpose for the use of this data collection tool was to meet the following objective:

- To determine the demographic and contextual circumstances of young drug users, as well as to determine their perceived reasons for drug use, as cited by the youth.

4.7.1.1. Respondents

The respondents in this study were selected through a purposeful sampling method. During purposeful sampling, the researcher selects a sample that would be able to yield the most relevant information. According to Patton (2002), purposeful sampling is a non-random method of sampling, where the researcher selects ‘information-rich’ cases for in-depth investigation. The 41 respondents for this study were selected from the five participating rehabilitation centres (four outpatient and one in-patient centre) on the Cape Flats areas, in the Western Cape. The respondents were aged between 14 - 19 years old, mostly males of mixed descent, commonly referred to as the ‘Coloured’ population. All these respondents were receiving treatment for substance abuse, including alcohol and other drugs (AOD), such as cannabis (also known as “dagga”), methamphetamine (commonly known as “tik”), cocaine and heroin. The participants were mostly referred to these rehabilitations through the school system; however, some of them had subsequently dropped out of school at the time of data collection.

4.7.1.2. Data Collection tool

- **Structured questionnaire**

The use of questionnaires could be an effective means of measuring behaviours, attitudes, preferences, opinions and intentions of relatively large numbers of subjects, and much quicker than other methods. An important distinction is the use of closed or open-ended questions. Closed questions structure the answer by allowing only answers that fit into categories, decided upon, in advance, by the researcher. Data that can be placed into a category is called nominal data (Creswell, 2009). A limitation of closed questions could be the lack of detail. The responses are fixed; therefore, respondents do not have the scope to answer in a manner that reflected their true feelings on a topic. Open-ended questions, however, allow individuals to express what they think, in their own words. Open-ended questions are often used for interrogations that are more complex. An example is, “Could you tell me the reason why you started using drugs in the first place?”

This current study made use of a questionnaire that employed both closed and open-ended questions to elicit information from the drug users. The questionnaire was constructed with the aim of determining the demographic and contextual situations of the young drug users, as well as determining the perceived reasons for the start of their drug use behaviour. The first section of the questionnaire deals with demographic information, such as gender, age, geographical location, family composition, age of first use and the type of drugs used (Appendix 2). The open-ended section of the questionnaire elicits details and information about the individual's environment along four broad themes such as, family, peers, school, and neighbourhood characteristics. These themes are based on the ecological determinants of Bronfenbrenner (1979). They include the perceived love felt from parents (mother/caregiver and father/father-figure), whether and by whom they were monitored after school, as well as the perceived reasons why they started their drug-taking behaviours. To ensure that the researcher gained the viewpoints of the respondents, the questions were mostly open-ended, giving them the opportunity to respond openly about relevant issues.

Questionnaires have the advantage of reaching a wider audience than interviews can, but have a disadvantage that it cannot be customised to an individual's predilection, as is possible with other methods of data collection. The responses from the questionnaire provided the basis for the probes of the individual, in-depth interviews, conducted with the willing participants.

4.7.1.3. Data collection procedure: Questionnaire

After receiving consent to conduct a research study at the various rehabilitation centres, the researcher visited the centres and held informal discussions with potential respondents, as well as key informants, namely, staff members and outreach workers. This exercise served a dual purpose, as the researcher was able to establish the suitability and language of choice for the instruments, as well as create a basis to build up good rapport and trust between researcher and potential respondents. It was ascertained that English was the language of choice for most

respondents, and the researcher availed herself to assist any student requiring clarification, or the Afrikaans translation to any of the questions.

At the start of the data collection process, the researcher verbally informed the cohort of youth about the aims, objectives and benefits of the study, the voluntary nature of their inclusion and the age criteria – they had to be between the ages of 14-19 years. The researcher guaranteed confidentiality and anonymity and invited any questions, reminding them of the process of informed consent, as well as their right to withdraw from the study at any stage, without prejudice. Subsequently, the respondents were asked to volunteer their involvement by completing and signing the consent form (see Appendix 1). They were also asked to indicate on the consent form which part of the study they chose to be involved – the questionnaire, in-depth interviews, providing a written account of their life story events leading up to the onset of drug-using or the focus group discussion.

Cooperative respondents under the age of eighteen years were requested to obtain written consent from their parents or guardians. Only those respondents who returned the signed parental consent forms were allowed to be included in the study. After the signed parental consent-forms were returned, the researcher arranged with the social workers, who conducted weekly group counselling sessions and activities at the five participating centres, for permission to administer the questionnaires to the volunteer respondents, at the end of these weekly sessions. The researcher was available to assist with the clarification and completion of the questionnaires. Altogether, 41 questionnaires were completed at the different treatment sites.

The concurrent embedded design allows all the data (both quantitative and qualitative) to be collected, analyzed, and interpreted in more than one way. One such method is the convergent parallel mixed methods whereby the researcher converges or merges the quantitative and qualitative data (Creswell, 2014). In this design, the researcher normally collects both forms of data at roughly the same time and then integrates the information in the interpretation of the overall results. The embedded mixed methods design allows either the converging (merging) of the results, or the sequential use of data. The core principal is that either

quantitative results or qualitative data should be embedded (play a supporting role) in the overall research design (Creswell, 2014). Researchers are able to make interpretations of the statistical results, and/or they can interpret the themes or patterns that emerge from the data, with the aim of providing a more comprehensive analysis of the research problem.

4.7.1.4. Data analysis: Questionnaire

Quantitative analysis is able to make use of statistical analysis not only for hypothesis testing of relating variables, but also for comparing groups and for description of trends/patterns (Creswell, 2009). In order to examine and determine the contextual and demographical factors of the drug users and determine the perceived reasons for their drug use, descriptive statistics (bar graphs) were used. The data processing procedures employed in the quantitative data analysis commenced with an examination of the data and measurement scale screening, followed by a description of statistical procedures used for data analyses. Quantitative analysis was conducted using the Statistical Product and Service Solutions (SPSS) Version 20.0 for the questionnaires after data collection. Data entry was done on an Excel Spread sheet and later imported into an SPSS version 20 for Windows data matrix, so that Microsoft Windows XP computer could be used to manipulate and analyse the data.

All data and measurement scales were screened for accuracy prior to analysis. The completed questionnaire was examined to ensure that the major demographic elements, such as age range, grade, drug use and family background (such as, who the drug users lived with; who else in the family used drugs) were represented in the study. A further check ensured the accuracy of the data entry process. The data entered, therefore, was cleaned (where the data was either incorrectly coded or captured) to eliminate possible errors. Where errors were discovered on the SPSS data matrix, the appropriate source questionnaires were located, to check and correct errors, before proceeding with the data analysis.

Preliminary data analysis included obtaining frequency distributions and descriptive statistics for the variables. Descriptive statistics were primarily used to provide data information on the distribution of research variables. Frequencies

were determined on the following categorical variables:

- age;
- area of residence;
- school attendance;
- grade;
- parental marital status;
- perceptions of childhood satisfaction;
- primary care-giver, monitoring/supervision;
- feelings on being loved and cared for by mother figure/father-figure;
- age at onset of drug use;
- drug types started using;
- drug types last used;
- who introduced them to drugs;
- how many of their friends used drugs (few, many or all etc.);
- who in the family used drugs;
- who in the family used alcohol;
- who at school did they trust to tell about their drug use;
- who at home did they trust to tell about their drug use;
- reasons for not confiding;
- main reasons for starting to use; and
- reasons for continued use.

The concurrent (embedded) mixed method design allows for the collecting, analysing, and interpreting of both qualitative and quantitative data in a single study, and for the integrating/mixing the data findings, and/or interpretations (Creswell, 2009; 2014). The findings of this quantitative data analysis are presented in the following chapter (five), and are incorporated in the discussion of the overall themes found in this study.

4.7.2. The Qualitative Method

The research question, “What are the main perceived reasons and contributing risk factors for drug use among youth?” could not be adequately addressed by quantitative means, such as questionnaires. The exploratory aim of the study was to gain understanding of the subjective experiences, social meaning and the context of drug use from drug users’ perspectives. In addition to the quantitative component of this study, an interpretive method of qualitative inquiry was chosen as it best suited the nature of the study; as it will depend on words to *describe* what young people say, feel and do in order to reflect how they live.

A number of qualitative data collection instruments were used to collect data with the aim of providing rich descriptions that would be able to build a fuller picture of the phenomenon at hand. These qualitative data collection strategies, which formed the larger or dominant part of the study, included in-depth semi-structured interviews, written life history accounts of precursors to drug-use pathways, and a focus group discussion. Additionally, an in-depth interview was also conducted with a school official at a high school on the Cape Flats.

The purpose of the qualitative data collection method set out to satisfy the following objectives:

- To explore the contributing risk factors for drug use among youth;
- To explore the childhood experiences and family contexts of the youth;
- To explore and analyze precursors to their drug-taking pathways; and
- To explore the focus of primary prevention of drug use, among youth.

4.7.2.1. Participants

The consent form made provision for all forty-one (41) volunteers from the five rehabilitation centres to indicate whether they would be willing to participate in an audio-taped in-depth interview, or provide a written life history account of their lives leading up to the start of their drug-use. After examining the replies on the consent forms, the researcher, subsequently, set up appointments with the individuals, who volunteered to participate in the in-depth interviews. In many cases, the appointments were not kept, as many of the would-be participants at the outpatient centres failed to return for their weekly treatment/counselling session at the rehabilitation centres. Subsequent to discussions with the social workers involved, the researcher was informed that the dropout rate for treatment was generally high, and that the centres were constantly seeking ways to increase the retention rate of drug users in rehabilitation. In the end, 14 *in-depth semi-structured interviews* (10 males and 4 females) were conducted at the five rehabilitation sites. A further in-depth interview was conducted with a school official (a Learner Discipline Support Officer) at an “at-risk” school community. Additionally, a focus group discussion was conducted with a group of participants of the study. The participants’ comments and interpretations contributed to provide a deeper understanding to the meanings of the findings.

4.7.2.2. Data Collection tools

- ***Semi-structured in-depth interviews with young drug users***

The data collection tools included taped *semi-structured in-depth interviews* with young drug users. The purpose for employing these instruments was to satisfy the following objectives of the study:

- To explore the contributing risk factors for drug use among youth;
- To explore the childhood experiences and family contexts of youth

In qualitative research, interviews are considered a form of discourse, and one of the major sources of data collection. Interviews are viewed as appropriate for research that requires detailed information regarding emotions and experiences from a small number of participants. In addition, interviews are suitable when investigating sensitive or personal

issues (De Vos *et al.*, 2011). According to Creswell (2009), interviews can be very productive, since the interviewer can pursue specific issues of concern that may lead to focussed and constructive suggestions. The main advantages of the interview method of data collection are that it is an effective tool to obtain detailed information, and few participants are needed to gather rich and detailed data. Qualitative interviews emphasise the role of the researcher's questions and the participants' responses. An interview is, therefore, a joint product and the record thereof provides a major source of data for analysis and interpretation.

Depending on the need and design, interviews can be unstructured, structured, and semi-structured with individuals, or may be focus-group interviews. This study employed the use of a *semi-structured, in-depth interview* approach. This method of interview has features of both structured and unstructured interviews and, therefore, use both closed and open questions. As a result, it has the advantage of both methods of interviews. In order to be consistent with all the participants, the interviewer had a set of pre-planned core questions for guidance, so that the same areas would be covered with each interviewee. As the interview progressed, the interviewee was given the opportunity to elaborate, or provide relevant information, as s/he wished. The researcher also used the participant's completed questionnaire to further probe or follow-up on responses provided in the structured questionnaire.

- ***Written life history accounts with young drug users***

In a literature review on life histories, Ojermark (2007: p. 4), drawing on the work of three co-authors (Hatch & Wisnieski, 1995; Denzin, 1989; Roberts, 2002, all three cited in Ojermark, 2007), defines life histories as:

The life history is based on the collection of a written or transcribed oral account requested by a researcher. The life story is subsequently edited, interpreted and presented in one of a number of ways, often in conjunction with other sources. Life histories may be topical, focusing on only one

segmented portion of a life, or complete, attempting to tell the full details of a life as it is recollected.

Data from life history accounts provide a researcher with a rich detailed account of a certain phenomenon that can focus intently on the perspective of the individual or family, and data can be collected in a number of ways, including through written or oral history accounts, interviews, documents and chronicles. It can be utilized on its own in a single study, and it is common for researchers and policy makers to use life histories in combination with other qualitative and/or quantitative methods of data collection (Ojermark, 2007).

Life history methods can be employed in a number of ways, for a number of purposes, which are, it can use a “single case to illustrate larger issues”; it can strengthen an existing theory; or it can be analysed for its content in order to highlight other findings about a particular phenomenon (Ojermark (2007: p. 44). According to Ojermark (2007: p. 3), life histories “have the potential to link macro and micro processes” as they “allow individuals to discuss not only themselves, and their lives, but also the social, economic, and political spaces that individuals inhabit”.

The purpose of using written life history accounts in this study was to explore the risk factors for drug abuse further, through the stories of the individuals in this study, in the hope of gathering data not captured through the interviews or other data collection tools. Utilizing a life history data collection method to complement the other methodologies that were used in this study, is particularly useful to this topic, as the childhood experiences of the drug users and the pattern of events leading up to the drug using trajectories, are useful to provide deeper insights into their lives.

Due to the complex nature of how young people become involved in substance abuse, qualitative methods, such as life history accounts of the processes and pathways of their drug using behaviour, are able to cast more light on the risk factors at work in their lives at the time of drug taking decision-making. Life history accounts in this study are also able

to provide familial and other social context to their lives. The knowledge of how young people become involved provides opportunities to explore why they become involved in drug-using behaviours. By exploring the life circumstances and events leading to the drug taking behaviour of the individuals in this study, Jadidi and Nakhaee (2014) assert that researchers and policy makers are, consequently, able to recommend, or plan relevant prevention measures and strategies.

- ***Focus Group Discussion with young drug users***

According to Patton (2002), this type of interview is useful to be conducted after a series of individual interviews, to explore the general nature of the comments from different individuals further. Focus group interviews are less structured, compared to the three categories of interviews (namely, structured, unstructured, and semi-structured) – this can be due because to the difficulty in bringing structure to a group. However, according to Denzin and Lincoln (2000), rich data can emerge through interaction within the group, for example, sensitive issues that could have been missed in individual interviews, may be revealed. In a group, people may develop and express ideas they would not have thought of independently (Patton, 2002).

Patton (2002) further asserts that focus groups are valuable for obtaining various in-depth perceptions of particular issues that are relevant to the research participants. Focus groups may also permit researchers to explore the reasons that particular views are held by individuals and groups. The method also provides insight into the similarities and differences of perceptions held. Creswell (2009) asserts that when conducted appropriately, the focus group method of inquiry enables researchers to examine how such perceptions differ in social groups (Creswell, 2009).

In this study, a focus group discussion was held at one of the centres where the researcher had collected data. The purpose of the focus group discussion was to explore the reasons and risk factors for drug use among youth, in order to note any new insights, or similarities and differences of perceptions held in relation to why young people use drugs.

4.7.2.3. Data collection procedures: Qualitative tools

Where agreed, the in-depth, semi-structured interviews were audiotaped, during which the participants were encouraged to express their real feelings about their childhood experiences, the nature of their parent-child relationships, or the development of their drug-using behaviours. The interviews were conducted with participants, who had completed questionnaires. The responses to their questionnaires, along with the semi-structured interview schedule, became the probes for the semi-structured interviews. Many adolescents expressed their willingness to participate in the interviews, but, ultimately, only 14 in-depth interviews were conducted at five drug treatment centres (2 in-patient centres and 3 outpatient centres) in the Western Cape.

According to De Vos, Strydom, Fouche and Delpont (2005: p. 292), “Semi-structured interviews are defined as those organised around areas of particular interest, while still allowing considerable flexibility in scope and depth”. The semi-structured interviews were guided by a number of broad question themes, and open-ended questions were used to facilitate the disclosure of knowledge by the participants. This helped the researcher to ensure that the main issues were covered, though not necessarily in a predetermined sequence (Creswell, 2009). The following themes guided the semi-structured interviews (see Appendix 3):

- home/childhood experiences;
- family/parent-child relationships
- drug use, including reasons for use; and
- the purported types of support that would have prevented their drug use.

Most of the interviews were conducted in English, however, where necessary, the researcher was also able to conduct the interviews in Afrikaans, or, at least, partly in Afrikaans. Where necessary, the researcher used gentle probing to elicit more information, when the participants answered the question in a close-ended manner. Probing refers to attempts made by the researcher to deepen the responses to questions, or increase the quality of responses by the interviewee.

Recording the information on audiotape allowed the researcher to focus on the interview process, instead of concentrating on taking comprehensive notes. A research assistant was used to transcribe the interviews, but did not have access to the accompanying questionnaires that contained the identifying information (such as the name and telephone number) of the participants. The research assistant was only handed the audiotapes and asked to transcribe them verbatim. The taped interview was labelled by means of numbers, and these numbers were cross-referenced on the completed questionnaires that the researcher had in her possession. The researcher was thereby able to match the questionnaire information to the transcribed interviews later, in order to provide a context to the participants' lives in the data analysis process.

The audiotaped, in-depth interviews took place in a private space, allocated to the researcher by the social workers at the various institutions. Creswell (2009) regards this interaction with the subjects, and the ability to observe them in their natural setting, as an important characteristic of qualitative research. Unlike quantitative research, qualitative studies are also most appropriate to identify processes and relevant contexts that strive to address the needs and experiences of the target group.

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One of the objectives of this study is to explore and establish the implications for primary prevention of drug use among youth. This was done by using the identified areas of risks emanating from the data to inform the focus of primary prevention efforts. To achieve this objective and to explore multiple perspectives, an in-depth interview was conducted with a school official at an "at-risk" school community. The purpose was to provide a fuller understanding in satisfying the following objective, "To explore the focus of primary prevention strategies".

The semi-structured interview guide (see Appendix 6), was used to interview a Learner (Discipline) Support Officer to establish the drug situation at the school and in the community, and to explore the views on why adolescents start using drugs and how drug use among learners and young people in general can be prevented in the first place. The officer referred to being a Learner Discipline Support Officer, but the Education department (WCED) used the term Learner

Support Officer (LSO) when referring to these individuals working at identified at-risk schools.

According to the South African Human Rights Commission (2006), the Learner Support Officers initiative was created through collaboration of the WCED and the Department of Community Safety. The aim of the initiative to introduce Learner Support Officers in the school environment was to promote the development of a safer school environment, and to reduce truancy, absenteeism, and school dropout rates. A further goal was to promote crime prevention in rural and urban schools. Through the intervention of the Learner Support Officers, it was hoped that at-risk schools would become supportive environments that would assist learners to reach their full potential and become contributing and productive members of society. In addition, the Learner Support Officers should teach learners, strategies on how to resolve conflicts peacefully and equip learners with the skills to be able to resist the pressures in the communities such as involvement in drug use and crime/gangsterism. The researcher refers to this school community as an “at risk community” due to the high levels of unemployment, poverty, substance abuse, gangsterism (Pinnock, 2016), and has been listed among the top ten highest total number of crimes in the country (Etheridge, Herman & Evans, 2016).

The Learner Discipline Support Officer (LSO) interviewed, was a voluntary community worker for many years in that community, and was involved in the neighbourhood watch, voluntary community policing, as well as the running of feeding schemes, such as soup kitchens in the schools and the broader community. The LSO explained that mothers, who were unable to pay their children’s school fees, were provided an opportunity to do voluntary work within the school communities. She described her role of Learner Discipline Support Officer, as that of a school security officer to keep the “illegal aliens” (unwanted visitors) off the school grounds, as well as a lay counsellor for the learners and their families. The LSO described some of her duties as searching children for drugs or weapons and arranging appropriate referrals to social workers for further attention. At the time of the interview, the LSO had been working at the school for a number of years. It was apparent that she was well respected by the

principal, who expressed his confidence in her ability to provide good insights about the phenomenon of drug use by the learners and the youth in the broader community.

The Learner (Discipline) Support Officer (LSO) was positioned at a Secondary School located in an area that is known for the highest drug-related crime statistics on the Cape Flats area of the Western Cape, according to recent police release of crime statistics (Etheridge, Herman & Evans, 2016; Western Cape Department of Community Safety, 2016). This particular school was randomly selected in this community, as many of the drug using adolescents' resided in this vicinity.

The school principal was first approached to obtain permission to conduct the interview with the LSO on the school premises. After permission was obtained, the researcher made telephonic contact with the LSO to explain the purpose of the study, as well as the ethical considerations, such as informed consent and voluntary participation. After verbal permission was obtained from the participant, a convenient date and time was set to conduct the interview. During the interview, the LSO was provided with an opportunity to read the consent form (see Appendix 5) and provide written consent. A semi-structured interview schedule (see Appendix 6) was employed to probe the drug-use situation among the learners at the school; the main perceived causes for drug use among the youth; and the perceived views on how this drug-use problem can be prevented or reduced among learners and young people in general. The interview was recorded on audiotape that allowed the researcher to focus on the interview process, instead of concentrating on taking comprehensive notes. A research assistant was used to transcribe the interview, but did not have access to the identifying information of the participant or the school.

The school is situated in an “at risk”, impoverished community with a neighborhood characterized by high unemployment, substance abuse, and crime, as well as elevated levels of gangsterism. This was confirmed by the LSO, who spoke freely of the increasing occurrence of drug use among their learners at the

school, and the prevalence of drug lords (persons who sell drugs – also referred to as “merchants”), as well as the availability of drugs in the community.

The interview probed the LSO’s views on what prevention remedies with young people starting drug-use behaviors in the first place. As the LSO had been a community worker in the neighborhood, she was able to provide rich data about the social and macro issues that plagued the community that contributes to the prevalence of drug use among youth.

In addition to the in-depth interviews, eight written life histories accounts were produced at three of the treatment centres. To further explore risk factors in the lives of young drug users, and discover any significant precursors in their lives leading up to their drug-taking behaviour, Life History guides (Appendix 4) were dispensed to willing participants, who agreed to provide a brief written account of their life histories and experiences leading up to their drug-using. It was anticipated that the use of this data collection tool would shed more light on the objective, “To explore and analyse precursors to their drug-taking pathways”.

The researcher realized at the pilot study stage that some participants might be more at ease to provide a written account of their life histories prior to their drug taking pathways, instead of participating in an interview process. The participants were asked to write an account on how they started using drugs in the first place, and to recall any significant events leading up to the initiation of their drug taking pathways. In an effort to gain a more comprehensive picture of family situations and life circumstances of the participants, the life history guide contained probes related to the following four broad themes, namely, their home/childhood experiences, parent/caregiver child relationship, drug use (including reasons for use), and their perceived forms of support that would have prevented their drug use. After handing out the guide to the willing participants, a date was set for the collection of their life history accounts at the centre.

As anticipated, it was very difficult to obtain the written life histories at the outpatient centres. The participants were only at the centre for a limited period, on a once-a-week basis and, therefore, had to complete their written life histories

at home and submit it on their next visit, a week later. Some forgot to bring the life history accounts back the following week, while others did not return to the centre, or dropped out of the outpatient programme in the weeks that followed. Ultimately, eight written life history accounts were produced: four by participants at the inpatient centre, and another four at two other outpatient centres.

A focus group discussion was also held at one of the treatment centres. The focus group consisted of six individuals at the centre where 19 of the 41 questionnaires were completed and four in-depth interviews were conducted. Patton (2002) recommends that the membership of an ideal focus group range from six to a maximum of twelve subjects. Focus groups are particularly suitable for exploring issues “where complex patterns of behaviour and motivation are evident, where diverse views are held” (Conradson, 2005: p. 131, as cited in Liamputtong, 2011).

Another objective of the focus-group discussion was to be able to triangulate data from yet another source, other than the questionnaires, in-depth interviews, and written life-history accounts. To strengthen reliability and enhance internal validity, strategies such as triangulation of data - the use of multiple data collection methods and analyses can be utilized in a particular study. The term triangulation refers to a procedure, where data from three (or more) instruments can be analysed and related to each other (Meijer, Verloop & Beijaard, 2002). It is used when a researcher wants to “verify a finding showing that independent measures of it agree with or, at least, do not contradict it”. (Miles & Huberman, 1994, cited in Meijer, Verloop & Beijaard, 2002: p. 146).

In this study multiple data collection methods such as questionnaires, interviews, life-history accounts, as well as a focus group data were used to increase the validity, and strengthen the reliability of the results of this study. The various instruments were able to elicit different data in seeking to explore the reasons and risk factors for drug use, and thus provided a more comprehensive and detailed account of the phenomenon of drug use among youth.

The main question posed to the participants was related to what they perceived to be the main reason(s) for their initiation into drug use. Their responses were

recorded in field notes, by a colleague, acting in the role of a research assistant, who was presented to, and sanctioned by, the group, as well as informed of the guarantee on the issues of confidentiality and anonymity. The group members appeared to be open about sharing their perceived reasons for drug use. The researcher assumed that this openness was due to them being regularly involved in group-counselling sessions at the centre. The researcher observed that they were more inclined to speak about the peer and social reasons for drug use, other than the more internal or family related reasons for drug use among young people.

During this session, the researcher used summarising and clarifying statements to ensure that the participants' voices were accurately captured by the research assistant. The field notes from this focus group discussion were typed up with the aim of merging the data with the other sources of data collection at the analysis stage of the study. The purpose was to discover any possible new insights into the phenomena of the reasons and risk factors for drug use among youth, and was valuable in providing a wider range of viewpoints and placing the data into context.

In summary, the data collection process with the young drug users consisted of an embedded mixed method approach that employed both quantitative and qualitative research methods and strategies to collect data from adolescents between the ages of 14-19 years old. Forty (41) questionnaires were completed by the participants across five treatment sites. Additionally, 14 of the 41 participants participated in in-depth interviews, eight (8) others provided written life history accounts of the precursors to their drug-taking pathways and a group of six (6) participated in the focus group discussion that provided valuable information and a wider range of viewpoints, as well as placing the data into context.

All the data from the three sources were analysed using a thematic data analysis process, and the key findings will firstly be presented separately in the following chapter. The embedded mixed methods design allows for the converging (merging) of the results, or for the sequential use of data. In this study, after the

thematic presentation of the results, the findings will then be merged with the overall findings from the other data to respond to the following objective: to explore the focus of primary prevention strategies.

Table 1: Breakdown of data collection with drug users

Treatment Centres	Questionnaires	Interviews	Life Histories	Focus Group
Bellville	10 (8 x male + 2 x female)	2 (females)	3 (males)	
Mitchells Plain	1 (female)	1 (female)	-	
Mitchells Plain	1 (female)	1 (female)	-	
Athlone(out-patient)	19 (males)	4 (males)	1 (male)	6 (males)
Athlone (in-patient)	10 (males)	6 (males)	4 (males)	
TOTALS	41 (37 males+4 females)	14 (10m + 4f)	8 (males)	6 (males)

The qualitative data analysis of the study will be discussed below. The researcher projected that the incorporation of the actual voices of the participants from the interviews and life histories would add a perspective in the report not commonly included in quantitative studies, such as questionnaires, or surveys. Direct quotes from individual responses and in-depth interviews will be presented selectively, based on the emerging themes. To ensure the credibility of the findings, a thorough interpretation will be performed in terms of existing literature and relevant theories in the discussion chapter (six).

4.7.2.4. Qualitative data analysis:

According to Braun and Clarke (2006), qualitative analysis entails the use of text and images for coding, for theme development, and for relating of themes. A thematic data analysis method was chosen to analyse the qualitative data due to the underlying assumption that qualitative data analysis is able to highlight descriptions, patterns and social contexts of drug use, as well as perceptions and attitudes concerning such risk-taking decisions (Fountain, 2004). The in-depth interviews were transcribed verbatim and the life history accounts, as well as the field notes from this focus group discussion were typed up. Data from the audiotaped interviews, life history accounts and focus group were manually analysed by utilising the thematic data analysis method. This process involves

identifying emerging themes through coding, the essential meanings of participants' narratives and drawing conclusions on the phenomena, based on these themes (Byrne, 2001).

Braun and Clarke (2006: p. 87) provide a guide for the process of a thematic analysis, which involves six logical steps:

1. *Familiarize yourself with your data*: Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. *Generate initial codes*: Coding interesting features of the data in a systematic fashion, across the entire data set, collating data relevant to each code.
3. *Search for themes*: Collating codes into potential themes, gathering all data relevant to each potential theme.
4. *Review themes*: Checking if the themes function in relation to the coded extracts and the entire data set, generating a thematic 'map' of the analysis.
5. *Define and name themes*: Ongoing analysis to refine the specifics of each theme, and the overall story that the analysis relates, generating clear definitions and names for each theme.
6. *Produce the report*: The final opportunity for the analysis, selecting vivid, compelling extract examples that relate back from the analysis to the research question and literature, to produce a scholarly report of the analysis.

According to Braun and Clarke (2006: p. 91), "coding is an ongoing organic process" and that coding and recoding within themes from the data set is to be expected as any additional data is added or were missed in earlier coding stages. In the case of this study, the data from the interviews, written life histories and focus group were merged in the data analysis stage and thematic data analysis techniques were applied to bring meaning to the participants' narratives.

To ensure the credibility of the findings, a thorough interpretation of the data was performed, in terms of existing literature and relevant theories (Creswell, 2009), that will be discussed in the following chapters. The findings were triangulated

with the relevant field notes and direct quotes from individual responses, based on emerging themes, and some written life histories will be presented selectively, in order to illuminate the overall findings.

4.8. Ethics Statement/Considerations

Ethical approval for the study was obtained from the Ethics Committee of the University of the Western Cape, in keeping with the ethics of psychological research (Sdorow & Rickabaugh, 2002), and the following ethical guidelines were applied in this study:

- **Informed consent:** To ensure that participation was voluntary, a verbal summary of the aims and process of the study, the benefits of participation, voluntary participation, confidentiality of the information, and the reporting of results were explained and a time for question asking was provided. Willing participants were provided with a copy of the consent form (Appendix 1) and written consent was obtained from the participants' parents or appointed guardians.
- **Confidentiality:** The informants were also guaranteed that what they disclosed to the researcher would remain confidential and used for research purposes only.
- **Anonymity:** The participants were assured that no personal identifying details would be provided by the researcher and that pseudonyms, or case numbers, would be used in the reports.
- **Risk of potential harm to the subjects:** The participants in this study were all enrolled in a rehabilitation programme and were encouraged to access the on-going counselling and support at their disposal, should the therapeutic need arise. Since the caregivers at the centres were made aware of the study, they were a resource, in terms of ensuring support to the participants, after their participation in this study.

4.9. Validity/Trustworthiness

The integrity of the researcher, who is the main instrument for obtaining information, remains crucial throughout the research process. Fountain (2004) suggests that, in an attempt to overcome problems and limitations, the researcher's sympathies, personal views, and prejudices should be kept to a bare minimum. The credibility of the interpretation of perceptions was established by reflecting back, throughout the interview, to clarify

‘meanings’. The combination of applying mixed methods (triangulation) of data collection, such as questionnaires, semi-structured individual in-depth interviews with drug users and a school official, written life history accounts and a focus group discussion, enabled the researcher to crosscheck findings and take into account the varied aspects of the findings. It also served to minimise the risk of biased research reporting. Additionally, member checks, at each qualitative phase, were conducted to establish credibility. For member checks, the researcher summarised, or paraphrased what the participants had shared during the session, and at the end of each session, clarified with the participants that their words had been portrayed in a credible and reliable way. Creswell (2009) noted that these control procedures serve to provide confidence in the accuracy of the findings, and aids to increase the validity of interpretations made from the analysis.

4.10. Credibility and Reliability

Establishing both credibility and reliability is crucial when conducting quality research that employs qualitative methods. According to Shenton (2004), establishing credibility would demonstrate internal validity with correspondence between the participants’ perspective and the researcher’s portrayal of their viewpoints. In efforts to establish credibility, the researcher used prolonged and substantial engagement, progressive subjectivity, member checks and triangulation in this study. Data collected from the questionnaires, in-depth interviews, a focus group discussion, life histories, and the researcher’s journal was triangulated to assess consistency throughout the research process.

4.11. Reflexivity

Reflectivity requires an awareness of the researcher’s contribution as an active participant in the construction of meanings in the research process. Willig (2003) describes two types of reflexivity, namely a personal and an epistemological reflexivity process. Personal reflexivity involves the way in which our own values, beliefs and social identities shape the research, and involves thinking about how the research has affected or possibly changed the person as researcher and human being. Willig (2003: p. 10) further asserts that the epistemological reflexivity process “encourages us to reflect upon the assumptions (about the world, about knowledge) that we have made in the course of the research, and it helps us to think about the implications of such assumptions for the research and its findings”.

The researcher, therefore, has taken the time to reflect and consider how the construction of the research question, the chosen design of the study, and the method of data analysis define the constructs of the research findings. An additional consideration is, to what extent these methodological underpinnings and assumptions would have given rise to a different understanding of the phenomenon under investigation. Gilgun (2010) suggests that researchers will do well to write, reflect upon and discuss their personal and professional interpretations throughout the research process, as it creates an awareness and an honest approach to their research, as well as the reporting thereof. The researcher is fortunate to be working in a research environment and was able to reflect upon and discuss her personal and professional interpretations of the data throughout the research process.

4.12. Limitations of the mixed-method approach

Despite its popularity, mixed-methods designs are not easy to implement. Researchers who choose to conduct mixed-methods designs have to consider certain methodological issues. These issues include the priority of, or weight given to, the quantitative and qualitative data collection and analysis in the study, the sequence of the data collection and analysis, and the stages in the research process, when the quantitative and qualitative phases are connected, as well as how the results are integrated (Creswell, 2009). Although some of these issues have been discussed in the methodology literature, and the procedural steps for conducting a mixed-methods (concurrent) embedded study have been outlined (Creswell, 2009; 2014), some methodological aspects of this design procedure may still seem unclear to researchers. According to Creswell (2009: p. 215), a possible limitation to using this mixed method approach is that “the data need to be transformed in some way so that it can be integrated within the analysis phase of the research”. He cautions that, “...the two methods are unequal in their priority”, and that care should be taken with the evidence in the study, so not to “disadvantage the interpretation of the final results” (Creswell, 2009: p. 215). In the case of this study, the dominant research method utilized was of a qualitative nature, with a much smaller component of quantitative data embedded in the overall design. The quantitative data served to provide demographical and contextual background to the participants in the study; and answered the first research question (what is the perceived reason for your drug use?). The responses to the questions on the questionnaire served as the prompts for further questioning in the in-depth interviews (qualitative data collection method).

4.13. Conclusion

In this chapter, the researcher aimed to outline the research methodology utilised in the study and attempted to demonstrate how an embedded (concurrent) mixed method design for data collection was the most appropriate approach to meet the aims and objectives of this study. The quantitative data collection tool was a questionnaire, embedded in prioritising qualitative data collection methods. The research design for this study was largely descriptive and interpretive, utilising a mixed method approach. Several steps involved in the design and development processes of the research was presented, described and explained. This includes the research paradigm, research methodologies, strategies and design used in the study, including participants, data collection tools, procedures, data analysis methods, and data credibility issues.

The data analysis methods were outlined, quantitative data (questionnaire) analysed using SPSS for descriptive statistics, and a thematic data analysis procedures were applied to the dominant qualitative data collection strategies (such as interview transcripts; written life-history accounts; typed up notes from the focus group discussion). The steps of the thematic data analysis were described, issues of trustworthiness were outlined, the ethics statements, as well as reflexivity considerations were discussed and a brief overview of the limitations of the mixed-method approach was provided.

The next chapter provides the findings of the data analysis, and the descriptions of the various themes are outlined.

CHAPTER FIVE

PRESENTATION OF THE RESEARCH FINDINGS

5.1. Introduction

In this chapter, the main findings of the research study are presented. The chapter is divided into three sections, namely Section A, B, and Section C. It starts with a restatement of the aims and objectives of the study, followed by the presentation of the results.

In order to provide a context of the young drug users lives, Section A presents the statistical findings of the questionnaire, which forms the quantitative part of the study, and includes a brief overview of the descriptive demographical and contextual (family and community) profiles of the respondents, as well as their drug use patterns. A summary of the results ensue, including the perceived reasons for drug use, as well as a report of the support that the users perceived as available to them after their onset of drug use.

A impression of the lived experiences of the young drug users is offered in Section B, as the results of the external risk factors for drug use are presented, obtained through the merging of the data of the in-depth interviews, the written life history accounts of the young drug users, as well as the focus group discussion. These descriptive themes are presented as two main categories, namely the family-related reasons for use, and their social life domains and sub-themes. These life domains, in turn, are sub-divided, according to Bronfenbrenner's (2005) micro level system, namely, peer, school and neighbourhood systems in the drug users lives. The responses to the perceived reasons (in section A), and contributing risk factors for drug use are presented as raw as possible, with very little integrated theory, in order for the reporting of the data to remain true to the raw data.

Section C shows the findings of the semi-structured in-depth interview conducted with a school official (Learner discipline/support officer) at a school situated in a 'high risk' school/neighbourhood community. The participant was asked about the learners' drug use problems, as well as the perceived reasons for drug use among youth. In addition, prevention strategies and ways to reduce drug use were explored from the perspective of the school setting. These findings are incorporated into the findings of the data collected from the young

drug users and forms part of the considerations for the implications of primary prevention measures. The following research questions and study objectives were carefully considered:

5.2. Research Questions

The research questions for this study are as follows:

- What are the main perceived reasons for drug use among youth?
- What are the contributing risk factors for drug use among youth?

5.2. Aim of the study

The aim of the study is to establish the main perceived reasons for drug use from the perspective of the young drug abuser, as well as to explore and identify the inter-related intrapersonal, familial, and environmental risk factors present in the lives of young drug abusers, and to use these findings to inform the focus of primary drug prevention efforts.

5.3. Objectives of the study

The objectives of the study are to:

- Identify and describe the demographic and contextual profiles of young drug users;
- Establish and describe the perceived reasons for the use of illicit drugs by young drug abusers;
- Discover areas of risk by exploring the childhood experiences and family contexts and inter-relationships;
- Explore and analyse precursors to their drug-taking pathways, in order to identify the contributing risk-factors in their lives;
- Identify and describe the perceived forms of support that young drug users had available to them at home and at school after they became involved in drug-using behaviour;
- Explore the perceived reasons for drug use and its implications for primary prevention from the perspective of a school official at an at-risk school community;
- Use the identified areas of risks emanating from the data to inform the focus of primary prevention efforts and programmes.

SECTION A: Demographical characteristics, Contextual circumstances and reasons for drug use, gathered from the quantitative data

5.4. Descriptive Characteristics

The following table provides the descriptive findings of the demographic characteristics of the participants in this study, regarding gender, race and school grade, at the start of drug use, as well as their area of residence and some aspects relating to it. Forty-one (41) respondents aged between 14 and 19 years old were involved in this quantitative segment of the study. Of these 41 respondents, who completed the questionnaires, 37 were males and four were female.

Table 2: Demographic information of respondents

Variables	Answers	N = 41	%
Gender	Male	37	90.24
	Female	4	9.76
Race	Coloured	37	90.24
	Black/African	3	7.32
	White	1	2.44
Grade when started to use	8	10	24.4
	9	10	24.4
	10	7	17.06
	11	5	12.2
	After dropping out of school	2	4.88
	Did not disclose	7	17.06
Area of residence	Manenberg	9	21.92
	Crawford	1	2.44
	Heideveld	2	4.88
	Mitchels Plain	3	7.32
	Khayelitsha	2	4.88
	Seawinds	1	2.44
	Cape Town	1	2.44

	Belhar	2	4.88
	Bellville	2	4.88
	Walmer Estate	1	2.44
	Elsies River	3	7.32
	Athlone	1	2.44
	Blue Downs	1	2.44
	Langa	1	2.44
	Bonteheuwel	1	2.44
	Hanover Park	4	9.76
	Kuils River	1	2.44
	Kraaifontein	1	2.44
	Delft	1	2.44
	Eerste River	1	2.44
	Lansdowne	1	2.44
	Stellenbosch	1	2.44
Liking the area of residence	Yes	35	85.4
	No	6	14.6
Aspects of the area of residence	Crime	1	2.4
	Family	2	4.9
	Friends	16	39.02
	Friends and family	2	4.9
	Gangsterism	7	17.07
	Nice and quiet	3	7.32
	Safe	6	14.63
	Too quiet and no friends	1	2.4
	Born in the area	2	4.9
	What people make of it	1	2.4

5.4.1. Gender

The demographic information in Table 2 indicates that there were more males ($n = 37$) than females ($n = 4$) who participated in the study. It was very challenging to locate

female participants as there were very few female drug users seeking treatment at the five treatment centres in this study. Other studies confirm that generally more males than females engage in substance abuse in the Western Cape (Ndondo, 2016).

5.4.2. Race

Under the Apartheid government, The Group Areas Act (No. 41) of 1950 separated groups of peoples in South Africa by race, and created four official racial categories, namely, Black, Coloured, White and Asian/Indian persons. People were then displaced to various living areas according to race classifications. Present government policies, such as Black Economic Empowerment (BEE) still make use of racial categorizations to distinguish between previously disadvantaged groups in the country. According to literature, people from disadvantaged histories and communities, are more likely to engage in substance abuse behaviours (Chetty, 2015). It is, therefore, noteworthy that, in this study, the majority of the respondents that were recruited from the five treatment sites were of Coloured (or mixed) descent ($n = 37$ [90.24%]); three participants were Black/Africans; and one (female) participant was White.

5.4.3. Grade at start of drug use

The majority of the participants, 32 (78%), had started using drugs while still at school. Ten respondents (25.6%) indicated that they were in Grade 8 when they started using, another 10 (25.6%) reported being in Grade 9, and a further 12 (29.26%) reported being in Grade 10 and 11 when they started using substances. Two respondents (4.9%) started using drugs after they dropped out of school, and the rest ($n = 7$ [17.0%]) did not indicate which grade they were in at the onset of their drug using habit.

5.4.4. Area of residence

Table 1 further indicates that the majority of the respondents (90%) resided in and around the Cape Flats areas of the Western Cape, with nine (22%) living in Manenberg; four in Hanover Park; three in Elsies River; and some others in areas like Bonteheuwel, Heideveld, Delft; Kraaifontein. Langa and Khayelitsha. During the Apartheid era, thousands of families were relocated through forced removals from well-established areas, such as District Six, to newly constructed housing projects, such as Bonteheuwel, Manenberg, Mitchells Plain, Lavender Hill and Hanover Park (Cooper, 2009 cited in Chetty, 2015). Other large townships, such as Khayelitsha and Gugulethu, were

specifically zoned to house Black/African people. These and other surrounding areas, often referred to as “apartheid’s dumping ground” became known as the “Cape Flats” areas of Cape Town. These areas mostly consist of over-crowded housing, with high incidences of unemployment, school dropout rates, substance abuse, gangsterism and crime (Adhikari, 2006; Chetty, 2015).

The majority of the respondents indicated that they liked the area they lived in ($n = 35$ [85.4%]), with most of them ($n = 16$ [39.02%]) citing their reason for liking the area as, ‘because of their friends’. This is usual, as adolescence is the period of development, when young people’s friends/peers interactions and relationships start playing a bigger and more significant role in their lives.

5.5. Age of onset

This table provides the mean age of the participants at the time of data collection, as well as the mean age at which they starting using drugs in the first place. It also provides the minimum and maximum ages of the participants during those periods.

Table 3: Current age of participants and age of onset of drug use

Variables	N	Minimum	Maximum	<i>M</i>	<i>SD</i>
Age	41	14	19	16.22	1.42
Age of onset for drug use	41	11	17	14.22	1,65

In Table 3 the average age of the respondents was 16.22 ($SD = 1.42$) years. The minimum age was 14, and the maximum was 19 years of age. In addition, the respondents indicated when they *first started* using drugs. The mean for age of *onset of drug use* was 14.22 ($SD = 1.65$) years, with a minimum age of 11, and a maximum age of onset at 17 years. This mean age of onset (about the age of 14) is consistent with other global (McDowell & Futris, 2002; Resnick *et al.*, 1997; Van Ryzina, Foscoa, Dishion, 2012), and local studies (Reddy *et al.*, 2003; Reddy *et al.*, 2010).

5.6. Familial characteristics

Table 4 provides a description of the family contexts of the substance users. It includes information about their primary caregivers, such as the marital status of their parents;

presence of a father/father-figure in their lives; perceived feelings of being loved and cared for by their parents/caregivers; substance abuse of family members; and monitoring or supervision by the adults in their lives.

Table 4: A description of the family contexts of the substance users

Variables	Answers	N =41	%
Primary caregiver at home	Aunt	1	2.4
	Both parents	1	2.4
	Biological father and step mother	1	2.4
	Biological father	2	4.9
	Foster mother	1	2.4
	Guardian	1	2.4
	Grandparents	6	14.6
	Mother	28	68.3
Marital status of parents	Married	11	26.83
	Living together	2	4.9
	Mom died	1	2.4
	Divorced	14	1
	Unmarried	12	29.3
	Foster parents	1	2.4
Monitoring or supervision	Both parents	2	4.9
	Biological father	1	2.4
	Grandparents	11	26.8
	Mother	11	26.8
	No one	16	39.02
Feeling of being loved, cared for or wanted by a mother/primary caregiver.	Yes	37	90.2
	No	4	9.8
Presence of a father or stepfather	Father	24	58.5
	Stepfather	5	12.2
	No father	12	29.3
Feeling of being loved, cared for or wanted by a father or stepfather	Yes	28	68.3
	No	13	31.7
Experiences of childhood	Happy	28	68.3
	Okay	6	14.6
	Unhappy	6	14.6

Substance use by a family member	Aunt	1	2.4
	Brother	5	12.2
	Cousin	5	12.2
	Cousin and brother	1	2.4
	Father	2	4.9
	Father and brother	1	2.4
	Mother	1	2.4
	Stepfather	3	7.3
	Uncle	1	2.4
	Uncle and cousin	1	2.4
	No family members	20	48.8
Family member who drinks <i>alcohol</i>	No family members	18	43.9
	Biological father	4	9.8
	Stepfather	2	4.9
	Stepmother	1	2.4
	Aunt, mother and father	1	2.4
	Biological father and sisters	1	2.4
	Grandmother	1	2.4
	Grandmother and mother	1	2.4
	Mother	2	4.9
	Parents	2	4.9
	Sister	2	4.9
	Uncle and cousin	1	2.4
	Uncles	1	2.4
	Many family members	4	9.8

5.6.1. Primary caregiver at home

Regarding the primary caregiver item at home, the majority of respondents listed their mothers ($n = 28$ [68.3%]) as the primary caregiver. Two (4.9%) were cared for by a biological father, one participant named that he was cared for by both parents, and another one indicated that he was cared for by a biological father and stepmother, (blended family unit). A further six (14.6%) participants were cared for by their grandmother; and the other three participants were cared for by extended family members (an aunt, a foster mother, and a guardian).

5.6.2. Marital status of parents

In response to what the marital status of their parents were, an overall sample of 11 respondents (26.83%) reported their parents as married, and two (4.9%) reported that their parents were living together. Fourteen respondents (34, 1%) indicated that their parents were divorced, and 12 (29.3%) reported that their parents were unmarried (single) parents. One other participant lived with foster parents and another reportedly lived with his father as his mother had passed on.

The family structures reported by participants were indicated as follows: 13 (32%) respondents listed that they grew up with both parents, eight (20%) in blended families (with a parent and stepparent); and 20 (54%) grew up in single-parent family homes (two lived with single fathers, one lived with a grandmother and 17 males lived with single mothers). These figures are consistent with research of the South African Institute of Race Relations by Holbern and Eddy (2011), where researchers found that majority of South African children grew up in single-parent households headed by mothers mainly.

5.6.3. Presence of a father/father-figure while growing up

The item dealing with a father or father figure (such as a stepfather) drew the responses that, overall, twenty-nine participants (70.7%) reported that they had the presence of a father/father-figure in their lives (twenty-four had biological fathers and five had stepfathers). Twelve (29%) participants reported that they never grew up with a father or father figure in their lives.

5.6.4. Felt loved and cared for or wanted by mother/primary caregiver

Thirty-seven respondents (90.2%) reported that they felt loved, cared for and wanted by their mothers, or primary caregivers, while four (9.8%) reported that they did not feel loved, cared for or wanted by their mothers/primary caregivers.

5.6.5. Felt loved and cared for or wanted by father/stepfather caregiver

The majority ($n = 28$ [68.3%]) of the participants reported that they felt loved, cared for, or wanted by their fathers. Thirteen (31.7%) indicated that they did not feel loved, cared for, or wanted by their fathers.

5.6.6. Experiences of childhood

The item dealing with the experiences of childhood drew the response that most of the participants ($n = 28$ [68.3%]) indicated that they had a happy childhood; six (14.6) reported having an unhappy childhood and a further six (14.6) reported experiencing an acceptable childhood.

5.6.7. Alcohol and other substance use by a family member

Twenty-three (56.0%) respondents indicated alcohol use by live-in family members, and 18 (44%) participants reported that no one in the family drank alcohol. More than half ($n = 21$ [51.2%]) reported that family members used illicit drugs, while 20 (48.8%) participants did not have family members, who used other drugs.

5.6.8. Monitoring/supervision

In terms of being monitored or supervised, 16 (39%) of the respondents indicated that no one supervised, or monitored, their whereabouts after school hours. Eleven (26.8%) were monitored by a grandparent, and a further 11 (26.8%) were monitored by their mother.

5.7. Drug use patterns

In order to understand the reasons and risk factors of drug use among youth to a fuller extent, it becomes important to investigate their drugs of choice, as well as how they first became involved in drug taking behaviour. A recent finding by the Medical Research Council (Dada *et al.*, 2016) revealed that across the six sites that they monitor in South Africa, cannabis was the most common illicit drug that was abused, followed by methamphetamine (commonly known as 'tik') as the second substance of choice among patients 20 years and younger. In addition, across all nine provinces, poly-substance abuse remained high, with 51% of the Western Cape patients reportedly to abusing more than one substance. This following table provides the substance(s) of choice at the onset of use of the participants of this study, the substance(s) last used, as well as who introduced them to drug use, and how many of their friends use drugs.

Table 5: Substance use description

Variables	Answer	N = 41	%
Substance of choice on <i>onset</i>	Alcohol	2	4.9
	Cigarettes	23	56.1
	Cigarettes/Alcohol	8	19.5
	Dagga	22	53.7
	Dagga/Mandrax	2	4.9
	Heroine	2	4.9
	Tik (methamphetamine)	12	29.3
Substance last used	Alcohol	1	2.4
	Cigarettes	3	7.3
	Dagga	20	48.8
	Dagga/Mandrax	2	4.9
	Ecstasy	1	2.4
	Mandrax	2	4.9
	Heroine	3	7.3
	Rocks	1	2.4
	Methamphetamine (Tik)	20	48.8
	Tik/rocks	1	2.4
Person to introduce substance use	Boyfriend	1	2.4
	Cousin's friend	1	2.4
	Friends	32	78
	Gangsters	1	2.4
	Myself	5	12.2
Number of friends using drugs	All	18	43.9
	Few	14	34.1
	Many	8	19.5

5.7.1. Substance of choice on onset

It should be noted that many of the respondents started using more than one substance at the onset and used multiple substances at the last time of use. The results suggest that cigarettes ($n = 23$ [56.1%]) and dagga ($n = 22$ [53.7%]) were the substances of choice at the *onset*. The next highest substance of choice was methamphetamine with 12 (29.3%) participants reporting that to be their drug of choice at onset of their drug use.

5.7.2. Substance last used

The most common substances last used were dagga ($n = 20$ [48.8%]) and methamphetamine, commonly referred to as 'tik' ($n = 20$ [48.8%]). The above findings are consistent with a recent statistics released by SACENDU. The report revealed that methamphetamine (tik) remained the most common primary drug among patients, and that cannabis is reported as the primary substance of abuse by the majority of patients who are younger than 20 years (SACENDU, 2015).

5.7.3. Who introduced to drug use?

Friends were reported as the chief introducers to drug use at the onset ($n = 32$ [78%]), and five participants reported that they introduced themselves to drug use. The literature reports the finding that young people are normally introduced to substances by drug-using peers.

5.7.4. Number of friends who used drugs

Eighteen participants (43.9%) indicated that *all* their friends used substances, 14 (34%) reported that a few of their friends used drugs, whilst eight (19.5%) reported that many of their friends used drugs. Overall the vast majority of participants 26 (63.4%) reported that all or many of their friends used drugs. This finding is consistent with the literature that young people who use drugs are more likely to associate with drug-using peers.

5.8. Perceived support for drug use

From an ecological perspective, the individual is nested in, and between the family/peer/school/and neighbourhood, as well as other levels of their environment, and according to Bronfenbrenner (2005), the quality and nature of the interactions between the persons within these systems, is believed to hold the ability to modify responses and behaviours of individuals in these systems. For example, an adolescent with a strong supportive network of caregivers/adults, in whom they feel they can confide, may lead to early intervention in their drug use behaviours. The following table presents the findings of whether or not the adolescents in this study supposed that they could confide in someone at school or home, when they started using drugs, and if not, what the reasons were for not being able to do so.

Table 6: Confiding in someone about substance use

Variables	Answers	N = 41	%
Trusting someone at <i>school</i>	Deputy principal	1	2.4
	Friends	12	29.3
	No one	22	53.7
	Principal	1	2.4
	Social workers	1	2.4
	Teacher	4	9.8
Trusting someone at <i>home</i> or in the family	Brother	4	9.8
	Biological father	1	2.4
	Grandmother	2	4.9
	Mother	6	14.6
	No one	27	65.9
	Parents	1	2.4
Reasons for not confiding in someone at home	Did not want to	2	4.9
	Did not trust anyone	1	2.4
	Did not want to disappoint	3	7.3
	Did not want to get into trouble	1	2.4
	Did not want my family to know	4	9.8
	Mother would send me away	1	2.4
	They may inform my mother	1	2.4
	They will hit me	3	7.3
	To protect myself	1	2.4
	Wanted to continue using	1	2.4
	Fear of consequences	6	14.6

5.8.1. Confiding in someone at school or home about substance use

When the respondents were asked whether they had told anyone at school, or at home, about their drug use, the vast majority did not tell anyone at school ($n = 22$ [53.7%]), nor at home ($n = 27$ [65.9%]), about their drug use after the onset. Six respondents (14.6%) confided in an educator in the school system, another 6 (14.6%) confided in their mothers, and a further two confided in their parent(s) – one in both parents, and the other in a biological father. Significantly 16 (39%) of the respondents choose to confide in a friend ($n = 12$), or sibling ($n = 4$) about their drug use after the onset.

5.8.2. Reasons for not confiding in someone at home

In terms of not informing, or confiding in someone about using substances, the reason

most frequently provided ($n = 6$ [14.6%]) was the fear of consequences. Other reasons for not confiding, included that they did not want their family to know about it ($n = 4$), and they did not want to disappoint their family ($n = 3$). According to these findings, most drug-using youth perceived that they would not have the necessary support from adults in their home, or school systems and, therefore, did not disclose their drug-using behaviour to the adults in their world, because of mistrust. They seemed more willing to confide in a friend or sibling.

5.9. Perceived reasons for drug use

One of the main aims of this study was to explore the reasons for drug use as perceived by the young drug users. The following table provides a list of the perceived reasons for drug use, as well as the perceived reasons for continuing the use of drugs.

Table 7: Perceived Reasons for substance use

Variables	Answers	N = 41	%
Perceived reasons for onset of substance use	Experimentation	3	7.3
	Peer pressure	24	58.5
	Family issues (Violence, physical abuse, absent father, rejection/loss)	18	2.4
	Free time	1	2.4
	For fun/felt good/cool	4	9.8
	Depression/Anxiety/Stress/Calming	6	14.6
	Father did it	1	2.4
	Partner's encouragement	1	2.4
	Area of residence	1	2.4
Maintaining reasons for substance use	Addictive habits	10	24.4
	Peer pressure	3	7.3
	Unhappiness, Sadness, Loneliness	8	19.51
	Family issues	5	12.2
	Calming/Feels good/Cool/Escape	22	53.7
	Sense of belonging/Being loved	2	4.9
	Provided strength	3	7.3

5.9.1. Perceived reasons for onset of substance use

Regarding the item addressing the main perceived reasons for their substance use, in terms of the onset and continued use, the respondents cited more than one perceived reason. The majority in Table 6 offered peer pressure ($n = 24$ [58.5%]) and family-related problems ($n = 18$ [43.90%]), such as domestic violence, physical abuse, an

absent father or father figure, rejection and loss, due to divorce, or the death of a parent, as the perceived reasons for the onset of their substance use. A further 10 respondents (24.39%) cited individual/psychological reasons for drug use, such as fun, felt good, cool, calming, depression, anxiety and stress.

5.9.2. Reasons for continuing to use

The reasons for *continuing* the use of substances was reportedly, mainly due to experiencing a sense of calmness when using, feeling cool, or escaping from reality ($n = 22$ [53.7%]). This was followed by becoming addicted ($n = 10$ [24.39%]), and due to unhappiness/sadness/loneliness ($n = 8$ [19.5%]).

5.10. Summary of perceived reasons for drug use

Nine respondents reported internal (individual/psychological), 18 cited family-related and stressful life situations, while 14 stated that peer/school/and neighbourhood-related factors were the reasons for their drug use. The internal factors (individual/psychological, or person-factors), are presented next, as reasons for drug use.

5.11. Internal (Individual/psychological) factors as reasons for drug use

The individual and psychological factors cited as reasons for drug use are grouped into three main categories, namely, a positive attitude towards drugs, a deficit in social skills, and poor/maladaptive coping mechanism skills. Examples of some of these individual/psychological factors (person-factors) cited, are provided in Table 8.

Table 8: Individual/psychological factors (person-factors) as reasons for drug use

A positive attitude towards drugs	Deficit in social skills/Lack of self-esteem	Poor/maladaptive coping mechanism skills
"I felt there was nothing wrong with using dagga"; "It feels nice"; "I speak easier now"; "I can speak easier now. I am more confident now"; "I see my friends are happy when they use".	"To be accepted" "I wanted a sense of belonging" "Not good self-esteem. It feels nice." "I want to party with my friends. It makes me laugh"; "I don't know why... it feels good" "Depression and boredom"; "To impress friends and take away the stress"	"To cope. To suppress my hurt"; "whenever I'm stressed or frustrated, I would turn to drugs"; "I was stressed. To feel nice"; "Bored. Nothing to do. I wanted to experiment"; "It feels nice-makes me forget"; "Gave me a nice feeling. I felt down and rejected"

5.12. Summary of Findings of Section A

Section A provided an overview of the demographical and contextual situations in young drug users' lives, as well as the reasons for drug use gathered the quantitative data collection process. Some of these contextual findings have been identified as the factors that could put young people at risk of drug-using behaviour. To avoid overlap, these risk factors will be presented along with the other risk factors that were revealed in the qualitative data collection procedures, such as the in-depth interviews, life histories and focus group.

However, the major finding of this quantitative inquiry method was the revelation of perceived reason(s) for drug use, from the perspective of young drug users. These findings were categorised in terms of the *internal factors* (individual/psychological or person-factors) cited as reasons for drug use. This section also explored and identified the types of support (or lack thereof) that the drug users expected to receive from the adults in the home and school environments. In the following section (B), the researcher provides a presentation and a brief overview of the *external factors* (family/peer/school/neighbourhood) cited as reasons for drug use by young drug users. It will also present the risk factors, found to be present in the lives of the drug users, as explored through the in-depth interviews and written life-histories accounts of young drug users, as well as a focus group discussion.

SECTION B: Themed external factors: Reasons for drug use and Risk factors, extracted from the qualitative data

This section comprises a presentation and a brief overview of the themed external factors (family/peer/school/neighbourhood) cited as reasons for drug use by young drug users. The themes of the risk factors, found to be present in the lives of young drug users, will also be presented, as explored through the various data collection techniques, including questionnaires, in-depth interviews, written life-history accounts of the young drug users and a focus group discussion. These different forms of data are merged at the data analysis stage, and are presented below. These results will be presented with very little theory integration at this stage, as the main findings will be discussed more fully in the following chapter.

5.13. Family-related reasons for use

One of the objectives of the qualitative data collection techniques, such as the individual in-depth interviews, the written life-histories and focus group discussion were to explore and

uncover the family contexts and the parent-child relationships, as well as the childhood experiences and life events leading up to the drug using habits of young drug users. Eighteen (18) participants cited family-related reasons for drug use and, in many cases, home lives were characterised by stressful, conflict-ridden and often abusive family situations. These reasons were sub-themed into absent fathers and troubled parent-child relationships, poor family communication/interactions, parental/family substance abuse, and conflict-ridden, stressful and violent/abusive family situations. Examples of some of these perceived family-related reasons are provided in Table 9.

Table 9: Family-related reasons for use

Absent fathers and troubled parent-child relationships	Poor family communication patterns	Parental/family substance abuse	Stressful/abusive family situations
<ul style="list-style-type: none"> • “My father did not seem to care about me when he came out of jail” • “I want my parents to be together. Since step-father came, I felt my mother no longer loves me” • “No love from parents, although they gave me everything” • “My father doesn’t care about me”; • “I moved to and fro. I wanted to live with my own father” • “... [I] wanted my father to be alive. I cry a lot for him” • “My father was not there for me...” • “To heal my thoughts and age my body. I was introduced to a brutal society. Not even God cares” 	<ul style="list-style-type: none"> • “Lots of problems, no-one to talk my problems out with” • “Problems build up. Relief when I used” • “ I never knew my parents care so much for me” 	<ul style="list-style-type: none"> • “...my father didn’t care about me. Because if I take drugs he can care about me because he also takes drugs.” • “ I saw my biological father using, and I used too” • “My parents drink and humiliate me in front of my friends” 	<ul style="list-style-type: none"> • “Stress at home. It makes me feel better” • “Found out my mom had a lesbian affair. Felt hurt, embarrassed, and suicidal”; • ‘The way my mom suffers under her boyfriend” • “Step-father physically abusive. Argues with my mom when she tries to stop him hitting us children” • “Anger due to my father’s abuse. He treated me like a dog. My Mom cries and I cannot do anything” • “Because of my friends and violent step-father. I had a fear for him” • “Due to step-father’s cruelty”

5.13.1. Troubled parent-child relationships

The following quotes from some of the participants cited as reasons for their drug use, which pointed to troubled parent-child relationships in their lives:

“I want my parents to be together. Since my step-father came, I felt my mother no longer loves me”

“No love from parents, although they gave me everything”

“To heal my thoughts and age my body. I was introduced to a brutal society. Not even God cares”

“My father did not seem to care about me when he came out of jail”

“My father doesn’t care about me”.

5.13.1.1. Absent fathers

A number of the participants (8 = 20%) lived with a stepfather in a blended family environment. Some of these stepparent environments were characterised by unhappiness, as expressed by this participant as his reason for drug use:

“The main reason is because of my father and my stepfather [be]cause why, I actually misses my father because he don’t actually phone me. And for me to see all my friends, they are living with their father.... Now for me I feel like I’m actually out of the group because I’m living now with my stepfather. And I can’t maybe show them my real father and that. That’s actually why I also starting to using drugs... and the way my stepfather also abuse and treat me”.

Other participants cited reasons for their drug use due to the absence of their fathers in their lives, as demonstrated in the following statements:

“I moved to and fro. I wanted to live with my own father”

“My father was not there for me...”

“... [I] wanted my father to be alive. I cry a lot for him

5.13.2. Poor family communication patterns

The participants also cited problems in their lives and reasons pointing to a lack of communication in their family systems, as these quotes reflect:

“Lots of problems, no-one to talk my problems out with”

“Problems build up. Relief when I used”

“I never knew my parents care so much for me”

5.13.3. Parental/family substance abuse

Reasons relating to parental substance abuse and poor role modelling were also cited as reasons for drug use by the participants of this study. These are some of the statements provided for the reason for their drug use:

“...my father didn't care about me. Because if I take drugs he can care about me because he also takes drugs.”

” I saw my biological father using, and I used too ”

“My parents drink and humiliate me in front of my friends”

5.13.4. Stressful/abusive family situations

Many of the participants in this study cited stressful and abusive family situations as the reasons why they started to use drugs, as the following quotes demonstrate:

“Stress at home. It makes me feel better”

“Found out my mom had a lesbian affair. Felt hurt, embarrassed, and suicidal”;

“The way my mom suffers under her boyfriend”

“Step-father physically abusive. Argues with my mom when she tries to stop him hitting us children”

“Anger due to my father's abuse. He treated me like a dog. My Mom cries and I cannot do anything”

“Because of my friends and violent step-father. I had a fear for him”

“Due to step-father's cruelty”

5.14. Family *risk factors* for drug use

The following risk factors within the family domain were also identified in the data analysis, which included single parenting; absent fathers/lack of a positive father-figure; troubled parent-child relationships; poor parent-child communication patterns; parental/family substance abuse; familial discord and physical abuse; lack of monitoring of after-school activities. These identified risk factors are outlined below:

5.14.1. Single parenting

The overall sample comprised of 14 (34%) participants, who lived with both biological parents ('intact' families); seven (17%) lived with blended families/step-parents. Almost half (49%) of the participants, lived in single parent/caregiver households. The family structures, according to gender, were as follows: 11 of the 37 male participants lived in in-intact family systems, six in blended and 20 (54%) lived in single-parent family homes (Eighteen males lived with single female caregivers and two with their biological fathers). Three of the four female participants lived in intact families and one lived in a blended family situation. More than half of the 37 male participants reported growing up with their mothers only.

5.14.2. Lack of a positive father figure

Sixteen (43%) of the male participants reported having absent, non-resident, or uninvolved father figures in their lives. A participant, who lived with a physically abusive stepfather and whose parents divorced when he was two years old described his relationship with his biological father, as well as his longing to see him again:

"I was eight years old and I actually enjoyed seeing my Dad. I enjoy myself also with my dad because he's actually funny sometimes, makes jokes and that. He just wants to get to know me and I just want to get to know him. So we had a nice conversation and that, and.... I only saw him twice. When I was eight and eleven years old...I loved to see him ...and I wish that I could see him again..."

5.14.3. Troubled parent-child relationships

Overall, 22 (male) participants reported having experienced troubled parent-child relations. This was expressed by some of the youth in the following statements, when asked why they started to use drugs,

“...my father was not there for me. The way he abused my mom...”

Another participant cited his reason for drug use as,

“To heal my thoughts and age my body. I was introduced to a brutal society. Not even God cared”.

This young man lived with his mother in a single-parent home, and clearly felt that nobody cared for him.

5.14.4. Poor parent-child communication patterns

Other participants experienced and spoke about poor parent-child communication and interactions. This was expressed by one of the participants as:

“I have lots of problems, no-one to talk my problems out with”.

Another participant stated:

“Problems build up...I feel relief when I used”.

5.14.5. Parental/family substance abuse

The majority (51%) of the participants had a father/father-figure, sibling or other family member, who also used illegal drugs. Twenty-three participants (56%) reported that one or more parent, sibling, or family member drank alcohol. Overall 40 (98%) of participants had a parent or family member, who either used alcohol and/or other drugs (AOD), which often resulted in abusive and conflict-ridden home-lives.

5.14.6. Familial discord and physical abuse

Eleven participants reported familial discord, and stressful home conditions that included domestic violence and physical abuse by fathers/step-fathers. This was expressed through the following excerpt from an interview with a young man, whose parents are divorced, and who lived with his father. He spoke about parental substance abuse by his mother and stepfather:

“...But my Mom, she had a problem with alcohol. She drinks a lot and her husband. She worked in town, my mommy and then she paid for me...she don't wanted me...and because when her husband he hit her, then I also want to hit him because it is my mommy and that's why I moved... because my boeta [brother] also will beat him up man...I just wish that my Mommy and my Daddy they could still get together, but I know it's not going to happen cause my Mommy, her life is not nice... Her husband is hitting her and both of them is drinking...But one day I'm gonna get my Mommy, when I finish school I want my Mommy to stay with me man. So that I can look after my Mommy...”

5.14.7. Monitoring of after-school activities

Sixteen (39%) of the participants reported not being monitored or supervised by an adult after school. One young man expressed himself this way,

“Parents should monitor and read their children more closely. To see when they are down”. They [parents] must have open communication and closeness with their children. Young people mostly take drugs due to their home situations. Peer pressure?... I do not think friends can make you do something you don't want to do...”

5.15. Peer-related reasons for use

The participants of this study also provided peer-related reasons for their drug use. It is noteworthy that 32 (78%) respondents reported that they had first been introduced to drug use by their friends. Twenty-six (63%) reported that *all or many* of their friends used drugs. Fourteen respondents wrote about peer-related reasons for drug use. Examples of these peer-related reasons are as follows:

Some peer-related reasons cited for use

<ul style="list-style-type: none"> • “Wanting to experiment. To party with friends” • “Made me feel good. Can dance and everybody loved me” • “To impress friends” • “Peer pressure” 	<ul style="list-style-type: none"> • “To cope with stress. My friends do it” • “To feel nice. To party with my friends. It makes me laugh” • “Because my friends did it” • “Every one of my friends did it” • “Wanting to impress my friends”
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5.16. School-related risk factors for use

Some school-related factors were also identified as risk factors in the lives of the young people in this study. This included school/drop-out and lack of trust in the adults in the school environment.

5.16.1. School drop-out/failure

It was noted earlier that 95% of participants started using drugs while still at school and that 41% of them have since dropped out of school. One female participant cited that she took drugs because she was ‘stressed out’ due to school failure and that friends, as well as her boyfriend told her that taking drugs would make her feel calm and less concerned about the consequences of her failure.

5.16.2. Lack of trust and adult support

The vast majority of respondents did not tell anyone at home or at school about their drug use. Only 10 (24%) participants spoke to an adult at home about their drug use, and another seven (17%) confided in an adult at school about their drug use. Most participants cited that they did not trust anyone at school.

5.17. Neighbourhood reasons and risk factors for use

Some neighbourhood reasons and risk factors were identified in the lives of the young drug users. These risks were related in the neighbourhood contexts and its associated norms.

5.17.1. Neighbourhood context and norms

Overlapping reasons cited were, “...because of the area and friends, it is not easy to stop”, and, “I felt like an outsider. All my friends used”.

5.17.2. Neighbourhood context

Most of the participants (90%) resided on the Cape Flats area of the Western Cape. The Western Cape has the largest Coloured population than any province in South Africa, and the Cape Flats is an area of the Western Cape that was established through the ‘forced removals’ during the apartheid era. People from widely divergent backgrounds and experiences, were uprooted from their communities and thrown together in a wasteland that has become known as the Cape Flats. With the standard of living being

low and the unemployment rates high, communities in the Cape Flats have been plagued with violence and substance abuse issues (Parker, Wills & Wills, 2008).

Life in the townships with names like Bishop Lavis, Steenberg, Hanover Park, Bonteheuwel, Manenberg, Elsies River, Nyanga, Gugulethu and many others, is hard. For the most parts, the townships are dreary places, bordering on qualifying for the description of ‘urban ghettos’. Houses are usually tiny and overcrowded, and in most townships, there are blocks upon blocks of flats, which are equally tiny and serve as a breeding ground for substance abuse and gang, or other unsavoury activities (Leggett, Louw & Parry, 2002; Standing, 2003). The high unemployment rate in the Cape Flats area leaves a huge number of teenagers and adults on the streets every day, many of whom turn to gangs for an income, so that they can feed their families. While there are some public recreation halls in the Cape Flats, the majority of them are riddled with gang members trying to recruit the youth into gangsterism and criminal activity. One can safely assume to say that where gangsterism and crime abides, drugs would also be freely available within these communities. This is confirmed by the findings of this study, as 73% of the participants reported that *all* or *many* of their friends used drugs.

5.18. Summary of Findings of Section B

Section (B) comprised the presentation and overview of the findings for the perceived reasons and risk factors of drug use among the young participants in this study. These findings included perceived reasons and risk factors in the individual/family/peer/school and neighbourhood domains of the young drug users’ lives. These findings will be interpreted and discussed in chapter six. The following section (C) will provide the findings of the in-depth interview with the Learner (Discipline) Support Officer (LSO) at a school situated in an ‘at-risk’ community on the Cape Flats, where a number of the participants resided.

SECTION C: Implications for the primary prevention

Another objective of this study was to explore the perceived reasons for drug use and the implications for the primary prevention thereof from the perspective of other stakeholders, namely, school officials in a ‘at risk’ school community. The focus of primary prevention strategies for drug use among youth will emanate from all the data that were collected,

including the perceptions of the school official, who was a long-term community worker that worked as a Learner (Discipline) Support Officer at a school situated in an ‘at-risk’ community plagued by substance abuse, gangsterism and crime.

The drug use prevalence in the community was confirmed by the school official (LSO) that was interviewed. The LSO reflected on the increasing occurrence of drug use among their learners, and the prevalence and availability of drugs and gangsterism in the neighbourhood. In addition, to gain further insights and a more comprehensive understanding of drug use among youth, the perspectives of the LSO was probed around the perceived reasons for drug use among youth, as well as the perceived strategies to prevent drug use among youth. In this section, a brief overview of the findings of the in-depth interview conducted with a school official on the perceived reasons and perceived drug prevention strategies for drug use among youth is presented. These findings will be discussed more fully in the next chapter, and will be integrated with the findings emanating from the other data sources, such as the in-depth interviews, life-history accounts of the young drug users, as well as the focus group discussion. After talking about the general prevalence of drugs in the community and among learners, the following main questions were discussed at length:

- What do you think are the main causes for drug use among the youth?
- How do you think this drug-use problem can be prevented or reduced among our youth?
- School drug policy/procedures: How are learners’ drug problems addressed at school; What are some of the difficulties experienced, when implementing the school drug policy and procedures?

The following themes and sub-themes emerged from the interview data that was grouped according to Bronfenbrenner’s micro-level systems in the family/school/peers and neighbourhood domains. For the most part, the findings of this interview were located in the family and neighbourhood/community levels of the microsystem. A brief overview of the findings of this data set will be presented below and these findings will be integrated in the discussion of the main findings in the following chapter.

5.19. Perceived reasons for drug use:

The following table (Table 10) displays a summary of the themes and sub-themes of the perceived reasons for drug use among young people at school and in the neighbouring

community, as provided by the LSO. The perceived reasons for drug use were located in the family and neighbourhood/community domains of the users as described by the LSO:

Table 10: Perceived reasons for drug use (LSO)

Domain	Themes	Sub-Themes
Family	<p>Family structure</p> <p>Poor family functioning</p> <p>Troubled parent-child relationships</p> <p>Parental/family substance abuse</p>	<p>Stressors of single parenting mothers</p> <p>Lack of adult supervision/monitoring</p> <p>Lack of father involvement</p> <p>Parental denial and enabling</p> <p>Neglectful parenting practices</p> <p>Ineffective parenting strategies</p> <p>Poor parent-child interactions</p> <p>Lack of warmth/nurturing</p>
Neighbourhood/community	<p>Lack of neighbourly bonds/connections</p> <p>Community norms and practices</p>	<ul style="list-style-type: none"> • Availability of drugs • Community protection of drug lords

The participant (LSO), mainly referred to issues in the learners' microsystem around the family and neighbourhood systems and sub-systems (see Table 10 above) as the reasons for drug use among young people in general and learners at the school. The following themes and subthemes emanated from the reasons that she cited for drug use among youth, which are substantiated with excerpts from the interview.

5.19.1. Family structure

Stressors of single parenting mothers

The participant referred to the prevalence of single parenting mothers in the community. She spoke about the challenges of single working mothers and the pressures of working and then having to attend to their homes and families upon returning home in the evenings, as expressed in this statement:

"...parents are sometimes to be blamed for how our children turn out to be or even going to this drug problem, we've got such a lot to do. We are parents, mothers that come out of work now we've got to jump doing our

housework. We've got to make food, that child is all the time unattended..."

Lack of supervision/is monitoring of whereabouts

The interviewee also expressed a concern around the fact that children are left unattended with no parental supervision, or monitoring of the activities that they are involved in, or who their friends are. The participant expressed these concerns about the lack of monitoring:

"We are forced that after all we have to do our jobs, we have to get home so that we can do the work that must be done, otherwise it will be a filthy home, and that is the time when the child is unattended. The government says...or the police says, look after your children and every fifteen minutes know where they are. But we are so busy with our homework, it comes over three hours and hopefully now we realize where is Sam or where is Janie or where...you understand? And the parents should also take note the child's friends.... The child operates with a group of friends that does things that he's doing. If the child loves baseball he's gonna operate with baseball kids, if a child loves football he's gonna operate with football kids, if a child is in drugs he's gonna operate with kids in drugs."

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5.19.2. Poor Family functioning

Lack of father involvement

The school official also spoke of the lack of father-involvement in the division of labour in the home, as well as the lack of involvement in the lives of their children's activities, as expressed in this excerpt:

"...it makes the child also feel wonderful if the father participates in whatever role there's got to be played. That's why I say it's such a lot also for a mother to handle nowadays because we mothers also want to do everything on our own, ourselves. We want to rear the children ourselves, we run to the meetings, we do everything, we have spoilt that fathers already. They are moulded already to be spoilt, they are not used to going to the meetings, so it's so new now...to remould them, it's very difficult"...Uhm, like I once said to my husband I said to him...you never had the time to play soccer with our children because you did wrong in life,

but God is giving you the chance now to play soccer with your grandchildren”.

Parental denial and enabling

The participant spoke about parents being in denial about their children’s wrongdoing and drug use. She stated that being in denial was not helpful, but rather damaging to the child, and was enabling the child in the behaviour, as expressed in this excerpt below:

“Some parents know that their child is doing wrong, but somtyds is hulle skaam dan gee hulle vir jou ‘n verkeerde word [but sometimes they are embarrassed then they give you a wrong word]. But you are damaging that child. You are encouraging the child...We know the dangers of the drugs but we are still giving our children big money. Look at the rich child. They also deeply in drugs because they’ve got too much money, you understand. Ag, we’re in denial....

Neglectful parenting practices

The participant expressed her concerns about parents, who sometimes neglected to spend time with their children and provide the guidance that young people need in their lives, as described in the following excerpt:

“That is bad ja because they don’t get that guidance man, and like I said it’s a norm to them...And our children today they need guidance in life. Because a lot of parents are too busy, we are forced to have jobs of our own. We are forced that after we have to do our jobs, we have to get home so that we can do the work that must be done, otherwise it will be a filthy home, and that is the time when the child is unattended...”

Ineffective parenting strategies

Another theme that emerged in the interview was about parents, who neglected to guide and discipline their children, and tended to use ineffective parenting strategies to cope with the stressful situations in the home. These parenting strategies were recalled as buying their children expensive name brand clothing and cell phones, as well as giving them too much spending money as expressed below:

“Because like the saying goes ‘easy come easy go’, they get things in gratification, they don’t’ know what it’s like to work and to earn it, like

everything we try to make a plan for them.... It is wrong, things must only be bought for our children when we can afford it....”

5.19.3. Troubled parent-child relationships

Poor parent-child interactions

The participant cited the following concerns around the parent-child relationship that may lead to drug use among youth.

“Yes, any parent has got love, but kids of today want to be shown. We’ve got parents at school that say ‘ek kan nie meer nie ek voel wil die kind uitsmyt [I cannot cope any longer, I feel like I want to put the child out of the home] It is because we are such busy mothers that we don’t realize that we are neglecting our own children and we are actually giving them to the drug addicts. We are giving them because they don’t find the love here in our house.”

Lack of parental nurturing

The LSO spoke about the lack of parental nurturing and care when she described an incident of a mother, who put her troubled 13-year-old child out of her home:

“And you’ll start seeing on a child’s dress. He starts becoming untidy, he’s moody, he’s aggressive, that lovely child’s attitude has changed, but don’t push that child away. It is difficult for us parents as I say again that was reared those years back... I had a parent in here the other day that threw a thirteen-year-old out of her house. And I said God no matter what that child did, how can you throw a thirteen-year-old child out. That thirteen-year-old child is just gonna take it so ‘ek is nou vry [I am now free], I can do whatever I want, I’ve got nobody to...then I also said the other mother that took that child in, she is wrong... ... But it is because it is the parent that is not reminding the children how much they love them and not remind them what would hurt them, and what they are proud of to that children. A naughty child, if he did something good for the day, tell him that he did something good even if you don’t have money, just ten cents sweets will make him feel good.”

5.19.4. Parental/family substance abuse

Another reason cited by the LSO for drug use among youth, is that parents are poor roles models, who themselves are involved in substance abuse, and may even send the child themselves to purchase the alcohol, and even end up drinking with their children. She explained:

“You get homes where the parents send the child to go buy the wine. And in the long run the child is sitting with the parent drinking. I’ve seen that already and I mean to me no age gives you the right to drink with your father.”

5.19.5. Neighbourhood reasons for drug use

Lack of neighbourly bonds/connections

The participant discussed the lack of neighbourly bonds and connections, where people no longer cared for each other’s children as this excerpt demonstrates:

“We must adapt the attitude that your child is my child and my child is your child. ...Neighbourliness.... you see that is something that somehow along the way got lost”.

5.19.6. Community norms and practices

Availability of drugs in the community

The participant expressed her knowledge of the availability of the drugs and drug lords in the neighbourhood that contributes to drug use among learners and young people, in general. She referred to the perceived callousness of the merchants/drug lords (people who sell drugs):

“You see why drugs is easily accessible to our children is that this merchants don’t care. I think if you should send your four-year-old baby to buy [drugs], they gonna serve that child...its very nice to take a nice packet [money] to the bank, they run to the bank while we run and sit with the problem. You understand, those parents have now got the problem.”

Community protection of drug lords

Another risk factor that was identified through the data analysis was the perceived lack of a collective effort from the community in the intolerance of drug dens (homes that sell drugs) and merchants (persons who sell the drugs) in the neighbourhood. This

theme is interrelated to the availability of drugs in the neighbourhood that emerged clearly in the analysis of the data collected from the young drug users. The participant stated that there was only one way to prevent drug use in the community – to get rid of the neighbourhood drug lords. She also mentioned that almost everyone (including die South African Police [SAPS]) knew where the drug lords (people who sell the drugs) resided, but nothing was being actioned. She recalled the following incident:

“I recall in the newspaper that a lady stopped selling drugs when she found out that her own child was using – she is now a community worker – but the damage is done – how can a mother sell drugs to another mother’s child? They run to the bank, whilst we sit with the problem [of our kids using drugs].”

From the above findings, it is apparent that the LSO believed that the family system and sub-systems held the greatest risk for substance abuse among youth. Additionally, risks in the neighbourhood, such as a lack of neighbourly bonds and connections, as well as community norms and practices, including the availability of drugs and favourable attitudes towards the drug lords, were considered perceived reasons for drug use among youth.

5.19.7. Perceived prevention of drug use among youth

The prevention of drug use among youth was also explored in the interview with the LSO. The table below (Table 11) provides a summary of the themes and sub-themes that emanated out of the perceived prevention strategies for drug use among youth. These themes and subthemes were located in the family/school and neighbourhood/community domains of the young drug users:

Table 11: Prevention of drug use: LSO

Domain	Themes	Sub-Themes
Family	Effective parenting styles Effective management of drug abuse Adolescent involvement in pro-social activities	<ul style="list-style-type: none"> • Communication, love and warmth • Seek out assistance/help
School	Encourage school/parent communication and involvement Dissemination of school drug policy and education	
Neighbourhood/community	Involvement of neighbourhood watches and community support in the eradication of drug lords Effective policing and sentencing of drug lords	

5.20. Summary of Section C

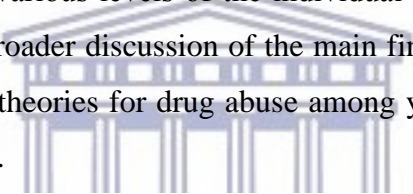
Section C comprised the findings of *reasons* for drug use among learners and youth from the perspective of a Learner (Discipline) Support Officer (LSO) situated at an at-risk school community. A table with the summary of perceived strategies on how drug use among youth can be prevented was also presented. These findings will be integrated with the other findings emanating from the data and will be discussed when considering the implications for primary prevention of drug use among youth. This is congruent with Tashakkori and Creswell (2007: p. 4), who assert that mixed methods research is a process of development and, therefore, should be broadly defined as “research in which the investigator collects and analyses data, integrates the findings, and draws inferences using both qualitative and quantitative approaches, or methods in a single study or a program of inquiry”.

5.21. Conclusion

This chapter provided the presentation of the findings. Section A provided the demographic and biological characteristics of the young drug user, as well as the perceived reasons for drug use, as conveyed on the questionnaire by the young drug user. Results of the perceived reasons for drug use were categorized into an individual/psychological domain, with themes/sub-themes in the family domain, and the interrelated peer/school/neighbourhood life domains. Section B provided the reasons and risk factors for drug use as identified from the in-depth interviews, the written life-history accounts of the adolescents and the focus group in

this study. Risk themes were identified and integrated into categories namely: Individual; Family; Peer; School; and Neighbourhood factors, as summarized in Table 8. Section C provided the themes and sub-themes of the in-depth interview conducted with a Learner Discipline Support Officer at the school, in terms of her experience of reasons for drug use among learners at the school. It also provided a summary of the perceived strategies to prevent drug use among youth, which could be considered for incorporation into the strategies for the implementation of primary prevention of drug use.

The following chapter will synthesize all the findings and provide the discussion of the main findings of this study. This includes the internal factors (individual domain/person factors), as well as the external factors (in the social domain) that contribute to the reasons and risk factors for drug use of the participants in this study. These interrelated findings are consistent with Bronfenbrenner's theory that views all aspects of human development as interconnected and requires consideration on various levels of the individual's ecology (environment). The following chapter provides a broader discussion of the main findings gained from this study, and the relevant literature and theories for drug abuse among youth will be integrated in the discussion of the main findings.



CHAPTER SIX

DISCUSSION OF MAIN FINDINGS

6.1. Introduction

The primary goal of this study was to explore the perceived reasons and to identify the contributing risk factors in the lives of young substance abusers. In this chapter, the researcher discusses the main findings of the study. A thematic discussion of the reasons and risk factors, identified through the analyses of the data that were collected, is provided. These findings are categorised as the internal factors for drug use (themed into an individual/psychological domain), and the external factors are located in the participants' immediate social domains (the family, peer, school, and neighbourhood systems of influence). These themes and sub-themes are based on Bronfenbrenner's (2005) most direct system of influence that surrounds the individual, which is entitled the *Microlevel system*. (See Table 10 for an explanation of all major systems in Bio-ecological Systems Theory, and Table 11 for a summary of the main findings of this study). The discussion of the relevant themes and significant findings are related back to the literature review and integrated with relevant theory. The participant's voices from the in-depth interviews, the written life histories and the focus group discussion will be used to illuminate the main findings.

The themes and sub-themes of this study are organised according to Bronfenbrenner's (2005) Bio-ecological systems theory. Bronfenbrenner's (1992; 2005) process-person-context model, allows for the inclusion of the individual, or person-factors, as well as the interactions among multiple domains of influence, such as the social domains (the family, peer, school and community/culture systems) operating in the lives of the individual. The particular focus of this study was to explore the innermost, or microsystem of the young drug user, but the contextual factors, such as the societal/cultural environment, in which the individual lives and operates, are discussed, as it cannot be ignored. Bronfenbrenner's Bio-ecological theory is applied and discussed in relation to the findings, and gaps in the theory are highlighted. The overview of findings of the perceived prevention of drug abuse is discussed, and is integrated with the overall findings that emanated from the data. These findings, therefore, inform the recommendations for the primary prevention of drug use among youth.

Table 12 below provides an overview of the main systems nested within Bronfenbrenner's Bio-ecological Systems theory that formed the theoretical framework of this study.

Table 12: Bronfenbrenner's Bio-ecological systems theory

Ecological level	Description	Examples	Issues affecting child development/well-being
Microsystem	Social settings where people directly engage in face-to-face interactions	Relations/interactions in the Family/Home, School, Peer, and Neighbourhood	Quality of interactions Responsiveness of adults Quality of relationships
Mesosystem	The relations between two or more microsystem settings in which the child is active	Relations and communication <i>between</i> family and school settings etc.	Respect for each other Support for each other Collaborative decision-making
Exosystem	One or more settings that do not involve the child but have an indirect effect on the child	Parents' workplace Services available in the community	Flexibility in work hours Family-friendly policies Availability of support for parents
Macrosystem	Blueprints for society's broader systems i.e. values, customs, laws, beliefs, resources	Ideology Religion Culture Social policy etc.	Individualist or collectivist orientation Democratic or autocratic How society defines parenting
Chronosystem	Time-related - Reflects dynamic environmental (ecological) transitions, entries, milestones, or turning points in an individual's life.	Disruptive effects of parents' divorce or critical events may coincide with entries into the adolescent life-stage and may impact negatively on a young person's development	The timing of this transitions or socio-historical conditions may affect children's development.

6.2. Perceived Reasons and Risk factors for drug use

The reasons for young people using or experimenting with illicit substances vary greatly. It is highly unlikely that research will ever be able to explain fully why some young people engage in substance abuse behaviours, and others do not. However, one important set of reasons is closely tied to adolescent development itself. Generally, the adolescent period is characterized by multiple transitional changes, and an increase in risk-taking behaviours (Michael & Ben-Zur, 2007, cited in Leather, 2009). Adolescents are also faced with the complex and emotionally charged task of developing a personal identity - a sense of who they are, and where they fit into their world. During this time, they are highly prone to peer-pressure and will often disregard parental guidance. Sometimes they may not have anyone with whom to discuss their concerns. Their larger social and environmental context, namely, their family/school/peer/neighbourhood is also important factors in their development during

this time. Table 13 below provides a summary of the main findings of this study that was organized according to the inter-related systems of Bronfenbrenner.

Table 13: Themes/Subthemes of perceived reasons and risk factors for drug use

Domain	Themes	Sub-Themes
Individual	A positive attitude towards drugs Social skills deficit Lack of self-esteem Poor coping mechanism skills Early age of onset	
Family	Family structure/single parent families Absent Fatherhood Troubled parent-child relationships Dysfunctional family functioning/poor parenting styles and practices Parental/family substance abuse Stressful, abusive family contexts	<ul style="list-style-type: none"> • Stressors of single parenting on mothers. • Lack of monitoring/ supervision • Lack of positive father-figure role models • Poor parent-child communication patterns. • Lack of trust in parents • Harsh and punitive parenting styles and practices. • Neglect and physical abuse in the family
Peer	Peer pressure/peer use	
School	Failure/ School drop-out Lack of communication and positive interaction between school and parents	<ul style="list-style-type: none"> • Lack of trust in adults at school
Neighbourhood	Availability of drugs Community norms and practices	<ul style="list-style-type: none"> • Favourable attitudes towards druglords. • Lack of neighbourly bonds/connections
Societal/macrolevel	Poverty/Cultural Laws and Policies	

Adolescent risk and risk-taking behaviours have been described in various ways. According to Moore and Gullone (1996, as cited in Leather, 2009: p. 287), risk-taking behaviour “involves moderate to high short-term gain, followed by the potential for greater long-term loss”. Irwin and Ryan (1989, as cited in Leather, 2009: p. 287) defined adolescent risk-taking as “young people with limited experience engaging in potentially destructive behaviours with or without understanding the consequences of their actions”. Adolescence is a time of great exploration, and during this time, adolescents have increased vulnerability to engage in risk-taking behaviours, including drug use. According to Plant and Plant (1992), risk is perceived by some to be synonymous with excitement and sensation seeking. While certain risk factors may predict drug use among adolescents, these factors cannot necessarily be assumed as causal. Most researchers agree that no single risk factor predisposes an individual to substance abuse, but rather an interplay of multiple risk factors, which interacts on the individual and his/her environment, that contribute to drug-using decision-making.

Additionally, according to Jessor’s (1992) Problem-behaviour Theory, involvement with psychoactive substances during this period is usually associated with a “cluster” of other risk behaviours. For example, an adolescent, who smokes marijuana, is more likely to be sexually active. Young people, therefore, are not only vulnerable to the consequences of psychoactive substance use, but also to unprotected sex, unplanned pregnancies, school dropout, criminal activities, and other delinquent behaviours. Much research has been done to try to understand why young people, not only become involved in drug use, but continue to use despite these adverse consequences on their lives. In this study, the reasons cited for drug use as risk factors identified in the lives of the participants, included factors in their individual/psychological domain, as well as in their social life domains, which include interactions within the family, peer/school/neighbourhood systems. These interacting areas of risk are grouped under two main headings, namely, internal factors (or person factors) and external (or social domain factors) for drug use.

6.3. Internal factors (or person factors) for drug use

Bio-ecological Systems Theory describes the complex interplay between the individual at the centre of their environments and social contexts in which they develop. Researchers have sought to uncover the genetic predispositions and biological factors associated with drug use among youth. According to Kumpfer *et al.* (1998: p. 45), genetically inherited individual risk

factors include neurological deficits in prefrontal cognitive functioning and verbal abilities, difficult temperament, hyperactivity, autonomic hyperactivity, depression, anxiety, low threshold for pain, thrill-seeking, and different reactions to alcohol and other drugs making the drugs more pleasurable and easily abused.

It was beyond the scope of this study to account for the genetic risk factors present in the lives of the adolescents in this study, but some individual and psychological factors were uncovered, as described by the participants. The participants cited person-factors as reasons for their drug use, which included a positive attitude towards drugs, a deficit in social skills, a lack of self-esteem and poor or maladaptive coping mechanism skills. These themes are discussed below:

6.3.1. Positive attitude towards drugs

Consistent with the literature (Brook, Brook, Morojele & Pahl, 2006), permissive attitudes towards drug use are associated with higher levels of drug use. These attitudes were expressed by participants in the following statements:

“I felt there was nothing wrong with using dagga”,

Another participant stated that:

“It feels nice” and “I see my friends are happy when they use”.

This finding is consistent with results of previous studies on adolescent substance abuse. A study conducted by Lo and Globetti (2000) on high school youth, aged between 15 and 18 years, on their beliefs about moderate drinking, revealed that young people believed alcohol to lower inhibitions and cause relaxation. The young women in the study believed that alcohol increased confidence by removing inhibitions, and provided an escape from problems.

An article by Greydanus and Patel (2005) revealed that young people abuse substances to show that they are mature. The presence of tolerable attitudes towards substance use, suggests that they are more likely to continue abusing drugs. They also could be abusing these substances in rebellion against authority, like parents and teachers.

6.3.2. Deficit in social skills

Typically, adolescents, who are at risk of drug use, and/or abuse, are those who are depressed, have a low self-esteem, lack appropriate social skills, and feel like they do not fit in with their peers or society, at large (Chesang, 2013). The participants in this study expressed poor, or maladaptive, social skills in the following statements:

“I can speak easier now”;

“I am more confident now”;

“To be accepted”,

“Made me feel good. Can dance and everybody loved me”;

“To feel nice. To party with my friends. It makes me laugh”.

These findings concur with the revelations of previous research that the increased risk of drug use has been associated with poor social coping skills, inappropriately shy, or aggressive classroom behaviour, affiliation with deviant peers, perception of approval for drug use, and general anti-social behaviour (Kumpfer & Tala, 2009).

6.3.3. Lack of self-esteem

Self-esteem refers to an individual's overall view of himself/herself. Self-esteem is also referred to as self-worth or self-image. For example, a child with high self-esteem might perceive that s/he is not only a person, but also a good person. Interest in self-esteem arose from the work of psychotherapist, Carl Rogers (1961, cited in Louw, Louw & Ferns, 2007). Rogers asserts that the main reason individuals have low self-esteem is because they had not been given adequate emotional support and social approval. He especially alleges that, when children grow up with harsh reprimands and little praise, it leads to a lowering of self-esteem, or self-worth. For many young people, periods of low self-esteem come and go. However, for some, persistent low self-esteem translates into other, more serious problems. Persistent low self-esteem is linked with low achievement, depression, eating disorders and delinquency, including substance abuse (Trzesniewski, Moffitt, Poulton, Donnellan, Robins & Caspi, 2006). The

seriousness of the problem depends, not only on the nature of the adolescent's low self-esteem, but also on other conditions, as well. When low self-esteem is compounded by difficult school transitions (such as the transition to middle school), or family problems (such as divorce), the young person's problems can intensify.

Researchers have found that self-esteem changes as children develop. In one study, both boys and girls had high self-esteem in childhood, but their self-esteem dropped considerably in early adolescence (Erol & Orth, 2011). To boost their self-esteem, young people may turn to substance abuse to feel better about themselves, or they may start using to please their friends and gain acceptance from their peer group. In response to the reasons why they started using drugs, some participants stated:

"To be accepted";

"I wanted a sense of belonging";

"Not good self-esteem... It feels nice"

6.3.4. Poor/Maladaptive coping mechanism skills

Many participants seemed to have used drugs as poor or maladaptive coping techniques/mechanisms, as illustrated by the following excerpt. In this case, the youth cited the reason for his drug use as:

"For a sense of belonging. To cope and suppress my hurt".

He further stated:

"...My father was not much of a father to me- we didn't do normal father-son things. He also always embarrassed me. He used to beat up my mom and my sisters. Even the hidings I got I could feel that extra power he put in. I felt helpless. I could not save my mother from this suffering...I was around twelve where I saw people and friends smoking dagga and drinking alcohol. I joined in and found a sense of belonging as being a drug addict. I went on to using ecstasy and rocks..."

This attitude of despondence and frustration was also identified as one of the reasons given by the respondents in this study. One female participant cited that she took drugs

because she “...*was stressed out due to school failure*” and that friends, as well as her boyfriend told her that taking drugs would make her feel calm and less concerned about the consequences of her failure. These findings are confirmed by the literature that supports the idea that negative emotional states frequently trigger poor coping mechanisms, such as self-medicating with substances (Alberta Alcohol and Drug Abuse Commission [AADAC], 2003). These findings are confirmed by Madu and Matla (2003), who conducted a study among high school adolescent students in South Africa, mean age 17.25 years. They found that the young men stated anger, stress, and fatigue as reasons for illicit drug abuse (marijuana, glue, cocaine, and benzene) and alcohol. They also found that these young men abused these substances, when they were bored and in a party mood, implying that they enjoyed the effects of these substances. The young women, in turn, abused these substances, when they were angry, stressed, tired, and bored.

6.3.5. Age of onset as a person risk factor for drug use

The age of the onset of use was considered an additional individual risk factor for drug use. The majority of the participants started using drugs between the ages of 12-16 years, and one was as young as ten years old. Factors that influence the effects of substance usage include the following: age, gender, physical condition and state of mental health; expectations about the substance; the effect of the substance; and the person's past experiences with the substance. For some young people, experimental and recreational use does not represent a long-term problem, for the individual, their family, or the community. More sustained use, however, and, in some cases, relatively limited exposure to particular substances, can lead to problems. Studies show that early initiation of drug use was found to be a risk factor not only for future substance-use disorders, but also for other negative outcomes, such as low academic achievement (Mrug, Gaines, Su & Windle, 2010).

According to Odgers *et al.* (2008, cited in Mrug, Gaines, Su & Windle, 2010), when adolescents start using alcohol and other drugs (AOD) before the age of 15, it more than doubles the risk for substance addiction and a range of other dysfunctions, including criminal convictions, sexually transmitted diseases, and teenage pregnancies. Overall, strong relationships have been found between early initiation and later

problematic misuse of alcohol and other drugs (National Institute for Drug Abuse [NIDA] 2003; 2005)

In addition, adolescents who initiate the use of a particular substance at an early age tend to confront the following: parents, who caution less often about use; mothers, who use the substance frequently; and fathers, with a positive attitude towards the substance (Cavanagh & Huston, 2006; Hawkins, Catalano & Miller, 1992). Despite the research evidence, parents do not have a strong sense of the importance of parental influence and modelling of behaviour on the subsequent behaviour of their children. It would seem to be of primary importance to educate parents about their own behaviour in influencing young people's use of drugs (Hawkins, Catalano & Miller, 1992).

6.3.6. Drug types used

Twenty-eight (68%) participants started with tobacco, before starting to use stronger illicit drugs. The most popular drugs of choice for the participants of this study were cannabis (or “dagga”), methamphetamine (tik) and mandrax (methaqualone). A number of the respondents reported drinking alcohol, in addition to other illegal substances. Alcohol remains the dominant substance of abuse in South Africa, and according to the World Health Organization (WHO) (2011), South Africa has one of the highest rates of substance abuse in the world.

A recent finding by the Medical Research Council (Dada *et al.*, 2016), revealed that across the six sites that they monitor in South Africa, cannabis was still the most common *illicit* drug of abuse, especially among youth. Further analyses of the data for 3524 patients, who were treated across 33 specialist treatment centres in the Western Cape for the period January – June 2015, methamphetamine (commonly known as tik) was the second substance of choice among patients 20 years and younger. In the Western Cape (WC), 76% of patients were males, and the majority of them were Coloured (70%), followed by 16% of Black African patients (Dada *et al.*, 2016). Furthermore, across the provinces poly-substance abuse remained high, with 51% of the WC patients reporting to use more than one substance of abuse.

In this study, the majority (68%) of the participants started with tobacco, before starting to use stronger drugs, such as cannabis and methamphetamine. The above finding of this study seem to be consistent with the Kandel's “Gateway Hypothesis” that was

developed in the 1970's (Rosner, 2013: p. 135), which posits that an adolescent's early experimentation with alcohol, or tobacco, or cannabis, escalates to more addictive illicit drugs later in adulthood. Kandel's hypothesis also refers to "gateway drugs", which suggests that "softer" proactive substances, such as alcohol, tobacco and cannabis, open the pathways, or become the "stepping stones" for the use of more "harder" substances (Rosner, 2013: p. 135). Kandel asserts "there is a progressive and hierarchical sequence of stages of drug use that begins with tobacco or alcohol, two classes of drugs that are legal, and proceeds to marijuana, and from marijuana to other illicit drugs, such as cocaine, metamphetamines [sic], and heroin" (Kandel, 2002, as cited in Vanyukov *et al.*, 2012: pp. 54-55). Overall, the sequence of the stages of the gateway theory has not always been found to be the case that licit drug use leads to illicit use/abuse, as many young people, who experiment with drug use (licit or illicit), do not go on to abuse drugs in the long-term. Albeit, it would be safer to discourage young people to initiate the use of proactive substances (whether licit or illicit), as the risk of transitioning from the experimental stage to substance-dependence, remain high.

6.4. External factors (or social factors) for drug uses

The participants cited external factors from their social life domains as reasons for their drug use, which included interactions within the family, peer, school and neighbourhood systems. These themes are discussed below:

6.4.1. Family factors

6.4.1.1. Family structure

Although family circumstances are unique to each family, some family characteristics were common to the group, as a whole, for example, single female-headed households. Many still define family as two or more people living together related by blood, marriage or adoption, but society is starting to acknowledge that an increase number of families do not fit this definition. Amoateng, Richter, Makiwane and Rama (2004) found that South Africa is characterised by both the nuclear and extended family systems, with the White families living predominantly in a nuclear family system, while the Asian, African and Coloured households, predominantly adopted an extended family system. According to Amoateng *et al.* (2004), the Coloured and African families

maintained the extended family system for various reasons, such as culture preferences, housing shortages and poverty. He believed that there is a popular perception that modernity and other societal influences have contributed to a decline in two-parent, or nuclear families, as well as a significant increase in the number of single-parent families, childless families, alternate families and non-marital cohabitation.

In the quantitative phase, most of the respondents were males ($n = 37$), with more than half of them ($n = 20$) living in female-headed single-parent families, without the presence of a positive father figure in their lives, as portrayed by the following written life history:

Life-history events - 17year old male (LH 7)

The reason why I took drugs is because I had a lot of stress. I was staying with my mother in Pretoria for only a year. When she picked me up in Cape Town she also brought a man with her. He's my mother's boyfriend.

One day in Pretoria my mother's boyfriend was drunk. He smacked my mother around. What could I do as a child? We were fighting with each other. My mother was going to lay a case against him, but she didn't. I was so angry with my mother. How could she take his side?

I made a decision to stay with my aunty for two weeks. I had a friend who stayed in the same area and I would always go to his house and sleep over every weekend at his house. His father works with my mother and we understood each other.

I finished Grade 9 there and did not want to stay in Pretoria anymore. I came back to stay with my father. Four months later my mother resigned and came back to Cape Town with her boyfriend. I have two other brothers. We did not like my mother's boyfriend at all. We used to have fights every weekend with him. Then I realized why must I waste my time on him. It is not worth it. My mother is old enough to know what is right and wrong in life. My brothers and I can't make decisions for my mother.

My mother chased us away from her home in April 2006. I stayed with my father and my brothers [stayed] with their father. We still see each other today.

Studies revealed that children are at risk for poor outcomes, when they are exposed to a high-risk environment in their immediate family, characterised by family crisis and conflicts, such as having substance-misusing parents, incarcerated parents, or parents undergoing divorce (Frederick, 2010). There also appears to be some risk when children experience parental remarriage. While

some studies indicate protective effects, others show remarriage to be a risk factor, when comparing stepfamilies to intact families. Pagani, Boulerice, Tremblay and Vitaro (1997) conducted a longitudinal study in Quebec that followed children from six through twelve years of age. They found that divorce and remarriage are associated with higher levels of anxiety, aggression, hyperactivity, disobedience and deviant behaviour. Children, who experienced parental divorce before the age of nine years, were more anxious at age twelve years, than children from intact families. Children, whose parents divorced before the age of eight years, were more aggressive, and those whose parents divorced before the age of six years, were more disobedient and defiant.

Several factors can hinder positive family outcomes for single parents. First, is being economically disadvantaged. A reasonable income from employment is critical to building family well-being, through meeting the family's basic needs, achieving a reasonable standard of living, and supporting the aspirations of individual family members. This is also necessary to increase the chance of achieving successful outcomes, both short term, and across generations (Stevens & Schaller, 2009). Another issue is time constraints. One of the most prevalent challenges reported is the ability to balance family time and income, without compromising the standard of living. Work-life balance seems even more challenging for low-income and, especially, for single-parent families.

In addition, single-parenting often goes hand in hand with poverty and producers stressors that compromises the available time and energy single parents have left to dedicate to some elements of parenting, such as spending quality time with their children (McLanahan 1991, cited in Lezin *et al.*, 2004). According to Lezin *et al.* (2004), although single parenthood consistently surfaces as a possible risk factor for compromised parenting practices, it does not always function that way. It is largely dependent upon the parenting style and practices operating within the family system. One of the key researchers in parenting styles, Dianna Baumrind found that if the single parent applied an authoritative parenting style, children from such families do not differ from their counterparts in two-parent authoritative parenting families (Baumrind, 1991). Roman (2008) concurs that the behavioural outcomes of children are directly linked with the manner in which

they were raised by their parents, or caregiver. Authoritative parenting style, therefore, can be viewed as a protective factor for child outcomes.

6.4.1.2. Absent fathers and the lack of a positive father figure

Recently, there has been a growing interest and demand for information relating to the topic of fatherhood and father involvement in childcare and nurturing. A larger focus has been placed on how the role of men have been affected within the family, in terms of diverse demographic, socio-economic, cultural transformation, as well as how this has influenced the well-being of families (SA, DSD, 2013d). According to Richter and Morrel (2006), fatherhood is generally defined as the social role that men fulfil; however, more significantly, it refers to the physical and emotional presence in the child's life. Additionally, fathers are recognised as contributors to the social, emotional, and cognitive development of their children (SA DSD, 2013d).

South Africa has good legislation that promotes the role of fathers in families. An example is the Children's Act (38 of 2005) that makes provision for fathers, who are involved in their children's lives, to gain full parental rights and responsibilities, and significantly, the default in divorce decree is now shared custody for both parents (SA, Children's Act, 2005). However, not all men accept the role and responsibility of fatherhood, and seem to have many reasons, such as denial, abandonment, and un-involvement, to avoid being a father, or be absent from their children's lives (Richter & Morrell, 2006).

According to the Fatherhood Strategy (SA, DSD, 2013), a study conducted between 1996 and 2010 in South Africa, revealed that the number of fathers, who are alive, but absent, increased from 41,6% to 47,4%. In contrast, the percentage of fathers, who are present, decreased from 49.2% to 36, 5% during the same period. In terms of racial dimensions, African children have the lowest numbers (31,3%) of present fathers, Indian children had the highest (83.0%), with White children following closely with a percentage of 80.8%, while Coloured children are in the middle with a percentage of 54,2 % (Holborn & Eddy, 2011).

The reality is that one-in-two children grow up with an absent father in South Africa (Statistics South Africa, 2011). This is consistent with the findings of this current study. More than half of the 37 male participants reported growing up with their mothers only, and sixteen of them reported having absent, non-resident, or uninvolved father figures in their lives. The participants placed a strong emphasis on the fact that their fathers were absent from, and did not play a supportive role, in their lives. Many had not had contact with their biological fathers for many years, and others reported exposure to abuse and domestic violence by their fathers and stepfathers. The following life-history account highlights some of their concerns:

Life-history events 17-year-old male (LH 4)

When I was 2 yrs old my father went to jail. So me and my mom had to struggle alone. We moved from place to place [and] I had to go to 5 schools in one year. I was the only child in the house. My mom spoilt me a lot and I had everything. My aunts also spoilt me because they had no children at that time.

My mom was pregnant with my sister. When she [my sister] came my life was different. I was not spoilt anymore and I started to steal money. At that time I was only 5 years old. At the age of 10 yrs I had a stepfather. He was good to me for only one year after that my mom got pregnant with his child. Then the bad things started. He always chases me away from my mom. If I feel like sitting by her and talking to her, he tells me to get out of the room and that I got my own room. If I ask money from my mom, he tells her not to give me and he always hit me for petty things. Like if I break a glass he hits me- and not soft. He hits me with a thick belt. He did not work so he was everyday on my case. Not just me, on my older sister as well.

When I was 12 years old my mom got a house for us and my step dad still did not work. He used drugs as my mom started to build herself up to better promotions. He steals everything and just breaks down and down [in the house]. He also fights a lot in the house when he's drunk and when he craves for buttons [mandrake drugs].

When I was 14 he cooled down and my life went a little smooth but not too smooth. I was 15 when I went to High School and I had bad friends. I started with tik and it took my fear away for him and I started to stand chest to chest with him. And he did not work on my nerves any more and he tells my mom to sort me out.

My real father came in 1999. He only visited me and my sister once and I saw him never again. He comes and he goes and that's like year after year it's almost like I never see him at all. BUT NOW I'M SAVED

Consistent with the literature (Resnick *et al.*, 1997; Richter & Morrell, 2006), data of the life contexts and experiences of the participants' lives, revealed an absent or troubled relationship, as well as interactions with the father/father-figures in their lives. Bronfenbrenner (2005) defines person-environment interrelations in terms of micro-, meso-, exo-, and macrosystems. The first three systems are relevant to the current investigation because they define social contexts. Microsystems are the principal and immediate socialisation contexts, in which human development takes place; it is the family, peer, and school contexts for adolescents. An exosystem comprises of more remote social environments, such as the parents' workplace environments, in which microsystems are embedded. The concept of mesosystems is that processes operating in different contexts are in need of each other. According to Bronfenbrenner (2005), a mesosystem is formed from the interrelations among microsystems, for example, processes in the family may impinge on relationships in the peer group (Bogenschneider, Small & Riley, 1994), which will be further discussed below.

6.4.1.3. Troubled parent-child relationships

The family unit plays a critical role in providing the most amiable atmosphere for adolescents to form their life-style, to achieve their aspirations, values, goals and basic patterns of behaviour. Whether an adolescent develops into a well-adjusted sociable person, or a maladjusted individual, depends primarily on the family, as it is the basic system, in which an adolescent is raised. Many of the lives of the youth were characterised by troubled parent-child relationships. One participant, who lives with his mom and step dad, and first met his father when he was 11 years old, noted:

"I don't like it, growing up at home ...Because my father didn't care about me..."

Another youth reported his reason for use as:

“Because of my friends and my stepfather. I was scared of him when I did not use...To be able to face my stepfather”.

The basic dyadic relationship between parents and adolescents’ builds bonds and attachment, which, in turn, grows stronger throughout the person’s life. One factor that is of particular relevance is the parent-adolescent relationship. In the existing literature, the term parent-adolescent relationship is described using different family relationship variables, and as a result, various types of specific constructs, or variables, were used in these studies. For example, it has been studied in terms of parenting styles (Baumrind, 1991), emotional closeness or attachment (Bowlby, 1980), the degree of conflict (Berk, 2010) parental warmth (Rohner, 2004), psychological control (Barber, 1996), communication (Sarah, 2006) and involvement (Spath, Clair, Shin & Redmond, 2006).

For instance, Steinberg and Morris (2001) indicated that the overall quality of parent-adolescent relationships, and the changes that occur in parent-adolescent relationships, during adolescence, have implications for the adolescents’ overall adjustment and development. Adolescents’ parents provide a context where learning and socialisation take place, and apart from other variables, the quality and characteristics of the parent-adolescent relationship have important consequences for adolescent adjustment. In addition, a good parent-adolescent relationship, with opportunities for learning and exploration, as well as one that provides warmth and emotional support, will foster healthy growth and development in children (Berk, 2010). However, the challenge during adolescence is that warm, responsive, and involved relationships must be maintained at a time when the asymmetries in power that characterised earlier parent-child relationships are shifting to more equality (Steinberg, 2002). These changes may result in more confrontations between parents and adolescents, which create adjustment problems among adolescents (Steinberg, 2002). The shift to more equality is motivated by the adolescent’s development of social and cognitive skills, as well as broader contacts with the environment, outside the family.

The close family relationship exerts a great influence over the adolescents' adjustment throughout their life. The quality of the parent-adolescent relationship is, therefore, a key factor for the wholesome development of the adolescent. In the cases of the participants in this current study, there was a clear deficit in the quality of the parent-child relationship. The research clearly reveals that a positive and conducive relationship between parents and adolescents allows them the freedom to grow, explore, gain experience and adjust to the developmental challenges they encounter, and acts as a protective factor for substance use.

6.4.1.4. Poor parent-child communication and interactions

Others described difficulties with establishing open lines of communication, or healthy interpersonal relationships with their parents. One participant cited his reason for use as:

"I have lots of problems, no-one to talk my problems out with".

An example thereof is a 17-year-old young man, who lives with his single-parent mother, and only discovered who his father was, when he was 12 years old. He discovered this at school from a half-sibling, who lived with his father in the same neighbourhood. He said that he never dared to ask his mother about his father, as she did not communicate openly with him. He hated the fact that she either would shout at him, or refuse to speak to him, after a disagreement. He found it very frustrating and wished it could be different, as he would have loved to discuss important issues with her, openly and freely. He also mentioned that, in turn, he has learnt to keep his feelings and problems to himself, as he "...can't trust anyone".

Communication is generally regarded as a central important feature in the parent-child relationship, and any other significant relationship. It is particularly significant, when children reach adolescence and begin to establish a clearer sense of their own identity and ability to make decisions for themselves. According to Werner and Silbereisen (2003), when parent-adolescent communication is good, the family is closer, more loving and more flexible in solving family problems. To support this view, Kumpfer, Alvarado and Whiteside

(2003) assert that communication helps the adolescent to clarify his/her position in the family; s/he learns to be sensitive to the ideas and feelings of others. Parent-child communication is, as a result, a potentially modifiable protective factor of adolescent substance use (Velleman, Templeton & Copello, 2005). Moreover, research also shows a positive relationship between parent-adolescent communication and adolescent self-esteem (Walsh, 2006).

6.4.1.5. Parental/family substance abuse

Forty (98%) of the participants had a parent, or family member, who used alcohol, or other drugs (AOD), which often resulted in abusive and conflict-ridden home-lives. Bio-ecological Theory posits that young people are actors in, and acted on by, their environment in the forms of different systems that frame the developmental period of adolescence (Bronfenbrenner, 1994). Similarly, the family is considered as one of the micro-system influences, as one of the systems in which adolescents grow. In addition, Bandura's (1986) Social Learning Theory emphasises the importance of attending to and modelling the behaviours, cognitions and emotions of others. This theory also sees an interactive process between cognitive, behavioural, and environmental influences (Mann, 2003).

There are three principles that help define Social Learning Theory. Firstly, observational learning is achieved when the modelled behaviour is structured, or organised, practiced symbolically, and explicitly acted out. Secondly, the adoption of the modelled behaviour is strengthened, when the outcomes of that behaviour are seen as important to the individual, or lead to a desirable and expected outcome. Thirdly, the modelled behaviour is more likely to be integrated by the observer, when the model has characteristics similar to the observer, there is a cognitive-behavioural connection with the model, the model is admired by the observer, and the behaviour that is adopted has practical or functional value (Ward & Gryczynski, 2009).

Social Learning Theory recognises the importance of observing and modelling the behaviours, emotional reactions, and attitudes of others. It is based on the idea that it is not prudent to rely on the self for information about the world and how

to behave in it (Bandura, 1986). Applied to the present study, Social Learning Theory suggests that adolescents interpret the messages that their parents convey or display via their parenting behaviours, which could alter the adolescents' cognitions and behaviours, in a positive or negative way. For example, when a parent displays low, or no, caring (warmth) for the adolescent, the adolescent may feel uncared for, or rejected, and may show signs of sadness or depression. Additionally, if parents, or significant others (peers or family members), use mood-altering substances for a variety of reasons, including as a coping mechanism, adolescents are likely to repeat those behaviours.

6.4.1.6. Stressful, conflict-ridden, and abusive family situations

The following interview excerpt illustrates the extent to which a young person can be exposed to stressful events in their home lives. A 16-year-old interviewee gave an account of physical abuse at the hands of his biological father. When he was eleven years old, he ended up stabbing his father and has since had to leave the family home to live with his grandmother. He then started using drugs at the age of twelve, got involved in gangsterism, and has been arrested for criminal behaviours. He explained:

“...my father used to beat me up. But he was hard...he didn't take a belt, he would take a hammer and hit me in the head, not belts, plank, and chairs- broken, everything, he also tied me up and hit me. So I didn't like it, he hit me, every time he hit me. My mother tried to stop him, but my mother also couldn't stop him because he was very aggressive. He also hit my mother if she talks too much.... Ja, and I couldn't take it you see. So one day I took a knife and I stabbed him and so he went to hospital. So my mother said I should go stay with my granny”.

A 16-year-old boy also spoke about his unpleasant childhood with an alcoholic father and a conflict-ridden home-life:

“Well, all my sisters and I believe we are all affected by what happened. My eldest sister of three [girls] used to torture me and I could not play with my friends. I was locked up and treated like an

animal. The second eldest was constantly using anti-depressants to help her cope. The third eldest became suicidal, she tried overdosing on painkillers and used to cut herself...”

Many other (n = 11) participants reported familial discord, and stressful home conditions that included violence and physical abuse by fathers/step-fathers. The following written life history highlights the traumatic life experiences of a youth living in a physically and mentally abusive, substance abusing and conflict-ridden household. In this Life-history account, a 17-year-old male describes the turbulent home conditions and his life of physical abuse by both his father and his older sister.

Life History 17-year-old male (LH 5)

From before being born whilst still being in my mom's stomach, my father was abusing her. In this I could have possibly had died. When I was born I was suffocated by veins I ate on [sic]. Me or my mom could have died, luckily we both survived.

My father was not much of a father to me- we didn't do normal father-son things. He also always embarrassed me. He used to beat up my mom and my sisters. Even the hidings I got I could feel that extra power he put in. I felt helpless. I could not save my mother from this suffering.

Well all my sisters and I believe we are all affected by what happened. My eldest sister of three [girls] used to torture me and I could not play with my friends. I was locked up and treated like an animal. The second eldest was constantly using anti-depressants to help her cope. The third eldest became suicidal, she tried overdosing on painkillers and used to cut herself.

I was around twelve where I saw people and friends smoking dagga and drinking alcohol. I joined in and found a sense of belonging as being a drug addict. I went on to using ecstasy and rocks. Later tik was my drug of choice. I was addicted to tik for almost three years. And God saved me from this life, during my drug using stages I was attending church and I was baptised Catholic when I was a baby. I prayed and went to church a lot, I could feel God's presence inside me, He opened up my eyes and saved me.

Among the various sources of risk and protective factors, family-based influence has been established as one of the strongest precursors of adolescent substance use initiation (Brook, Brook, Morojele & Pahl, 2006). Regarding the influence of family conflict, Scheer and Unger (1998, cited in Vakalahi, 2002) conducted a

study among Russian adolescents, and found that family conflict was positively related to the risk for adolescent substance use. Likewise, Brook, Brook, De La Rosa, Whiteman, Johnson & Montoya, 2001, identified family conflict as a significant factor affecting adolescent substance use. Consistent with the outcome of this current study, other researchers have also found that family conflict is predictive of adolescent substance use. That is, adolescents use substances as a coping mechanism for family conflict, disorganisation, and parental rejection (Barnes & Farrell, 1992, cited in Vakalahi, 2002).

6.4.2. Peer-related risk factors for use

It is noteworthy that 36 (88%) respondents reported that they had first been introduced to drug use by their friends and 73% of the participants reported that all, or many, of their friends used drugs. It is common knowledge that individuals tend to seek out, and are selected by peers, who have similar goals, values and behaviours. Peer pressure could be referred to as urging by peers, regarded by individuals as their equal, to perform acts that the individuals might not chose to do by themselves (World Health Organisation [WHO], 2004). Additionally, the WHO (2004) reports that individuals are affected by the behaviours of their peers. If most of their friends are drinking alcohol, or using other substances, then they will often be coerced to join in the use of substances, as well.

It should be noted that, although 41 of the participants cited peer-related reasons for drug use, careful analysis of the interview data revealed that many of their life-situations were characterised by stressful life conditions, as the following example illustrates. The above-mentioned 16-year-old who endured extreme physical abuse by his biological father cited his reason for use as, *“it was peer pressure, my friends smoke so I just smoke”*. In his interview, he elaborated on his home-life:

“...My friends was taking dagga and they were laughing and so and having fun so I just told myself to try so I just ...and then I smoked buttons...I just wanted to try it to have fun but got used to it then there was nothing I could do I got addicted to it the whole time, just smoke the whole time...Maybe if my father wasn't so aggressive I would have not take

drugs....[I wish] that my mother is not so scared of my father. Because she is so scared, she can't even talk.... she just look at him and cry...

Within the ecological theory, it is pronounced that the context 'family' is not a single, autonomous environment, but that every family is embedded in a variety of social systems. The central assumption of Bronfenbrenner's theory (1994; 2005) is that individual development takes place within a larger social system. Individual development is influenced, not only by the on-going qualities of the social settings in which the child *lives*, but also by the extent and nature of interaction in other settings, in which the child actively participates, such as the peer, school and neighbourhood systems.

Generally, adolescence is characterised by a change in where, and with whom, time is spent. Adolescence is a time when individuals begin to spend more time outside of school with their peers, than with their parents (Berk, 2010), which gives adolescents the opportunity to meet many new friends of similar ages in school and other contexts. These forms of exposure allow adolescents to mix with many different peer groups, and often, to become part of multiple subcultures. As adolescents spend more time with new peers, they develop and accept a new adolescent culture, due to pressure from their peer group. This peer pressure usually weakens the parental level of control, makes the adolescent irresponsible and increases the possibility of having adjustment problems (Patrick, Schulenberg, O'Malley, Johnston & Bachman, 2011). Therefore, the decreasing amount of time that adolescents spend with their parents, and the pressure from deviant peers, leave adolescents with enormous challenges that may affect their decisions to participate in anti-social behaviour, such as drug use/abuse.

Although a number of the participants cited peer-related reasons for their drug use, the interview data revealed that many of their life-situations were characterised by other interrelated factors. The following are examples of the contextual factors in the lives of three users, who cited peer-related reasons for use:

A 16-year-old boy reported his reason for drug use as: *"I felt like an outsider. All my friends did. It felt good. I can dance. Everybody loves me"*. This particular young man grew up with his single-parent mom and

grandparents. His father died when he was four years old, and his mother had passed away just a few months before the interview. He also reported that his grandfather's drinking caused arguments in the home.

Another 16-year-old boy, who cited his reason for use as “...to impress my friends” lived with his single- parent mom and reported that he is not sure whether his father ever loved him, because his father was jailed before he was born, and died in jail when he was 11 years old. During that time, he only saw/visited his father on two occasions. He reported that his brother was also abusing drugs.

A 15-year-old boy cited his reason for drug use as: “...because my friends do. To feel nice. To cope with stress.” This young boy lived with a single-parent mother and saw his father for the first time, when he was 14 years old. He described his childhood as being unhappy, and reported that he did not feel loved and cared for by his mother, as she did not attend to his basic needs. He referred to stress related strife and conflict in the home, due to on-going arguments between his mother and her boyfriend, after drinking alcohol. This participant also reported that his brother uses drugs.

Young people are particularly at risk for substance use, as they are at a stage in life when patterns of behaviour are being formed and are most likely to be influenced by peers and role models, who may be involved in the use of substances. Consistent with previous studies (National Institute on Drug Abuse [NIDA], 2003; 2005), the data reveals that there is no one single reason why young people use drugs, but that many factors interact and overlap to influence drug-use decisions among youth. These findings are consistent with previous research that supports the notion of overlap between parental factors and peer substance use.

Almost all empirically tested models of substance abuse and other youth problems find that peer influence is the most proximal and final pathway to problem behaviours in adolescence. Other social context variables, such as school and family, precede and may predict the selection of antisocial and substance-using peers (Biglan, Duncan, Ary & Smolkowski, 1995; Kumpfer & Turner 1990; 1991; Newcomb 1992). Brook, Brook, Whiteman, Gordon & Cohen (1990, cited in Brook, Brook, Morojele & Pahl, 2006)

found that adolescents, who have positive relationships with conventional parents (with low levels of substance use), are less likely to associate with deviant, substance-using peers.

6.4.3. School-related risk factors for use

6.4.3.1. School drop-out/failure

As noted earlier, 95% of the participants started using drugs while still at school and 41% of them have since dropped out of school. One female participant cited that she took drugs because she “was stressed out” due to school failure and that her friends, as well as her boyfriend told her that using drugs would make her feel calm and less concerned about the consequences of her failure.

There is considerable evidence linking school pupils’ adverse behaviour (truancy, drop out and poor attendance) to drug use. Previous research has shown that school failure is shaped largely by an individual’s experiences in early childhood, within the family setting and during the preschool years, and that one of the strongest predictors of substance use and related problem behaviour is school failure (Brounstein & Zweig, 1999).

Other studies have concentrated on the effects of risk factors on adolescent school failure and antisocial behaviour (Blum, 2007). Some studies show the relation between early childhood experiences and later negative adolescent outcomes, with respect to low-level intelligence, negative school attitude, harmful peer influences, poor parenting techniques, and a difficult temperament (Bogenschneider & Pallock, 2008). It is possible that indications of potential for school failure and antisocial behaviour are evident during school entry age.

Besides identifying different layers of environmental influence, which may be more proximal (such as parent-child relationships), or distal (such as neighbourhood disruption) to the child, Bronfenbrenner (1994; 2005) also states that the nature and quality of the interactions between these layers may interact to modify each other. This interaction between the different layers is referred to as

the *mesosystem*, and an example thereof would be the quality of interactions between the home/family and the school system.

Research has shown that some school-related factors are believed to exacerbate pre-existing problems and dispositions. Principal among these are a negative, unsafe, and disorderly school climate, as well as the low teacher expectations of student achievement. In addition, a lack of clear school policies regarding drug use is closely associated with an unsafe and disorderly school climate and predictive of school-related substance abuse problems (Hawkins *et al.*, 1992).

Consistent with Bronfenbrenner's (1994; 2005) ecological perspective on the importance of the multiple social contexts, in which lives are embedded, attributes of family, peer, school, and neighbourhood contexts are able to uniquely predict the development of adolescent drug abuse. The presence of multiple within-context and between-contexts interactions, involving constructs from social learning and social control theories, largely affirm Bronfenbrenner's (1994; 2005) prediction that interactions, rather than main effects, will be the principal effects demonstrated in ecological research. In addition, the findings of this current study confirm that young drug users have various risk factors operating in their lives, which interact to put them highly at risk for drug use. Notably stressful home situations will always exacerbate the need for young people to use maladaptive ways of coping, such as substance use/abuse. Overall, these findings suggest the appropriateness of an ecological approach for examining reasons and risk factors for drug use among youth.

6.4.3.2. Monitoring of after-school activities

Thirteen (31%) participants reported not being monitored, or supervised, by an adult after school. According to Steinberg, Fletcher and Darling (1994), poorly monitored adolescents are more likely to use drugs, and drug-using adolescents seek out like-minded friends. Once an adolescent associates with drug-using peers, his/her own substance use risk increases. Results from a number of studies demonstrate that parental supervision, or monitoring, of children (knowing where children are and what they are doing) can prevent, or delay, the onset of youthful drug use (National Institute on Drug Abuse [NIDA], 2003; 2005). Surrogate

parental monitoring, by responsible adults or older peers, in structured after school programmes, or recreational activities, may also be effective. The influence of parental supervision may be direct (it keeps children away from drugs), or indirect (it reduces a child's contact with drug-taking peers). A lack of parental monitoring may allow the process of drug use to begin, and contact with peers may exacerbate the behaviour.

Social Control Theory posits that a tendency toward deviance is universally shared, but manifested only when the bond between an individual and society is weakened (Petratis, Flay & Miller, 1995). The social bond may be weakened, when conventional attachments are attenuated, as when parent-adolescent closeness is low, or parents do not exercise supervision of their adolescents (Fomby & Cherlin, 2007), as well as in the face of stress, such as in high conflict families (Brook *et al.*, 2006).

Parental monitoring is an effective tool both in the prevention of drug use and in the amelioration of drug use. The key to preventing substance abuse is setting limits for teenagers, when it comes to drugs and alcohol. If they clearly see the consequences for using these substances, and view them as fair, they are more apt to follow the rules that parents/caregivers set for them.

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6.4.4. Neighbourhood reasons and risk factors for drug use

6.4.4.1. Neighbourhood norms

Some overlapping reasons cited were, “...because of area and friends, it is not easy to stop” and, “I felt like an outsider. All my friends used”. Therefore, it would be reasonable to say that drugs are also freely available, in these communities, as 73% of the participants reported that all, or many, of their friends used drugs.

It should also be noted that all, but one, of the youths lived in previously disadvantaged and typically impoverished areas – unsafe neighbourhoods that were characterised by gangsterism and high crime rates. One young man stated:

“...the merchants [drug dealers] are just next door to my house. Everything is just next door, my friends also. Everybody....they catch up on me then we all....gangsters, what, what, what, brothers....gangsters that stealing cars, you hear muggings, you hear shootings...”

An important aspect of the Ecological Theory is the presumption that the impact of major developmental influences, such as family functioning, is dependent on the sociological characteristics of the communities, in which children and families reside. To illustrate how the life domains interact with one another, one participant makes reference to hindering neighbourhood influences and refers to his residential area as a ‘gangster’s paradise’. He cited his reason for drug use as, “*area and friends*”. It has been well established in the literature that young people who live in disorganized neighbourhoods, where drugs are freely available, are more vulnerable to drug use (Gottfredson, 1988 cited in Hawkins *et al.*, 1992).

6.4.4.2. Accessibility/availability of drugs

Some interviewees reported that they did not like living in their areas because of the availability of the drugs, while most participants stated that they liked their residential areas. One young man wrote, “*...all the gangsters know and like me*”. These findings are consistent with the literature, which reveals that impoverished and disorganised neighbourhoods, where alcohol and other drugs are readily available, remain one of the greatest risk factors for drug use (National Institute on Drug Abuse [NIDA], 1997). Additionally, community norms may indirectly promote substance use, due to the availability of drugs and/or a tolerant attitude towards drug use.

According to Bronfenbrenner’s theory, individuals cannot be studied in isolation to the communities and broader social norms and beliefs, in which they live and operate. As indicated earlier, the majority of the respondents (90%) resided in and around the Cape Flats areas of the Western Cape, namely Manenberg, Hanover Park, Elsies River, Bonteheuwel, Heideveld, Delft, Kraaifontein, Langa and Khayelitsha. The Cape Flats area is an expansive low-lying area situated outside

of Cape Town, usually characterized by disadvantaged residential communities (Puljević & Learmonth, 2014), and often referred to as “apartheid’s dumping ground” of Cape Town. These disadvantaged communities are notoriously characterised by over-crowded housing, with high incidences of unemployment, school dropout rates, substance abuse, gangsterism and crime (Adhikari, 2006; Chetty, 2015). With the standard of living being low and the unemployment rates being high, communities on the Cape Flats have been plagued with violence and substance abuse issues (Standing, 2003; Pinnock, 2016).

Drug use and abuse is most prevalent in these communities (Parry *et al.*, 2005; Reddy *et al.*, 2010; Dada, 2016). They are also characterised by a prominent gang culture that is directly linked to a strong drug trade industry (Pasche & Myers, 2012, cited in Puljević & Learmonth, 2014). Several schools on the Cape Flats are surrounded by a number of gangs, and in many instances, school fences often marked the borders of gangland territories. The ‘gang bosses’, also referred to as ‘merchants’, often recruited the vulnerable young people in the communities, including school going children, to become involved in the drug trade. They will do this, firstly, by introducing these young people to highly addictive drugs, such as methamphetamines (or “tik”), and, subsequently, use them to sell drugs in order to sustain their drug using habits and cravings. These anti-social practices, in turn, often resulted in school dropout, as well as youth crime and delinquency.

There are many theories on how and why young people become involved in substance abuse, delinquency and criminal activities. However, the consensus is, young people from adverse family situations, residing in disadvantaged communities, where drugs are easily available, are particular vulnerable to become lured into drug abuse and crime. A quotation from The White Paper on Families in South Africa (SA DSD, 2013) succinctly sums it up:

Children who for various reasons—including parental alcoholism, poverty, breakdown of the family, overcrowding, abusive conditions in the home, the growing HIV/AIDS scourge, or the death of parents during armed conflicts—are orphans or unaccompanied and are without the means of subsistence, housing and other basic necessities

are at greatest risk of falling into juvenile delinquency (Salagaev, 2003: 191, cited in SA DSD, 2013: 27).

6.5. Contributing risk factors for drug use

For the purposes of this report, the following definition for risk factors will be applied. Werner (1989, cited in Hawkins, Catalano & Miller, 1992) refers to a risk factor as an individual attribute, characteristic, situational condition, or environmental context that increases the probability of drug use, or abuse. He further purports that healthy development is compromised when multiple risk factors occur, and is not offset by compensating protective factors. The literature also supports the notion that being exposed to one risk factor is not likely to predict negative behavioural outcomes, but the more risk factors a youth experiences, the more likely s/he will experience substance abuse or related problems (Hawkins, Catalano & Miller, 1992). The age of the onset of use was considered an individual risk factor for drug use. Additionally, a perceived lack of trust in, and support from, adults in their home and school environments was considered an additional risk factor for the maintenance of their drug use, which is discussed below.

6.5.1. Perceived lack of trust and support

One of the objectives of this study was to establish the nature and form of the perceived support that the drug user had at school and at home after they became involved in drug taking behaviours. According to Bronfenbrenner (2005), the quality and nature of the interactions between these school/family systems, is believed to hold the ability to modify responses and behaviours of individuals in these systems.

In this study, the majority of respondents, 37 (90.2%) did not disclose their drug use to anyone at home, or at school. Only two participants spoke to someone at home about their drug use, and another two confided in educators at school. Most participants cited that they did not trust anyone at school. One adolescent reported,

“...what’s the use of telling a teacher, the teachers already know that most of the children are using drugs. They can do nothing about it”.

One participant, who described his childhood as unhappy, due to a cruel stepfather, had confided in the deputy principal about his drug use, and cited the reason as:

“...because I trusted him and he took an interest in me”.

This comment, coupled with the high prevalence rate of substance abuse among parents and family members of the users, highlights the need for supportive and positive role models/mentors for young people. The findings could be understood within Erikson's (1968) Psychosocial Lifespan Theory, which purports that the conflict of “basic trust versus mistrust” is the first developmental stage with which a child must grapple, and that the outcome of this first crisis in the infant's first year of experience is an enduring effect on self and the world.

Another important developmental stage is that of adolescence, which Erikson (1968) refers to as “Identity versus confusion”. The main task of this stage is to develop a sense of identity, and it often depends on having successfully attained trust, autonomy, initiative and industry in the previous stages. Identifying with healthy parents in a secure family unit facilitates this process.

Many participants did not wish to talk to their parents/caregivers and educators about their drug use problems, which could be interpreted as underdeveloped trust formation. This may have contributed to their inability to develop a stable, healthy identity and sense of self, which could have led to their apparent experience of confusion regarding their place in the world. As demonstrated in this study, the lack of a strong ‘sense of belonging’ may draw youth into joining anti-social groups, in order to identify with significant others. This could be exacerbated by the media and entertainment world's ‘glamorisation’ of the drug culture that is believed to play a definite role in attracting vulnerable youth into substance-using lifestyles. The lack of trust, by most participants, to confide in their parents about their drug use problems, points to a deficit in parent-child connectedness and communication.

6.6. Risk factors as perceived by School official

Creswell (2009: p. 220) asserts that, “In a concurrent study the qualitative and quantitative data collection may be presented in separate sections, but the analysis and interpretation combines the two forms of data to seek convergence or similarities among the results”. The results of the interview with the Learner Support Officer (LSO) at the school largely confirmed most of the reasons and risk factors for drug use, as per the findings of the data


collected from the young drug users. However, some new insights were gained about the perceived risk factors for drug use among youth, according to the LSO in the school setting. These additional themes and sub-themes are grouped according to Bronfenbrenner's microlevel system, which includes the individual/family and his/her surrounding social settings. Only the new insights, not discussed earlier are addressed in the following section.

6.6.1. Perceived family risk factors for drug use

Relevant findings relating to perceived family risk factors were highlighted in the analysis of the data collected from the LSO participant, as discussed below:

6.6.1.1. Parental denial of drug use

The participant spoke about parents being in denial about their children's wrongdoing and drug use. According to the LSO, being in denial is not helpful; instead, it is damaging to the child, enabling the child in behaviour, as expressed in the excerpt below:



"We know the dangers of the drugs but we are still giving our children big money. Look at the rich child. They also deeply in drugs because they've got too much money, you understand. Ag, we're in denial.... that's why the world outside can be saved if our parents, if we work together and stop being in denial about the children... Ag, we're in denial also man, I say I'm not twenty-four seven with my child. If you should come to me... your children was outside with those children and I'm sure I saw him also busy with some wrong doings there, I shouldn't say my child will never do it. Because the parent is the last one to know anything a child does wrong".

The theme, parental denial, is closely linked to parental supervision and monitoring. Consistent with research conducted by the South African Institute of Race Relations (SAIRR), where researchers Holborn and Eddy (2011) found that the majority of South African children grew up in single parent households, most of the participants in this study resided with their single-parent mothers. These single mothers, in low socio-economic environments, therefore, face challenges that are bound to have implications on healthy child outcomes and consequences for the well-being of the family. Literature concurs that persons in single parent

households tend to have lower levels of educational and economic achievements (Mueller & Cooper, 1986, cited in Davids & Roman, 2013). In addition, single parents, in general, have less time to devote to their children, because of having to balance the roles of both caregiver, as well as provider (Magnuson & Berger, 2009, cited in Davids, Roman & Leach, 2015).

Parents have various ways of, and approaches to, child-rearing practices, and differ in parenting styles that naturally have a direct influence on child outcomes. The role of parenting is to influence, teach, guide and control the whereabouts of their children, and to be aware of their activities, as well as with whom they associate themselves. In some cases, parents (especially single parents) may be too busy to monitor or supervise their offspring, and may be completely unaware that their child is, or children are, involved in anti-social behaviour, such as drug use. In other cases, parents may just not make the effort to be involved in their children's lives and activities, due to their own mental, physical or economic challenges. In this study, many of the parents and family members were abusing substances, which negatively affect family functioning and parenting practices, such as monitoring and supervision, which acts as a protective factor for drug use among adolescents. Ultimately, the child-rearing approaches that parents use to raise their children are directly related to the child's developmental and behavioural outcomes in his/her adult years (Roman, 2014).

6.6.1.2. Neglectful parenting practices and ineffective parenting strategies

The participant expressed her concerns that parents sometimes neglected to spend time with their children and provide the guidance that young people needed in their lives, as described in the following excerpt:

“Help the child, guide the child, tell the child whatever he does wrong what is his punishment gonna be....now we’re neglecting our children....and when it gets too much we wanna kill our children and that is when it’s wrong.”

She further expressed that parents were not just perceived to be inattentive in guiding and disciplining their children, but also tended to use ineffective parenting strategies to cope with the stressful situations in the home. Some of

these parenting strategies were recollected as buying their children expensive name brand clothing and cell phones, as well as providing them with too much spending money, as expressed below:

“It is wrong, things must only be bought for our children when we can afford it.... Children come to the tuck shop with a hundred rand, we parents are to be blamed. We know the dangers of the drugs but we are still giving our children big money. Look at the rich child. They are also deeply in drugs because they’ve got too much money, you understand...”

According to Darling and Steinberg (1999), parenting is a complex activity, which includes many specific behaviours that work individually and together to influence child outcomes. Dianna Baumrind was one of the first researchers to study parenting styles, as far back as the 1960s. She originally identified three different types of parenting styles that have been linked to various outcomes for children. These styles include authoritative, authoritarian, and permissive styles of parenting (Baumrind, 1991). Further parenting styles, such as uninvolved or neglectful parenting have been added since.

Parents who utilize the authoritative parenting style set clear guidelines, exercise firm control of the child’s behaviour, but also emphasize independence and individuality in the child. They allow their children freedom, within reasonable limits. According to Baumrind (1991), children, who have grown up in such families have a high self-esteem, are better able to internalize moral standards, and perform better academically.

Authoritarian parents, in contrast, exercise firm control over their children, without the nurturance or support. Parents, who practice this style, often place such a high premium on conformity and obedience, with little regard for the child’s individuality, frequently rejecting their children, when they do not comply with the parents’ wishes. The authoritarian parent values obedience as a virtue and believes in restricting the child’s autonomy. Children, who have grown up

with such parents, usually have a lower self-esteem, and are also less skilled in their social relationships and peer interactions (Louw, Van Ede & Louw, 1998).

According to Louw, Van Ede and Louw (1998) permissive parents set few limits on the child. They are very accepting of the child's impulses; appear cool and uninvolved, the children ultimately doing as they pleased. Therefore, the onus is placed on the child to become responsible, in order to regulate their own behaviours, and very often, these children have no idea of what appropriate behaviour entails in any given situation. The outcomes for these children are that they have difficulty in accepting responsibility, are least independent and self-controlled, tend to do less well at school, and appear to be less mature in their behaviour and attitude towards their friends at school. According to Baumrind (1991), children of permissive parents are also more likely to engage in risk-taking behaviour, including that of substance abuse.

Relative to the LSO participant's concerns above, parents, who apply permissive parenting styles, and supply their children with excessive amounts of pocket money, without monitoring how they spent it, further place young people at risk for drug use, as they provide the means for young people to acquire the drugs.

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6.6.2. Perceived neighbourhood factors for drug use

Some important findings around community norms and practices also emerged from that data collected by the LSO participant, as discussed below:

6.6.2.1. Lack of neighbourly bonds/connections

An important finding that emerged from the data was the lack of neighbourly bonds/connections regarding the caring for the children in the neighbourhood, as expressed by the LSO. The participant discussed the lack of neighbourly bonds and connections, where people no longer watched over each other's children, or parents go into denial or become defensive when other adults inform them of the misconduct of their children, as this excerpt demonstrates:

"We don't even care anymore if our neighbour has got a piece of bread for their children...we must get that again to each other, you

know. we must get that bond, that neighbourly bond again with one another...And another thing is that we should not always say to them 'is nie my besigheid nie' [this is not my business]. We must adopt the attitude that your child is my child and my child is your child.... The child don't want to be 'ombeskof' [rude]. It is the drugs that has changed the child's attitude. So don't push that child away."

The old proverb strikes a chord, "it takes a village to raise a child". The researcher is of the opinion that there has never a greater need to start caring about each other and looking out for each other's children, than in the present South African climate of unsafe neighbourhoods, with high crime rates fuelled by gangsterism and substance abuse. The researcher continues that rarely a day goes by when one does not read about young people being raped and killed, for no apparent reason at all. The very young seem to be most at risk, due to the gangsterism and the high crime rates, learners are not safe when making their way to and from school, or even when they are at school, as the violence in and around the schools often spill over into the school community. De Wet (2016) cites a newspaper article, in which a reporter states, "*teachers and principals became emotional as they told of their struggles to keep pupils safe amid daily shootings and gangsters at their schools*" (Jones, 2013: 5, cited in De Wet, 2016: p. 7).

It is in this climate that many children find themselves, without suitable adult supervision, and often, good role models are hard to find in the communities in which they live. In these cases, it is no wonder that vulnerable adolescents become involved in drug-taking and other anti-social behaviours. In the researcher's considered opinion, more than ever before, in the South African context, where the majority of children are growing up in female-headed single-parent households (Holbern & Eddy, 2011), and single parents are probably out working, there is a great need for communities to rally together and find ways to support single parents, by "*looking out*" for their children. These arrangements could be to be negotiated in a climate of open communication and trust, with an understanding of the spirit of Ubuntu, which simply put, in the African language means, "*I am, because we are*", to ensure that good endeavours do not become misconstrued as wanting to "meddle" in others' affairs.

6.6.2.2. Availability of drugs in the community

The participant expressed her knowledge of the availability of the drugs, as well as the drug lords in the neighbourhood, which contribute to the use of drugs among learners and young people, in general. She also referred to the perceived callousness of the merchants/drug lords (people who sell drugs) in the community:

“You see why drugs is easily accessible to our children is that this merchant don’t care. I think if you should send your four-year-old baby to buy [drugs], they gonna serve that child. I recall in the newspaper that a lady stopped selling drugs when she found out that her own child was using. She is now a community worker – but the damage is done. How can a mother sell drugs to another mother’s child? It’s very nice to take a nice packet [of money] to the bank, they run to the bank while we run and sit with the problem. You understand, those parents have now got the problem...”



According to data compiled by the South African Police Services (SAPS) data for 2014/2015, the Western Cape is known to have a severe problem with drugs and drug-related crimes. It is also labeled, ‘the Province with the highest number of drug-related crime cases’. Mitchells Plain, in the Western Cape, was on record as the worst affected area, by a large margin, closely followed by other areas on the Cape Flats, such as Kraaifontein, Manenberg, Delft, Bishop Lavis and others (South Africa, Department of Community Safety, 2015/16: p. 32).

It became clear in this study that the vast majority of participants, 26 (63.4%), reported that all, or many of their friends used drugs. The vast majority (78%) of them started using drugs while still at school, and 78% of the participants were introduced to drugs by their friends. In addition, 56.0% of respondents indicated alcohol use by live-in family members, and more than half (51.2%) reported that one or more family members used illicit drugs. Coupled to that the mean age of onset for the use of drugs among the participants were about 14 years of age, with a minimum age of 11, and a maximum age of onset at 17 years. This mean age of onset is consistent with other global (McDowell & Futris, 2002; Resnick *et al.*,

1997; Van Ryzina, Foscoa & Dishion, 2012), and local studies (Reddy *et al.*, 2003; Reddy *et al.*, 2010). These finding are clear indications of the availability of drugs in the community, in their homes, and even in their school settings. It is also consistent with previous research that young people, who use drugs, are more likely to associate with drug-using peers.

Social Learning Theory, developed by Bandura (1977), envisions social behaviour as acquired through direct conditioning, or through modelling of others' behaviour. In this theory, a person observes the behaviour of other persons and tends to model that behaviour, particularly so, if s/he feels a sense of attachment to the others, such as the parents or peers (Bandura, 1977). Behaviour is learned and moulded by watching others' behaviour and by integrating how others respond (Bandura, 1977; 1999). Substance use and abuse, therefore, is regarded as socially learned behaviours. Many social learning theorists focus on peers because of the significance, adolescents place on friends, as they begin to mature and gain autonomy from their parents. However, families also appear to be important for learning attitudes and behaviours about alcohol and other drugs. Although there may be many other possible mechanisms through which adolescents start using drugs, evidence has shown correlations, for example, between parental substance use and children's smoking and alcohol use (Hawkins *et al.*, 1992), which is consistent with such a modelling process. Based on this modelling process, and coupled with the prevalence and availability of drugs, some children may also learn to use alcohol and other drugs to help cope with stressors, if their parents, peers or other important people in their environment, model the use drugs as a coping mechanism. The prevalence and availability of drugs have long been identified as a risk factor for drug use among youth, and previous research has shown that young people, who do not believe that their friends use substances, are less likely to use substances themselves (Vakalahi, 2001).

6.6.2.3. Community protection of drug lords

Another risk factor that was identified through the data analysis was the perceived lack of a collective effort from the community in the intolerance of drug dens (homes that sell drugs) and merchants (persons who sell the drugs) in the

neighbourhood. This theme is interrelated to the availability of drugs in the neighbourhood, which clearly emerged in the analysis of the data collected from the young drug users. The LSO participant stated that there was only one way to prevent drug use in the community, which was to rid the neighbourhood of drug lords. The LSO explained that, previously, one of the strategies that the neighbourhood watch employed, was to stage a sit-in in front of the local drug lords' homes, to prevent them from selling drugs, particularly, to the young, under-age users. The rationale was that young drug users, and especially school-going learners, would be deterred from coming there to purchase drugs, while the neighbourhood watch members were silently participating in the sit-in protest. The participant expressed concern and frustration around the opposition that they received from the drug lords, the South African Police Services (SAPS), and the community members themselves. The drug lords would call the SAPS to remove the protesters, and some community members would even chase them away, in favour of the criminal activities of the drug lords. The neighbourhood members would display their favourable views of the drug lords that operated in the community, clearly and openly. According to the participant, this was due to the material support that some of the community members received from the drug lords, in the form of groceries and (rent) money, or even paying for the funerals of family members, in a time of need. She described her dismay about it in the following manner:

“For drugs, man there’s only one problem. There’s only one solution to that problem and we succeeded in two already. The neighbourhood watches are prepared to sit twenty-four seven in front of a drug lord’s house. But sometimes the drug lords will get the police in and the police will remove us. But, as long as we are in front of the drug lord’s house he is losing business and that child will not be able to come to that drug lord. And then again you sit in the road by that drug lord, the whole community stands up against you. So one way you are doing good, and the other side some of the community see it as a bad thing. Of either Uncle Druggie [drug lord] is giving us bread money or uncle Druggie is doing something to us or whatever,

that why...If you are sick and tired of that role that man is playing in your community, you're gonna stand it up. You understand?"

As frustrating as the community's protection of the drug lords were, it was simple to understand how people, who experienced poverty, unemployment and hardship on a daily basis, could become desperate enough, to accept hand-outs from anyone, including the very people who is partly responsible for the perpetuation of the cycle of hardship in their lives and communities. It is common knowledge that, where the prevalence of drug use abounds, criminal activities will increase and, consequently, contribute to unsafe and unsavoury community life. In addition, research clearly reveals that the increase in the prevalence of drug use (availability of drugs) acts as a powerful risk factor for vulnerable, young people, who live in these communities (NIDA, 2003; NIDA, 2016).

6.7. Perceived prevention strategies

Regarding the measures that are needed to prevent drug abuse by young people in schools and high-risk communities, the following suggestions were identified. These themes and sub-themes that emerged from the data were grouped according to Bronfenbrenners microlevel system and included factors in the family/school/peer/ and neighbourhood domains. In the previous chapter, Table 11 provided a full summary of the themes and sub-themes that emanated from the data. These themes and sub-themes are briefly discussed in the following section. They will form part of the recommendations that will be made in the following chapter, when the focus of the implications for primary prevention strategies is considered.

6.7.1. Family – sub-themes

- Effective parenting styles (consisting of communication, love and warmth);
- Effective management of drug abuse in the family (parents to seek out assistance, instead of going into denial about the child's drug use); and
- Adolescent involvement in pro-social activities.

Researchers have cited many reasons for drug taking behaviour, however, there appears to be consensus that children are influenced, first and foremost, by their parents and immediate family, and thereafter, by other social domains, namely peers, school and neighbourhood (Bogenschneider, Small & Riley, 1994; Brook, Brook, Morojele &

Pahl, 2006; SA DSD, 2013a). Consistent with previous studies, this study uncovered many risk factors within the family domains of the young drug abusers. These included family dysfunctions, such as troubled parent-child relationships, harsh and punitive parenting styles, and harmful family practices, such as parental substance abuse – which all work together to amplify the risk component on the lives of young people. The LSO identified the need for parents to apply effective parenting styles that included expressing good communication, warmth and a loving relationship with children. She expressed it in the following excerpt:

“Your children can be how old, they need still to be hugged...But believe me I’ve experienced that with my own kids, they are big but you can see how their face lights up if you hug them and you remind them how much you love them...this child lacks love. She’s holding out to her parent and the parent can’t see it. It is because we are such busy mothers that we don’t realize that we are neglecting our own children and we are actually giving them to the drug addicts. We are giving them because they don’t find the love here in our house.”

The family is the most direct form of influence on the lives of children, and what happens in the home serves to shape their character that can either hinder or enhance the developmental outcomes for young people. These early interactions in the home start as early as infancy, and have lasting effects on children well into their adult years. Bowlby (1980) developed the Attachment Theory and made a clear distinction between secure and insecure attachments, which relate to how infants see themselves and other people in relation to care provided. Infants, who had received responsive care, would be securely attached and assume that they were loved, and that other people could be trusted to care for them, while infants, who were exposed to abusive, neglected or insensitive care, would be insecurely attached. From a young age, children learn that they are not worthy of love, and that adults are generally unreliable to meet their needs (Sigelman & Rider, 2009). Bowlby (1980) asserts that the quality of the early parent-infant attachment has lasting effects on development, including the kinds of relationships people have with their friends, romantic partners, and children (Sigelman & Rider, 2009: p. 407). The significance of early attachment or bonding, and

maintaining that bond, which is sometimes referred to as Parent-Child connectedness (Lezin *et al*, 2004), therefore, is undisputed.

Bowlby's (1980) Theory of Attachment is congruent with, and complementary to Erikson's (1968) Psychosocial Lifespan Theory, which posits that "basic trust versus mistrust" is the first developmental stage, a child grapples with and transitions through. When caregivers respond appropriately to the child's basic needs to be loved and cared for, the outcome of this first crisis in the infant's first year of experience is an enduring attitude toward one self and the world. As was the case with the participants in this study, another important developmental stage is that of entering adolescence, which Erikson (1968) refers to as "Identity versus confusion". The main task of this stage is to develop a strong sense of identity, and it often depends on having successfully attained trust, autonomy, initiative and industry in the previous stages. If the foundation is secure, ongoing healthy parent-child relationships and identification with healthy parents in a secure family unit, aids to facilitate this process, successfully. According to Baumrind (1991), parenting is the child-rearing practices and styles employed to rear children, during the childhood years. It is of utmost importance that sound parenting styles and practices are implemented in the early years of development, as parents become the most influential contributor to healthy developmental outcomes and child well-being (Hendricks-Human, Roman & Rich, 2015).

It was also noted that parents should not be in denial about their children's use of drugs, and should be aware of their whereabouts, as well as the friends with whom they associate. They should also make use of the resources and support structures that are available to them in the communities, should they discover that their children are using drugs. Additionally, it was suggested that young people should be encouraged to get involved in pro-social activities and should be provided with opportunities to volunteer their services in the communities, which will make them feel good about themselves and keep them occupied in their spare time.

6.7.2. School – sub-themes

- Encourage school/parent communication and involvement.

- Schools have to engage in drug education and effective dissemination of the school drug policy.

The interviewee expressed that parents, more specifically, mothers, are ‘too busy’ to attend school meetings, or may not feel the need to attend the meetings, even when it involves the welfare of their drug-using child as the following statement reflects:

“...The parent would say I can’t I’m working, but I [interviewee] can’t help that child alone, I need the assistance of the parent also”.

The participant also expressed that the fathers were not always involved in the lives and activities of their children:

“...it makes the child also feel wonderful if father participate in whatever role there’s got to be played. That’s why I say it’s such a lot also for a mother to handle nowadays because we mothers also want to do everything on our own, ourselves. We want to rear the children ourselves, we run to the meetings, we do everything, we have spoilt that fathers already. They are moulded already to be spoilt, they are not used to going to the meetings, so it’s so new now to remould them, it’s very difficult.”.

The LSO reported on the low parental attendance of school meetings, which indicates low parental support towards school efforts and endeavours. It was also determined that, although a school’s drug policy existed, and was mentioned at the Parents/Teachers meetings, it was not disseminated in writing to the parents and learners of the school. Previous research has shown that some school-related factors are believed to exacerbate pre-existing problems and dispositions. Principal among these are a negative, unsafe, and disorderly school climate, and low teacher expectations of student achievement. In addition, a lack of clear school policies regarding drug use is closely associated with an unsafe and disorderly school climate and predictive of school-related substance abuse problems (Hawkins, Catalano & Associates, 1992). The lack of the distribution of a written set of guidelines and procedures for the prevention and intervention of drug use among learners at the selected school in this ‘at-risk’ community, indicate ineffective school-home communication and a lack of much-needed partnership and connectedness between learners’, their parents, and the school community.

6.7.3. Neighbourhood/community – sub-themes

- Parental involvement and support in neighbourhood watch membership and community initiatives.
- Effective policing and sentencing of drug lords.

There is a clear link between drug abuse and criminal activities in the community. A study by Burton and Leoschut (2013, cited in De Wet, 2016), revealed that 22.2% of South African learners were subjected to some form of violence and crime (including, assault, sexual assault, robbery and theft). The Western Cape is on record as having the second highest rate of learners, who reported being exposed to violent crimes of some sort (Burton & Leoschut, 2013, cited in De Wet, 2016: p. 1).

The participant's statement regarding the only one way to prevent drug use in the community, which is to get rid of the drug lords, therefore, is not surprising. She referred to the challenges that the neighbourhood watch members encountered when they attempted to stage a 'sit-in' in front of the drug lords' houses in the community. She expressed frustration, when the drug lord would allegedly call members of the SAPS, and the neighbourhood watch members/protesters would be asked to leave, as their actions were perceived as 'trespassing' on someone's property. Moreover, the main opposition appeared to be from members of the community, who held favourable attitudes towards the drug lords. These attitudes seemed to stem from the fact that the drug lords often provided members of the community with money for groceries or rent, or would pay for the funerals of impoverished family members in the community.

Another suggestion for the prevention and reduction of drug use that was provided by the participant was the role of the police and the courts to act more strictly when dealing with drug lords. This concern is expressed in the following excerpt:

“But if the law had to be the way that it was when I was a kid, this would never have taken place. Because if you had to drink, your baby gets removed and that would give you a wake-up call. If you sell drugs, you get locked up and you get severely punished, it's not like a hundred and twenty investigations and we must prove that that button or that tik was bought by

that person. If they knew you were selling it, they sommer [just] ...In the government, too much leniency.”

The above concerns point to weak community bonds and a need to strengthen social cohesion in fractured communities. Social cohesion is regarded as an important concept today, but there seems to be various conceptual definitions of the term. According to Cloete (2014: p. 1), “Social cohesion is simply referred to by some as ‘the glue that holds society together’, or put differently, ‘the property that keeps society from falling apart’ (Janmaat, 2011: 63, cited in Cloete, 2014). In addition, Langa, Masuku, Bruce and Van der Merwe (2016: p. 42) used the more encompassing definition of, “the shared sense of common purpose; aspects of social control and social order between people, groups and places, as well as the level of social interaction within communities or families; and a sense of belonging to place”.

Based on the findings of this study, which include family instability, troubled parent-child relationships, fractured community norms and practices, high levels of substance abuse and related crimes, a great need to find ways of strengthening social bonds has developed, as well as the need to “facilitate a spirit of solidarity and unity among community members” (Langa *et al.*, 2016: p. 47).

6.8. Revisiting Bronfenbrenner’s Bio-Ecological Systems Theory

In this chapter, the researcher provided a brief overview of the contextual circumstances of the participants, presented the findings and provided a discussion of the main results, which were related back to the literature and integrated with two developmental theoretical perspectives, namely Erikson’s (1968) Psychosocial Lifespan Theory and Bronfenbrenner’s (Bio) Ecological Systems Theory (1994; 2005). The results of the perceived reasons for drug use were categorised into an individual/psychological domain, with themes/sub-themes in the family domain, and the interrelated peer/school/neighbourhood life domains. The risk themes were identified and integrated into two main categories, namely, Family, as well as Peer/School/Neighbourhood risk profiles.

These findings are consistent with Bronfenbrenner’s (1994; 2005) theory that views all aspects of human development as interconnected and requires consideration on various levels of the individual’s ecology (environment). It is restated that substance use and abuse

does not have a single cause, and the literature points to many risk factors for drug use among youth. These include factors operating and interacting within and between the individual, family, peer, school, and neighbourhood systems (Alberta Alcohol and Drug Abuse Commission [AADAC], 2003; SA DSD, 2013a).

After reviewing all the themes and sub-themes, the findings reveal that the primary problem these young people experience is within their family systems. Family lives are characterized by stressful and conflict-ridden family situations, while many participants resided in single-parent homes, had substance-abusing parents, and broken and disconnected parent-child relationships, often from a very young age. A significant finding is that this strained/difficult relationship exists with at least one parent, more specifically with their father, or father figures.

Many reported peer influence and association with drug-using peers to be the reason for their drug use, but it was argued that factors within the family system could mediate the peer system influence on adolescent drug use. Previous research confirms that the presence and quality of an affectionate and non-conflicted parent-child relationship could protect a child from substance use (Lezin *et al.*, 2004). In addition, poor parent-child relationships and parenting practices, high levels of conflict in the family, and a low degree of bonding between children and parents, appear to increase the risk for adolescent substance use (Brook, Brook, Whiteman, Gordon & Cohen, 1990). Parents, therefore, influence adolescents' drug use, by establishing the foundation that leads the child to affiliate or not affiliate with drug-using peers (Resnick, Harris & Blum, 1993).

6.9. Expanding Bronfenbrenner's Bio-Ecological Systems Theory

Bronfenbrenner's Ecological Theory was a useful framework to guide the data collection instruments and processes, as well as to organize the findings into a coherent structure. Bronfenbrenner's framework served the aim of the study, which was to explore the perceived reasons and risk factors for drug use among youth. These multiple risk factors were located within the individual, family, peer, school, neighbourhood and societal domains of the participants in this study, and were able to guide the focus of primary prevention strategies and programmes in the lives of the young drug users residing in the townships of the Western Cape of South African.

Many studies have been conducted into factors (referred to as “risk factors”) which are believed to predict drug use (Home Office, 2007; Whitesell, Bachand, Peel & Brown, 2013). However, there is consensus that no single risk factor predisposes an individual to drug use, but rather the presence of multiple risk factors in the individual and their social domains, which interact to influence drug-taking decisions by the individual. It is also evident in the literature that the more risk factors young people are exposed to, the greater the risk of drug use (Hawkins, Catalano & Miller, 1992; Home Office, 2007). Conversely, other factors influence an individual’s decision to refrain from using drugs. These factors are generally termed protective factors, and can be viewed as the factors that buffer or protect an individual from drug taking decision-making and behaviours. From a social-ecological perspective, a protective factor can be described as “...a characteristic at the biological, psychological, family, or community (including peers and culture) level that is associated with a lower likelihood of problem outcomes, or reduces the negative impact of a risk factor on problem outcomes” (National Research Council and Institute of Medicine, 2009: p. xxvii, cited in Harper Browne, 2014: p. 19). As with risk factors, an individual may have several protective factors present in his life, which does not automatically mean that the individual will, or will not, decide to use. Hawkins, Catalano and Miller (1992) cautions that risk and protective factors are not simply the opposite of each other, but there are complex interactions between risk and protective factors, which influence a person’s decision-making processes.

Protective factors also moderate the effects of the risk factors that are present. For example, researchers Brook *et al.* (1990) reports that risks posed by drug-using peers, were moderated, when a strong parent-child attachment/bond was present in the lives of young people. In addition, protective factors in their family/home lives, such as supportive parents, who practice authoritative parenting styles (characterized by warm and nurturing parental practices), foster clear expectations for adolescent behaviours, and exercise firm monitoring strategies, are able to buffer the risks of their adolescent’s association with drug-using peers or becoming involved in drug use themselves (NIDA, 2003; 2016).

A noteworthy observation in this study is that, although many of the participants in this study described some form of dysfunction in family functioning, 44% of the participants reported that no-one in the family drank alcohol, and almost half (48.8%) of the participants reported

that none of their family members used other drugs. We also know that not all adolescents, who grow up in challenging family systems, or in adverse communities, resort to drug taking or other anti-social behaviours. Which begs the questions, (a) Which protective factors are at work in the lives of these other young people and family members, who are able to withstand the pressures of these risk factors in their social environments? and (b) Do these protective factors reside within the family, or other social systems in the lives of these adolescents, or are they present in the intrapersonal domain of the adolescent himself?

Consequently, the terms ‘resilience’ and ‘family resilience’ need to be considered at this point. Resilience is not a term that Bronfenbrenner’s Ecological theory considers in his theory. Simply put, resilience refers to a person’s ability ‘*to bounce back*’ after facing and overcoming adverse circumstances. In some cases, people are even able to be strengthened through these difficult trials in their lives, and may even emerge the stronger for it. According to Walsh (2012), previous studies were inclined to focus on individual resilience, looking for intrapersonal traits, such as ‘*hardiness*’ in the individual (Walsh, 1996, cited in Walsh 2012: p. 399). After reviewing the multiple risk factors embedded in the various individual and social/cultural domains, researchers now realize the need to explore resilience factors within the young people’s family systems. Walsh (2012: p. 399) further asserts that “Family resilience involves the potential for recovery, repair, and growth in families facing serious life challenges”. By expanding Bronfenbrenner’s theory to include research on resilience factors, both in the individual and the family domains, researchers will gain new insights on people’s innate strengths, activities and resources (also referred to as protective factors), that could be strengthened to enable them to become more resilient in the face of risk and vulnerability.

6.10. Conclusion

The main findings of this study were discussed in this chapter. It is apparent that the family functioning and processes in the lives of the young drug abusers in this study hold some of the most significant findings. These processes could serve to increase the risks of young people misusing substances and/or becoming involved in other activities, harmful to themselves and/or to society. Additionally, consistent with Bronfenbrenner’s theory, many other interrelated factors nested in the peer/school/and neighbourhood levels were found to be present in the lives of the young drug users. Bronfenbrenner’s theory was applied to unpack the outcome of the results, and a gap in the theory, namely, resilience or protective factors

were identified and discussed.

In the following and final chapter, the researcher provides some broad conclusions gained from this study, and offers a brief discussion of the limitations of the study. Finally, some recommendations for avenues of future research in this field are made, and guidelines for implications of primary prevention for parents, policy makers and professionals in the field of prevention are provided.

CHAPTER SEVEN

CONCLUSION AND RECOMMENDATIONS

7.1. Introduction

This chapter comprises the conclusions gained from this study on the reasons and risk factors of drug use among youth. The implications for primary prevention of substance abuse among youth are considered and recommendations for avenues of future research in this field are suggested. Finally, a brief discussion of the limitations of the study is presented, as well as a summary of the main conclusions emanating from the research objectives of this study.

7.2. Study aims and objectives revisited

The aim of this study was to establish the main perceived reasons for drug use from the perspective of the young drug abuser, as well as to explore and identify the inter-related, intrapersonal, familial, and environmental risk factors present in the lives of young drug abusers, and to use these findings to inform the focus of primary drug prevention efforts.

The objectives of the study are to:

- Identify and describe the demographic and contextual profiles of young drug users;
- Establish and describe the perceived reasons for the use of illicit drugs by young drug abusers;
- Discover areas of risk by exploring the childhood experiences and family contexts and inter-relationships;
- Explore and analyse precursors to their drug-taking pathways, in order to identify the contributing risk-factors in their lives;
- Identify and describe the perceived forms of support that young drug users had available to them at home and at school after they became involved in drug-using behaviour;
- Explore the perceived reasons for drug use and its implications for primary prevention from the perspective of a school official at an 'at-risk' school community;

- Use the identified areas of risks emanating from the data to inform the focus of primary prevention efforts and programmes.

The summary of the main findings are presented in the following section.

7.3. Summary of main conclusions

Consistent with previous studies, this research has revealed that drug-using behaviour does not have one single cause, but that multiple risk factors in and between the individual/family/school/ peer/neighbourhood and societal levels have been determined to be present in the lives of drug users and their families. Internationally, there also seems to be consensus that family functioning and practices play a key role in influencing and combating this phenomenon. The findings of the analysis reflect that the adolescents in this study experienced unstable family lives, characterised by unhealthy parenting practices, such as parental substance abuse, poor parent-child relationships/connectedness, and neglectful, as well as conflict-ridden home environments. Additional risk factors within their peer/school/neighbourhood domains were identified that may have added to their vulnerability to start using substances. The key findings are listed below, in relation to the bio-psychosocial domains – namely, individual factors and social domains, such as family, and contributing environmental factors in the peer/school/neighbourhood domains.

7.3.1. Main perceived reasons for drug use

7.3.1.1. *Individual factors*

Favourable attitudes towards drug use; social skills deficit; a lack of self-esteem; maladaptive coping mechanisms; and early age of onset were identified as the main person-factor reasons, as well as risk factors for starting to use drugs.

7.3.1.2. *Family factors*

Generally, the home lives of the young drug users were characterised by parental/sibling substance abuse, poor parent-child relationships, dysfunctional parenting styles and practices, neglect and abuse, as well as marital conflict and family disorganisation.

Family structure/stressors of single parenting – Most of the participants in this study lived in a single parent or blended family homes. The single-parent homes

were mostly female-headed, which placed a huge burden on working parents to use authoritative parenting styles and to monitor the whereabouts of their children.

Absent fathers/father figures – in many cases their home lives were characterised by poor relations with their fathers and/or stepfathers, who were either abusive toward them, or were emotionally, or physically, absent from their lives. These findings point to a lack of positive male role models in the lives of young people.

Poor parent-child relationships – The majority of the participants' biological fathers were absent and uninvolved in their lives. Most of the stepfathers in the blended family systems had substance abuse problems and the adolescents were residing in conflict-ridden homes. Mothers/caregivers did not cope well with their stressful home situations and were emotionally unavailable to their children, for the most part. The findings also revealed a communication deficit between parent and child, as well as a lack of trust by the adolescent to confide in the adults in his life.

Dysfunctional parenting practices – Parents were either detached or uninvolved, used harsh and punitive parenting strategies, or were overly permissive in their style of parenting. There was also a lack of authoritative parenting styles and practices.

Parental/sibling substance abuse – Parental/sibling substance abuse was common in the lives of the youth, who abused drugs. This sometimes led to conflict in the home, as well as harsh and punitive parenting styles, including family violence.

Stressful, abusive family contexts – Many of the drug-users' home lives were stressful, chaotic and conflict-ridden, due to family disruptions, such as marital conflict and domestic violence. Some of the adolescents in this study also experienced neglect and abuse, both emotionally, as well as physically. The physical abuse occurred mostly at the hands fathers, or stepfathers.

Lack of perceived support - Most of the participants of this study did not feel that they could speak to anyone at home, or at school, about their drug-taking behaviour, due to the distrust of the adults in their lives, at home and at school.

7.3.1.3. Peer/school/neighbourhood factors

Peer use – The youth reported that many, or all, of their peers used drugs, and that they were introduced to drugs through their friends. Many of the participants' after-school whereabouts and activities were not monitored or supervised by an adult or caregiver.

School – All the drug users started using drugs while they were still attending school and many had subsequently dropped out of school. The majority of the participants of this study did not feel that they could confide in an adult in the school system about their drug use. A lack of effective school/parent communication and positive interaction between school and parents, such as attendance of school meetings, was identified as an additional risk factor in the school domain.

Neighbourhood – The easy availability of drugs in their neighbourhoods were additional risk factors that may have influenced their drug-use decisions. The community's favourable attitude towards drugs and the drug lords were identified as an additional risk factor for drug use among youth.

7.3.1.4. Societal risk factors

On the societal level, the context of the drug users was as follows: poverty, disadvantaged communities with a lack of resources, and a high prevalence of drug use, and crime, where gangsters rule and protect their gang turf. Where the prevalence of drug abuse is so high, and drugs are so easily available, the laws and regulations that are supposed to combat drug abuse need to be stringently enforced. This was not the case for the Learner Support Officer, who expressed her frustration that the drug lords (merchants) were known to the Police in the area, but nothing was done about their illegal drug trafficking practices. There are many theories on how and why young people become involved in substance abuse, delinquency and criminal activities. However, there seemed to be consensus that young people from adverse family situations, who reside in disadvantaged, unsafe and violent communities, are more likely to become involved in drug using behaviours.

7.4. Implications for primary prevention of drug use

A secondary aim (and final objective of the study), was to consider the implications for primary prevention by using the identified risk factors that emanated from the data to inform the focus of primary prevention of drug use among youth in the Western Cape. Prevention can be broadly defined to encompass an array of non-coercive activities intended to prevent, reduce, or delay the occurrence of drug-taking or associated complications, such as drug dependence (SAMHSA, 1998). A number of possible factors exist that might be manipulated to prevent or reduce substance abuse among the youth. Many deliberate prevention activities are based on the expectation that altering one, or more, of these factors might result in reduced substance use (Mann, 2003; NIDA, 1997). A wide assortment of modalities, delivery schedules, and targeting mechanisms are usually used to alter these factors.

The following paragraphs provide some guidelines for primary prevention programmes that could be considered. These programmes provide recommendations for primary prevention, as well as family intervention, and describe some of the more common prevention modalities that could be introduced in the school and broader community settings. Based on a taxonomy for a national study of delinquency prevention in schools (Gottfredson, Gottfredson, Czeh, Cantor, Crosse & Hantman, 2000), it is apparent that these modalities are neither exhaustive, nor evaluative, but instead, are intended to provide a sense for the variety of different activities that can be, and are, undertaken for the purposes of preventing, or reducing substance use.

However, while these options are presented, it is important to note that it would not be possible to target all the identified risk factors in the various domains of the adolescents, as some are proximal and others more distal. In addition, it is unrealistic to think that all risk factors are amenable to change in the near future. The previous section (7.3) provides a brief summary of the main findings and areas of risk for the participants in this study. The next section (7.5) comprises some guidelines to possible programmes and strategies, which may be considered, with a focus on the risk factor domains that emanated from the findings of this study, as well as the main areas of risk that need to be addressed in the lives of young persons.

7.5. Guidelines for prevention strategies

Drug use and abuse among youth is a complex phenomenon that occurs simultaneously on a variety of systemic levels; therefore, a flexible and multi-theoretical approach is recommended for the prevention thereof. Many risk factors were identified on multiple levels, but not all risk factors are amenable to immediate change, for example, the socio-economic status, community norms and culture, such as the prevalence of gangsterism and drug use in the broader society. In this study, factors within the family systems, such as family functioning, ineffective parenting styles, parental substance abuse, deficient parent-child relationships, and low school bonding, are identified to be the key drivers of substance abuse in the lives of the participants.

On the individual level, factors such as social skills building (which include opportunities for learners to learn and practice improved coping mechanisms) and building learners' self-esteem, can be incorporated in the life-skills curriculum, as a universal programme for learners at school. Changing favourable attitudes to drug use and delaying the age of onset of use should be considered, which would mean that schools, as well as neighbourhoods and other role players should find ways to involve learners in pro-social activities and programmes.

Family factors, such as parenting training and support, with a particular emphasis on parent-child bonding/connectedness, and strengthening family functioning and processes, such as parental/care-giver monitoring of children, should be considered as key indicators for change. It is also of vital importance that these key indicators for change are considered by all stakeholders, including the drug users and their families, friends/neighbourhood, school officials, therapists, programme planners, policy makers and the larger society alike. Consistent with many previous studies, the family factors in this study are considered the most primary and significant risk factors to impact on the lives of the young drug users. Parents, families and extended families are recognised by research to have a very significant impact on the adolescent's intention to use, as well as actual use of drugs. As the child matures and attends school, the school and community environmental factors have more impact. Eventually, peer influences predominate, becoming the final common pathway to alcohol and drug use in youth (Kumpfer *et al.*, 2003). Consistent with the literature (Lezin *et al.*, 2004), young adolescents in this study recognised the family as a very powerful influence

on their lives. Therefore, if family is such a powerful influence, it follows that the messages directed to youth, most certainly need to come from the source that they are mostly influenced by, namely, their family. Many parents are unaware of how their parenting styles, or their own drug-taking behaviours, influence their children's decisions to use drugs.

Prevention programming, therefore, should send the family, including the youth, a message that has the following important components:

- The family is the most important factor in a child's intention to use drugs, selection of friends (who may or may not use drugs), and the decision to use (or not use) drugs. In addition, when parents monitor the behaviour of youth and use good communication patterns, the youth are less likely to use drugs.
- Using alcohol and other drugs could cause serious health related problems for youth. These substances affect the way they think, the decisions they make, and disable their capacity for good judgment. When young people start using drugs, they are at risk for other anti-social behaviour, including dropping out of school and criminal activities.
- The fewer substances parents use, the fewer substances their children are likely to use; the more love, attention and care parents offer their own family and other children, the stronger the resiliency factors, built into their lives would be (National Institute on Drug Abuse [NIDA], 1998. *Adapted from: Parenting IS Prevention Training of Trainers Workshop, 1998, SAMHSA Office of National Drug Control Policy*).
- The core assumption of the bio-psychosocial model of substance abuse (referred to as the bio-ecological framework) is that the individual's behaviours are mainly the result of socialisation/environmental factors and that in order to change the behaviour, society needs to change the social systems that shape it. From this study (and other research), it is clear that children need adults – preferably a mother and a father, who are constant, reliable, responsible, and mentally healthy figures in their lives. Unfortunately, this was not the case for most of the participants in this current study; biological fathers were absent and uninvolved; stepfathers were mainly substance abusers, with strained, or abusive, interfamilial relationships; stressors of family disruption and marital conflict led to a loss of a healthy mother/caregiver-child relationship. The interplay of anti-social peer and neighbourhood influences, all heighten adolescents' vulnerability for drug use.

According to Maseko, Ladikos and Prinsloo (2003), addressing root causes of conditions that put young people at risk for drug abuse should be considered the best long-term solution to the problem. Consistent with previous studies (Kumpfer & Bayes, 1995; Lezin *et al.*, 2004), this current study has highlighted the close relationship of adolescent substance abuse with family functioning factors. The researcher concludes that the parent-child relationship, as well as parenting practices and styles have a significant impact on the adolescent's drug-taking decisions.

Substance abuse prevention planning should take into account that:

- The family, as previously mentioned, is the most important factor that influences a child's intention to use drugs, select friends (who may or may not use drugs), and decide to use (or not use) drugs. In addition, parents should monitor the behaviour of youth and use good communication patterns, in order to reduce and prevent the likelihood of youth starting to use drugs.
- Parents need to increase their parent-school interactions and collaborate with schools to monitor their children's activities and school performance. They should also seek collaborations with schools to provide drug-education and awareness for learners and parents at a school level.
- Parents could also seek ways to involve their children in pro-social peer involvement, such as church and youth group involvement by parents and young people.
- There are many reasons (other than family) why youth may use substances. Certainly, most adolescents with serious drug use problems have multiple risk factors and few protective factors at work in their lives. Successful intervention programmes must recognise this fact, and address all the domains – individual, family, school, peer and community – that can help to ameliorate risk factors and accentuate the resiliency and protective factors for each individual. Some examples of how other domains in their lives, such as the peer/school and neighbourhood settings, can be strengthened are outlined below:
 - a) On the *individual level* adolescents, who are vulnerable to drug use, seem to lack self-esteem and pro-social coping skills.
 - b) In the *family system*, it appears that three major aspects of family interactions enhance self-esteem and pro-social coping skills:

- family attachment, bonding, and affective relationships;
 - guidance through supervision and support in making good friends; and
 - the transmission of norms and skills through discussions and positive role modelling.
- c) *Schools* could provide increased life-skills training for learners, in general, to teach coping skills, negotiation and personal problem-solving skills that could build a sense of competence, and boost the self-esteem of the learners. The research shows that learners, who are most vulnerable to substance abuse, are those who are exposed to multiple risk factors within their family and other social systems. Schools could ensure that a social worker is available, when ‘at-risk’ youth are identified, so that appropriate individual therapies can be provided to help adolescents reduce their risk and improve their psychosocial functioning.

7.6. Family assistance and support

A good starting point to build protective factors into the family system is to offer school and community-based drug awareness/prevention training and support groups for parents in a school, or faith-based, setting. In addition, an appropriate parental skills-training programme could be offered by trained volunteers within the church and other faith-based organisations. The United Nations (UN, 2011) has been working for many years to support good practice and have identified what works in different prevention settings, including the evidence-based family skills training programme and the Drug education training strategies.

7.7. Family interventions as prevention strategies

It is clear from many reviews of both risk and protective factors that the substance use of youth is affected by a huge number of interacting influences (Challier, Chau, Predine, Choquet & Legras, 2000; McIntosh, Gannon, McKeganey & MacDonald, 2003; Spooner, 1999). In addition, it is clear from the above research that, although there are many other influences, the factors associated with the family are highly important. This has huge implications for interventions aimed at preventing substance use of adolescents. Drug

prevention has been traditionally sub-categorised into *primary* (direct prevention), *secondary* (early identification and treatment) and *tertiary* prevention (treatment). More recently, three new categories of intervention have been identified as, *universal* (whole population approaches), *selective* (targeted at identified high-risk groups) and *indicated* (early intervention with at risk groups showing early evidence of problems, but who have not sought help) (Cuijpers, 2003).

The focus of this current study was to look at the implications for the *primary* (and most direct) prevention of substance abuse, with the focus on a *universal*, or a whole population, approach to prevent substance abuse among youth. Cuijpers' (2003) review of 30 years of drug prevention activity identified five key areas to be considered for prevention work:

- school-based prevention programmes;
- working with parents;
- working with professionals, who work with drug users;
- working more holistically, by involving schools, parents and the wider community; and
- mass media campaigns.

Cuijpers' (2003: p. 7) review suggests, "family-based drug prevention programs are a promising new area of drug prevention".

7.7.1. Family training

Velleman, Mistral and Sanderling (2000) argue that drug prevention work, involving parents, needed to equip parents with three types of skills, namely:

- parenting skills to develop family cohesion, clear communication channels, high-quality supervision and the ability to resolve conflicts;
- substance-related skills, providing parents with accurate information and highlighting the need to model the attitudes and behaviour they wish to impart; and
- confidence skills to enable parents to communicate with their children about drugs.

This category includes efforts to alter family management practices, or to build parenting skills, in general, through instruction, or training. These activities often teach parents the skills to monitor, or supervise, their children, increase emotional attachments, help their children succeed in school, or otherwise assist their children in the development of skills and competencies that will be needed to avoid substance use. An example of such a programme is the *Strengthening Families Program* (SFP) (Kumpfer *et al.*, 1998; Molgaard & Spoth, 2001).

SFP 10-14 is a programme for families with young adolescents that aims to enhance family protective and resiliency processes, in order to reduce family risk, related to adolescent substance abuse and other problem behaviours. The programme includes separate parent and child skills building. It includes family sessions, where parents and children practice the skills they have learned independently, work on conflict resolution and communication, as well as engage in activities to increase family cohesiveness and the positive involvement of the child in the family. Parents are taught how to clarify expectations (based on child development norms of adolescent substance use), use appropriate disciplinary practices, manage strong emotions regarding their children, and use effective communication. Children are taught refusal skills to deal with peer pressure, and other personal, as well as social interactional skills.

Most of the studies cited above have been of parents and families from within the general population, which is considered primary prevention. Some other programmes, however, work with families, who are very high risk - usually ones where the parents themselves have serious substance misuse problems. An example of such an intervention is 'Focus on Families', which aims to reduce risk of relapse in the parents, as well as use of substances by the children (NIDA, 2003). Other popular family intervention programmes include 'Preparing for the Drug Free Years' (Kosterman, Hawkins, Haggerty, Spoth & Redmond, 2001).

7.7.2. Programme effects on Risk and Protective Factors

Foxcroft, Ireland, Lister-Sharp, Lowe and Breen (2003) conducted a systematic review of primary psychosocial and education-based alcohol misuse prevention programmes among young people. The Strengthening Families Programme was the only programme that demonstrated effectiveness on any level, and this was revealed, particularly in the

long-term cases (more than three years). There were marked improvements in intervention-targeted parenting behaviours, which, in turn, had significant effects on parent-child affective quality, as well as general child management, at post-test and thereafter.

7.8. School/community based interventions

In this section, the researcher reviews some school/community-based social approaches to prevent drug abuse among youth, as well as reduce drug use among youth, who are not seriously involved with drugs yet. They include efforts to *educate* young people about the consequences of substance use and to change their beliefs about the acceptability, or utility, of substance use on the lives of young people.

7.8.1. Classroom instruction

According to UNICEF (2003), this is the most common strategy used in schools. The content of these interventions vary, but they can be grouped into three main classes:

- Information-only interventions teach students factual information about drugs and the consequences of use;
- Skills-building interventions increase students' awareness of social influences to engage in misbehaviour, and to expand their ranges to recognize and appropriately respond to risky or harmful situations.
- Normative education interventions change perceptions of the norms related to substance use.

Many instructional programmes contain different mixes of these three types. According to Gottfredson *et al.* (2000), the most effective of these instructional programmes use methods referred to as cognitive-behavioural or behavioural-instructional methods, which rely on modelling, rehearsal and coaching, in the performance of new skills.

7.8.2. Recreational, community service, enrichment, and leisure activities

The above activities are intended to provide constructive and fun alternatives to drug use. It includes drop-in recreation centres, after-school and weekend programmes, community service activities, dancing and sports, as well as other events that provide alternatives to riskier activities (Gottfredson et al. 2000).

7.8.3. Exclusion of intruders and contraband

These interventions are designed to prevent intruders (who might be drug dealers) from entering the school. They include the use of identification badges, visitor's passes, security personnel posted at school entrances, locks, cameras, and other surveillance methods. They also include efforts to prevent contraband from entering the school, such as random drug searches and drug-sniffing dogs.

7.8.4. Mass media campaigns

These efforts are most often aimed at changing norms regarding drug use, by demonstrating negative consequences for use, positive consequences for non-use, changing opinions about the prevalence of use, or the types of people who use, and increasing skills for resisting drugs. Media avenues might include the use of posters, newspapers, radio and television, as well as collaborations with the entertainment industry, music videos, or interactive media. Reducing pro-drug media messages is also included in this category of prevention activity.

7.8.5 Social approaches to prevention

The underlying conceptual framework for social approaches to prevention is that adolescents begin to smoke, drink, or use drugs either because they succumb to the persuasive messages targeted at them, or because they lack the necessary skills to resist social influences to indulge. The theoretical foundation for these prevention approaches is based on Bandura's Social Cognitive Theory (Bandura 1977) and Jessor's Problem Behavior Theory (Jessor & Jessor, 1977). Drug abuse is conceptualised as a socially learned and functional behaviour, which is the result of the interplay between social (interpersonal) and personal (intrapersonal) factors. Drug use behaviour, therefore, is learned through a process of modelling, imitation and reinforcement, and is influenced by an adolescent's cognitions, attitudes and beliefs.

Although social influence approaches are important because they recognise the role social factors play in the etiology of drug abuse, they have been criticised, because they do not pay sufficient attention to the intrapersonal factors involved in the etiology of drug use and abuse (Botvin & Botvin, 1992). They may be more comprehensive than either informational/educational approach; however, they may still be based on a

narrow understanding of the drug abuse etiology. They may also fail to appreciate fully, the array of etiologic factors, under the social influence model. These approaches also largely ignore the fact that there may be multiple developmental pathways leading to drug abuse, as in the case of the young drug abusers in this study.

Many risk factors in the family, peer, school and community were identified and highlighted in this study. Although some of the most significant risk factors were found to be present in the lives of the young drug users in this study, social influences may be the most potent factors promoting drug use for some individuals, while intrapersonal factors may be more important for others. For example, using drugs may not be a simple matter of yielding to peer-pressure for some adolescents, but it may be instrumental in helping them deal with anxiety, low self-esteem, or a lack of comfort in social situations. To the extent that this is correct, prevention approaches need to go beyond the social influences model of interventions, to broader based and more comprehensive ways of drug abuse prevention among the youth.

A most recent literature review on Drug and Substance Abuse among youth and young women in South Africa, commissioned by the Soul City Institute for Social Justice was just released (Ndondo, 2016). The findings show that about “close to 10% of South Africa’s children are abusing drugs before they turn 13” and that children’s drug of choice was cannabis (Mapumulo, 2016: p. 11). These findings are consistent with the participants in this study whose mean age of onset was about the age of 14, and their drugs of choice were cannabis and methamphetamine. The statistics are unsettling, as drug use/abuse has devastating and life-long consequences on the young developing brain. This study, therefore, is significant in adding to the body of literature on drug abuse among youth, as it unraveled some of the immediate and more indirect reasons, as well as the risk factors at play in the lives of young people in the Western Cape of South Africa.

7.9. Recommendations for future research

Further study that explores the role of multi-level influences, such as internal (individual) and external (social) factors for drug use, is recommended in the field of substance abuse. The degree to which, and the manner in which, these issues are addressed at different treatment

facilities in South Africa should also be explored. Although not many of the participants in this current study cited the absence of their biological fathers as a reason for their drug-use, it was quite a significant finding that very few of the adolescents in the blended family systems had any contact with their biological fathers, since they were very young. Future research should explore the role of the absent or uninvolved father figures in the lives of young adolescent drug users.

Multi-wave, contextually sensitive, longitudinal research is necessary to improve the understanding of how substance use fits into young people's lives, particularly during adolescence and young adulthood, when pervasive individual and contextual change is the backdrop. According to Zucker (2000), knowing an individual's substance use at only one or two points in time, relates very little about its developmental pathways, causes and consequences. Indeed, following the same individual's substance use over several occasions, whether as part of an etiologic study, or intervention evaluation (or both), represents the best strategy for effectively addressing the most important questions about substance use etiology and intervention (NIDA, 1997).

More research is needed to be able to better address substance abuse among young people in South Africa. For example, a search of the South African literature revealed a dearth of research that identifies protective factors (factors that buffer risk) for substance use. Of special significance, will be future investigations that could explore and identify mediating and moderating mechanisms for substance use among young people. In addition, more research should be conducted to explore the contexts of the personal and family protective factors for adolescent substance use in low socio-economic communities and test the individual and family resilience theory. Discovering these influencing factors (both risk- and protective) would decrease the probability of an individual using drugs, would once again pinpoint areas one could focus on with interventions, which would empower those in need of intervention, as opposed to educating only. A determination should also be done on evidence-based "best practices" for the primary prevention, as well as the treatment of substance abuse among adolescents in South Africa.

7.10. Constraints and limitations of the study

Although a mixed methodology was used to satisfy the aims of this study, the study was predominantly embedded within a qualitative design. It is widely accepted that the purpose of qualitative research is not to test hypotheses, but is often a necessary precursor not only to design meaningful questions, but also to generate future research questions (Carlson, Siegal & Falck, 1995). In addition, it is often the only means of gathering sensitive information about the way people perceive their worlds, and attribute meaning to their actions and behaviour. Consequently, a purposive sample of 41 drug abusers from five drug rehabilitation centres in Western Cape participated in this current study. Therefore, it should be noted that this approach and findings cannot be compared with existing quantitative findings, nor can it claim to represent population studies as a whole.

In addition, while the researcher cannot be certain that the self-reported reasons provided will be the cause for the behaviour, the findings do suggest that they are ‘perceived’ to be the cause of the problem, and, therefore, at the very least, it can be identified as risk factors at work in their lives. The researcher was only able to locate four female drug users in this study. More research should be done to whether gender differences exist in the reasons and risk factors for drug use. Additionally, due to the advances in neuroscience, many neurological reasons can now be attributed to why certain people are more susceptible than others are to drug use/abuse. These may include children suffering from genetic conditions, such as Attention Deficit Hyperactivity Disorders (ADHD) and other neurological predispositions. The scope of this study did not allow for the examining of these biological risk factors, and further research on the genetic factors for drug abuse should be considered, from a South African perspective with all of its socioeconomic and other challenges that young people are exposed to, which put them at risk for drug abuse.


7.11. Conclusions

Although limited in scope, this study presents a subjective understanding of the perceived reasons and risk factors for the problem of drug use among young people. Findings from the various significant individual/psychological and social factors that influence and perpetuate substance-using decision-making among youth were presented and discussed. The main results occurred within the family and school/community systems of the young drug users. This study was important and contributed to the understanding of drug abuse among youth, as

the level of substance use is on the increase among young South Africans, and remains a growing cause for concern, particularly due to its contribution to health and social problems, such as school dropout, gangsterism and crime.

To address substance abuse problems among young people effectively, it is important to recognise that their life-situations are complex and multi-faceted, which requires a holistic approach to drug use into current substance-related programmes. Further study in this area needs to be prevention. It was argued that prevention strategies and programmes should not only include knowledge and skills training within the school domain, but should also focus on strengthening the family and community systems of young people at risk for substance abuse. The implications and recommendations of this study reflect pertinent observations and understandings that emerged from this process and could be incorporated into future research, or implemented in order to identify protective factors and find ways in which to provide more effective prevention strategies for the growing numbers of drug using youth.

In summary, the results from this study contribute to the body of knowledge of substance abuse among youth. The contribution of this thesis is six-fold:

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- ❖ it puts a voice to the young drug user, as it focuses on the reasons provided for drug use from their own perspective;
 - ❖ it provides the demographic, individual, familial, and contextual factors at play in their lives;
 - ❖ it explores the precursors and unravels the inter-related environmental factors that put them at risk for drug-taking behaviours;
 - ❖ it uses the identified areas of risks to inform recommendations for the focus of primary prevention efforts;
 - ❖ it contributes to theory-building, as it identifies a crucial gap in Bronfenbrenner's theory, namely, the concept of individual and family resilience as protective factors for drug use; and
 - ❖ it contributes to primary prevention efforts as it highlights the need to investigate the factors that protect young people from starting drug use in the first place.

REFERENCES

- Adhikari, M. (2006) Hope, Fear, Shame, Frustration: Continuity and Change in the Expression of Coloured Identity in White Supremacist South Africa, 1910–1994, *Journal of Southern African Studies*, 32(3), 467-487, DOI: 10.1080/03057070600829542
- Alberta Alcohol and Drug Abuse Commission (AADAC). (2003). *AADAC Profile: Youth Risk and Protective Factors*. An Agency of the Government of Alberta.
- Amato, P.R. (2005). The impact of family formation change on the cognitive, social, and emotional well-being of the next generation. *Future of Children*, 15, pp. 75-96.
- Amoateng, A.Y., Barber, B.K. & Erickson, L.D. (2006). Family predictors of adolescent substance use: the case of high school students in the Cape Metropolitan Area, Cape Town, South Africa. *Journal of Child and Adolescent Mental Health*, 18(1), pp. 7-15.
- Amoateng, A.Y., Richter, L.M., Makiwane, M. & Rama, S. (2004). Describing the structure and needs of families in South Africa: Towards the development of a national policy framework for families. A report commissioned by the Department of Social Development. Pretoria: *Child Youth and Family Development, Human Sciences Research Council and Human Development*, 51(1), pp. 5-29.
- Anderson, E. (1991). *Neighborhood effects on teenage pregnancy*. In C. Jenks and P.E. Peterson (eds.). *The Urban Underclass*. Washington, DC: The Brookings Institution, pp. 375-398.
- Arnett, J.J. (2002). *Adolescence and emerging adulthood: A Cultural Approach*. Upper Saddle River, New Jersey: Prentice Hall.
- Bahr, S.J., Hoffman, J.P. & Yang, X. (2005). Parental and Peer Influences on the Risk of Adolescent Drug Use. *Journal of Primary Prevention*, 26(6), pp. 529-551.

Bain, K. (2004). *Chased by the Dragon: The experience of relapse in cocaine and heroin users*. Unpublished Master's Thesis. University of Pretoria.

Bandura, A. (1977). *Social Learning Theory*. Englewood Cliffs, NJ: Prentice-Hall.

Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Englewood Cliffs, NJ: Prentice-Hall.

Bandura, A. (1999). A Socio-cognitive analysis of substance abuse: An argentic perspective. *Psychological Science*.10(3). [Online] Available: <http://www.google.com> [Accessed 15 August 2010].

Barber, B.K. (1992). Family, personality, and adolescent problem behaviors. *Journal of Marriage and the Family*, 54, pp. 69-79.

Barber, B.K. (1996). Parental psychological control: revisiting a neglected construct. *Child Development*, 67(6), pp. 3296-3319.

Barnes, T. (2000). *The Impact of HIV/AIDS on the University of the Western Cape*. Association for the Development of Education in Africa.

Barrett, D. [ed]. (2011). *Children of the Drug War Perspectives on the Impact of Drug Policies on Young People*. USA: IDEBATE Press.

Baumrind, D. (1991). The influence of parenting styles on adolescent competence and substances. *Journal of Early adolescence*, 11(1), pp. 58-95.

Berk, L.E. (2010). *Development through the life span*.5th Ed. Boston, MA: Allyn & Bacon.

Biglan, A., Duncan, T.E., Ary, D.V. & Smolkowski, K. (1995). Peer and parental influences on adolescent tobacco use. *J Behav Med* 8(4), pp. 315-330

Blum, R.W., Beuhring, T.W., Shew, M.L., Bearinger, L.H., Sieving, S.E. & Resnick, M.D. (2000). The effects of race/ethnicity, income, and family structure on adolescent risk behaviors. *American Journal of Public Health*, 90, pp. 1879-1884.

Blum, R. (2007). Youth in Sub-Saharan Africa. *Journal of Adolescent Health*, 41, pp. 230-238

Boemmel, J. & Briscoe, J. (2001). *Web quest project theory fact sheet of Urie Bronfenbrenner*. National Louis University. Retrieved 10 October 2011. Available online: <http://pt3.nl.edu/boemmelbriscoewebquest.pdf>.

Bogenschneider, K. & Pallock, L. (2008). Responsiveness in parent-adolescent relationships: Are influences conditional? Does the reporter matter? *Journal of Marriage & Family*, 70, pp. 1015-1029

Bogenschneider, K., Small, S. & Riley, D. (1994). *An Ecological, Risk-focussed approach for addressing youth-at-risk issues*. Winconsin: University of Winconson-Madison.

Botvin, G.J. & Botvin, E.M. (1992). *School-based and community-based prevention approaches*. In J. Lowinson, P. Ruiz & R. Millman (eds.), *Comprehensive textbook of substance abuse* (pp. 910–927). Baltimore: Williams & Wilkins.

Bourdeau, B., Miller, B.A., Duke, M.R. & Ames, G.M. (2011). Parental strategies for knowledge of adolescents' friends: distinct from monitoring? *Journal of Child and Family Studies*. 20(6), pp. 814-821.

Bowlby, J. (1980). *Attachment and loss, Vol. III. Loss, sadness and depression*. New York: Basic Books.

Boys, A., Marsden, J. & Strang, J. (2001). Understanding reasons for drug use amongst young people: a functional perspective. *Health Education Research*, 16(4), pp. 457-69.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3 (2), pp. 77-101. ISSN 1478-0887 Available from: <http://eprints.uwe.ac.uk/11735>

Bronfenbrenner, U. (1979). *The Ecology of human development: Experiments by nature and design*. Cambridge: Harvard University Press.

Bronfenbrenner, U. (1989). *Ecological systems theory*. In R. Vasta (ed.), *Annals of child development* (6), pp. 187-249). Greenwich, CT: JAI Press.

Bronfenbrenner, U. (1994). *Ecological models of human development*. In M. Gauvain & M. Cole (Eds.), *Readings on the development of children*, 2nd edition. New York, NY: Freeman, pp. 37-43.

Bronfenbrenner, U. (ed). 2005. *Making human beings human: Bio-ecological Perspectives on human development*. California: Sage publications.

Bronfenbrenner, U. & Morris, P.A. (1998). *The ecology of developmental processes*. In R.M. Lerner (ed.). *Handbook of child psychology: Vol. 1, Theoretical Models of Human Development* (5th ed). New York: Wiley.

Brook, J.S., Brook, D.W., De La Rosa, M., Whiteman, M., Johnson, E. & Montoya, I. (2001). Adolescent illegal drug use, the impact of personality, family, and environmental factors. *Journal of Behavioral Medicine*. 24(2), pp. 183-203. [PubMed]

Brook, J.S., Brook, D.W., Morojele, N.K. & Pahl, T. (2006). Predictors of Drug Use Among South African Adolescents. *Journal of Adolescent Health*. 38 (1), pp. 26-34.

Brook, J.S., Brook, D.W., Whiteman, M., Gordon, A.S. & Cohen, P. (1990). The psychosocial etiology of adolescent drug use and abuse. *Genet Soc Gen Psychol Monogr*. 116 (2), pp. 111-267. [PubMed]

Brounstein, P.J. & Zweig, J.M. (1999). *Understanding Substance abuse prevention, Toward the 21st Century: A Primer on Effective Programs*. Department of Health and Human Services Publication No: (SMA) 99-3301, Washington DC: Government Printing Office.

Byrne, M. (2001). Understanding life experiences through a phenomenological approach to research. *AORN Journal*. [Online]. Available at: <http://www.findarticles.com/p/articles/mi> [Accessed April 06, 2009].

Carlson, R., Siegal, H. & Falck, R. (1995). *Qualitative research methods in drug abuse and AIDS prevention research: An overview* [Online]. Available: www.wright.edu [2010, May 3]

Cavanagh, S. & Huston, A. (2006). Family instability and children's early problem behavior. *Social Forces*, 85(1), pp. 551-581.

Challier, B., Chau, N., Predine, R., Choquet, M. & Legras, B. (2000). Associations of family environment and individual factors with tobacco, alcohol and illicit drug use in adolescents. *European Journal of Epidemiology*, 16(1), pp. 33-42.

Chesang, R. (2013). Drug abuse among the youth in Kenya. *International Journal of Scientific & Technology Research*, 2(6), pp. 126-219.

Chetty, R (2015). Social complexity of drug abuse, gangsterism and crime in Cape flats' schools, Western Cape. *Acta Criminologica: Southern African Journal of Criminology Special Edition No 3/2015*: 54-65. Illicit Drugs: international and local realities.

Cloete, A. (2014). Social cohesion and social capital: Possible implications for the common good. *Verbum et Ecclesia*, 35(3), 1-6. <https://dx.doi.org/10.4102/VE.V35I3.1331>

Creswell, J.W. (2009). *Research design. Qualitative, quantitative and mixed methods approaches (3rd ed)*. California: Sage Publications Inc.

Creswell, J.W. (2014). *Research design. Qualitative, quantitative and mixed methods approaches (4th ed)*. California: Sage Publications Inc

Cuijpers, P. (2003). Three Decades of Drug Prevention Research. *Drugs: Education, Prevention and Policy*, 10(1), pp. 7-20.

Dada, S., Harker N., Erasmus, J., Parry, C., Bhana, A., Timol, F., Wilford, A., Fourie, D., Kitshoff, D., Nel, E., Weimann, R. & Johnson, K. (2014). The South African Community Epidemiology Network on Drug Use (SACENDU): Monitoring Alcohol and Drug Trends in South Africa - January to June 2013, (Phase 34), *SACENDU Research Brief*, 16(2), pp. 1-16. Retrieved on April, 2014 from http://www.sahealthinfo.org/admodule/sacendu/2013-Dec-Update_Final.pdf

Dada, S., Harker, N., Burnhams, N.H., Erasmus, J., Parry, C., Bhana, A., Timol, F., Nel, E., Kitshoff, D., Weimann, R., Fourie, D. (2016). *The South African Community Epidemiology Network on Drug Use (SACENDU) Monitoring Alcohol, Tobacco and Other Drug Abuse Treatment Admissions in South Africa*. February 2016: January - June 2015 (Phase 38). [Onl Available from: <http://www.mrc.ac.za/adarg/sacendu/SACENDUFullReportPhase38.pdf> [Accessed 12 August 2016]

Darling N, Steinberg L. (1993). Parenting style as context: An integrative model. *Psychological Bulletin*, 113, pp. 487-496.

Davids, E.L. & Roman, N.V. (2013). Does family structure matter? Comparing the life goals and aspirations of learners in secondary schools. *South African Journal of Education*, 33(3), 1-12.

Davids, E.L., Roman, N.V. & Leach, L. (2015). The effect of family structure on decision making, parenting styles and healthy lifestyle behaviour of adolescents in rural South Africa. *African Journal for Physical, Health Education, Recreation and Dance*, 21(3:2), pp. 953-967.

Denzin, N.K. & Lincoln, Y.S. (2000). *Handbook of qualitative research* (2nd Ed). California: SAGE Publications.

De Vos, A.S. (ed), Strydom, H., Fouche, C.B. & Delport, C.S.L. (2005). *Research at grass roots for the social science and human service professions* (3rd ed). Pretoria: Van Schaik Publishers.

De Vos, A.S., Strydom, H., Fouche, C.B. & Delport, C.S.L. (eds). (2011). *Research at grass roots for the social science and human service professions* (4th ed). Pretoria: Van Schaik Publishers.

De Wet, C. (2016). The Cape Times's portrayal of school violence. *South African Journal of Education*, 36 (2), pp. 1-12. doi: 10.15700/saje. v36n2a1231

Dishion, T. J. & Kavanagh, K. (2000). A multi-level approach to family-centered prevention in schools: Process and outcome. *Addictive Behaviors*, 25(6), pp. 899-911.

Driscoll, D., Appiah-Yeboah, A., Salib, P., Rupert, D. (2007). Merging Qualitative and Quantitative Data in Mixed Methods Research: How To and Why Not. *Ecological and Environmental Anthropology* (University of Georgia). Paper 18. Available: <http://digitalcommons.unl.edu/icwdmeea/18> [Accessed 6 August 2016].

Dull, R. (1983). Friends' Use and Adult Drug and Drinking Behavior: A Further Test of Differential Association Theory. *Journal of Criminal Law & Criminology*.4(74), pp. 1608-1619. [Online]. [Accessed 06 November 2015]. Available from: <http://scholarlycommons.law.northwestern.edu/cgi/viewcontent.cgi?article=6411&context=jcl>.

Etheridge, J. Herman, P. & Evans, J. (2016). *Crime stats 2016: 'The stuff of nightmares'*. News24, 02 September, 2016. [Online]. Available: <http://www.news24.com/SouthAfrica/News/crime-stats-2016-the-stuff-of-nightmares20160902>

Erikson, E. (1950). *Childhood and Society*. New York: Norton.

Erikson, E. (1968). *Identity: Youth and Crisis*. New York: Norton.

Erikson, E.H. (1975). *Life History and the Historical Moment*. New York: Norton.

Erol, R. & Orth, U. (2011). Self-Esteem Development from age 14 to 30 Years: A Longitudinal Study. *Journal of Personality and Social Psychology*, 101(3), pp. 607-619.

European Monitoring Centre for Drugs and Drug Addiction [EMCDDA]. (1998). Annual report on the state of the drugs problem in the European Union. Lisbon: EMCDDA. [Online]. [Accessed 15 September 2015]. Available from: http://www.emcdda.europa.eu/system/files/publications/142/AR98HighlightsEN_69777.pdf

Florence, M. & Koch, E. (2011). The difference between adolescents and non-users of addictive substances in a low socio-economic status community: contextual factors from the perspective of subjective well-being. *South African Journal of Psychology*, 41(4), pp. 477-487.

Fomby, P. & Cherlin, A.J. (2007). Family instability and child well-being. *American Sociological Review*, 72(April), pp. 181-204.

Fountain, J. (2004). *The GAP Toolkit Module 6. Focus Assessment studies: A Qualitative approach to data collection*. Vienna: United Nations Office on Drugs and Crime.

Foxcroft, D.R., Ireland, D., Lister-Sharp, D.J., Lowe, G. & Breen, R. (2003). Longer-term primary prevention for alcohol misuse in young people: a systematic review. *Addiction*, 98, pp. 397-411.

Frederick, L. (2010). *Older relatives raising adolescents: The relationship between age of caregiver and youth delinquent acts. Presentation paper at the 9th Global Conference on violence: Probing the boundaries*. US: Texas A&M University – Kingsville

Garbarino, J. & Abramowitz, R. (1992). *Sociocultural risk and opportunity*. In J. Garbarino (ed.), *Children and families in the social environment* (pp. 38-63). New York: Aldine de Gruyter.

Ghuman, S., Meyer-Weitz, A. & Knight, S. (2012). Prevalence patterns and predictors of alcohol use and abuse among secondary school students in southern KwaZulu-Natal, South Africa: demographic factors and the influence of parents and peers. *South African Family Practice*, 54(2), pp. 132-138.

Gilgun, J.F. (2010). Methods for enhancing theory and knowledge about problems, policies, and practice. In Katherine Briar, Joan Orme, Roy Ruckdeschel, & Ian Shaw, *The Sage handbook of social work research*, pp. 281-297. Thousand Oaks, CA: Sage.

Goode, E. (2007). Theories of drug use. *Drugs in American society*, 7th ed. (pp 58-88). Boston: McGraw-Hill. <http://www.docs-engine.com/pdf/1/sociological-theories-of-drug-abuse.html>

Gottfredson, G.D., Gottfredson, D.C., Czeh, E.R., Cantor, D., Crosse, S.B. & Hantman, I. (2000). *National study of delinquency prevention in schools: Summary*. Ellicott City, MD: Gottfredson Associates. [Available: <http://www.gottfredson.com/national.htm>] (Accessed 22 October 2015).

Greydanus, D.E. & Patel, D.R.P. (2005). The adolescent and substance abuse: Current concepts. *Current Problems in Pediatrics and Adolescent Health Care*, 35(3), pp. 78-98.

Griffin, K., Botvin, G. (2010). Evidence-Based Interventions for Preventing Substance Use Disorders in Adolescents. *Child Adolesc Psychiatr Clin N Am*; 19(3): 505–526. doi: 10.1016/j.chc.2010.03.005

Hamdulay, A.K. & Mash, R.J. (2011). The prevalence of substance use and its associations amongst students attending high school in Mitchells Plain, Cape Town. *South African Family Practice (Geneeskunde: The Medicine Journal)*, 53(1), pp. 83-90.

Hanson, W.E., Creswell, J.W., Plano Clark, V.L., Petska, K.S., & Creswell, J.D. (2005). Mixed methods research designs in counselling psychology, *Journal of Counseling Psychology*, Vol. 52, No. 2, 224–235.

Harker, N., Kader, R., Myers, B., Fakier, N., Parry C., Flisher, A., Peltzer, K., Ramlagan, S. & Davids, A. (2008). *Substance abuse trends in the Western Cape: A review of studies conducted since 2000*. Pretoria: Human Sciences Research Council.

Harper Browne, C. (2014). *The Strengthening Families Approach and Protective Factors Framework: Branching out and reaching deeper*. Washington, DC: Center for the Study of

Social Policy. Available: www.cssp.org/reform/strengthening-families. [Accessed: September 30, 2016]

Hawkins, J.D. (1999). Preventing crime and violence through Communities That Care. *European Journal on Criminal Policy and Research* 7, pp. 443-458.

Hawkins, J.D., Catalano, R.F. & Miller, J.Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. *Psychological Bulletin*, 112(1), pp. 64-105.

Hawkins, J.D. & Weis, J.G. (1985). The social development model: An integrated approach to delinquency prevention. *Journal of Primary Prevention*, 6(2), pp. 73-97.

Hengelaar, W. (1999). Multisystemic Therapy: An overview of clinical procedures, outcomes and policy implications. *Child Psychology & Psychiatry Review*, 4 (1), pp. 2-10.

Hoberg, S.M. (2003). The crisis generation: peer influence on adolescent substance abuse. *Educare*, 32(1&2), pp. 240-260. IOL Independent Online News. (2011). [Online] Half of South Africa's youth are unemployed. Available at: <http://www.iol.co.za/news/south-africa/half-of-sa-s-youth-are-unemployed> (June 28, 2013).

Holborn, L. & Eddy, G. (2011). *The first steps to healing the South African family*. South African Institute of Race Relations: Johannesburg.

Home Office (2007) *Identifying and exploring young people's experiences of risk, protective factors and resilience to drug use*. Home Office Development and Practice Report 47. <http://dera.ioe.ac.uk/6904/1/dpr47.pdf> [Accessed 14 October 2013].

Huitt, W. (2003). A systems model of human behavior. *Educational Psychology Interactive*. Valdosta, GA: Valdosta State University. Retrieved [2008-08-13] from <http://chiron.valdosta.edu/whuitt/materials/sysmdlo.html>

Human-Hendricks, A.R., Roman, N.V. & Rich, E. (2015). *The role of parents, society and the state in the development of childhood: A retrospective qualitative study*. In Nicolette V.

Roman (ed.) *Parenting: Behaviors, Cultural Influences and Impact on Childhood Health and Wellbeing*. NOVA Science Publications: New York (ISBN: 978-1-63482-651-8).

Jadidi, N. & Nakhaee, N. (2014). Etiology of Drug Abuse: A Narrative Analysis. *Journal of Addiction*. Volume 2014, Article ID 352835, pp. 1- 6 [Accessed 12 May 2015]. Available: <http://dx.doi.org/10.1155/2014/352835>

Jessor, R. & Jessor, S.L. (1977). *Problem Behavior and Psychosocial Development*. New York: Academic Press.

Jessor, R. (1992). Risk behaviour in adolescence: A psychosocial framework for understanding and action. *Developmental review*, 12, pp. 374-390.

Johnston, L.D., O'Malley, P.M. & Bachman, J.G. (1995). *National survey results on drug use from the Monitoring the Future study, 1975-1994. Volume I: Secondary school students*. (NIH Publication No. 95-4026). Rockville, MD: National Institute on Drug Abuse, 316 pp.

Johnston, L.D., O'Malley, P.M., Bachman, J.G. & Schulenberg, J.E. (2007a). *Secondary school students. Monitoring the Future national survey results on drug use, 1975–2006. Vol. 1*. Bethesda, MD: National Institute on Drug Abuse. (NIH Publication No. 07-6205).

Johnston, L.D., O'Malley, P.M., Bachman, J.G., Schulenberg, J.E. & Bethesda, M.D. (2007b). *National Institute on Drug Abuse: Monitoring the Future national survey results on drug use, 1975–2006; Volume II, College students and adults ages 19-45*. (NIH Publication No. 07-6206).

Johnston, L.D., O'Malley, P.M., Bachman, J.G. & Schulenberg, J.E. (2009). *Monitoring the Future national results on adolescent drug use: Overview of key findings, 2008* (NIH Publication No. 09-7401). Bethesda, MD: National Institute on Drug Abuse.

Kaiser Family Foundation. (2002). *Youth knowledge and attitudes on sexual health: A National survey of adolescents and young adults*. National Centre on Addiction and Substance Abuse (CASA): Columbia University.

Kapp, C. (2008). Crystal meth boom adds to South Africa's health challenges. *The Lancet*, 371(9608), pp. 193-194.

Kellam, S.G. & Anthony, J.C. (1998). Targeting early antecedents to prevent tobacco smoking: findings from an epidemiologically-based randomized field trial. *Am. J. Pub. Health*, 88, pp. 1490-1495.

Kibble, S. (1997). *Drugs and development in South Africa: How Europe could help*. London: CIIR Publications.

Kinnes, I. (2000). *From urban street gangs to criminal empires*. ISS Monograph 48. Pretoria: Institute for Security Studies.

Kosterman, R., Hawkins, J.D., Haggerty, K.P., Spoth, R. & Redmond, C. (2001). 'Preparing for the Drug Free Years': Session-specific effects of a universal parent-training intervention with rural families. *Journal of Drug Education*, 31(1), pp. 47-68.

Kumpfer, K.L. (1987). *Special populations: Etiology and prevention of vulnerability to chemical dependency in children of substance abusers*. In B.S. Brown and A.R. Mills (eds.), *Youth at high risk of substance abuse*. Rockville, MD: National Institute on Drug Abuse. Available from: www.nida.com (Assessed 11 April 2011).

Kumpfer, C. (1999). *Strengthening America's families: Exemplary parenting and family strategies for delinquency prevention*. U.S. Department of Justice: University of Utah.

Kumpfer, K.L., Alvarado, R. & Whiteside, H.O. (2003). Family-based interventions for substance use and misuse prevention. *Substance Use and Misuse*. 38(11-3), pp. 1759-1787.

Kumpfer, K.L. & Bayes, J. (1995). Child abuse and drugs. In: Jaffe, J.H., (ed.). *The Encyclopedia of Drugs and Alcohol*, 1, pp. 217-222. New York: Simon and Schuster Macmillan.

Kumpfer, K.L.; Olds, D.L.; Alexander, J.F.; Zucker, R.A.; and Gary, L.E. (1998). *Family etiology of youth problems*. In: Ashery, R.S., Robertson, E.B., and Kumpfer., K.L. (Eds).

Drug Abuse Prevention Through Family Interventions. NIDA Research Monograph No. 177. Washington, DC: U.S. Government Printing Office, pp. 42–77, 1998. Available from: <https://archives.drugabuse.gov/pdf/monographs/monograph177/monograph177.pdf>. [Accessed 18 September, 2016]

Kumpfer, K.L. & Tala, K. (2009). *Guide to Implementing Family Skills Training Programmes for Drug Abuse Prevention*, pp. 1-52. United Nations Office on Drugs and Crime-Vienna, UN: New York, New York. [Online] Available at: <http://www.C:/Users/admin/Desktop/strengthening%20family-guidelines-E.pdf> [Accessed 18-08-14]

Kumpfer, K.L., Trunnell, E.P. & Whiteside, H.O. (1990). *The biopsychosocial model: application to the addictions field*. In R.C. Engs. (ed). *Controversies in the addiction field*. Available from <http://www.indiana.edu/~engs/cbook/chap7>. [Accessed 08 September, 2010]

Kumpfer, K.L. & Turner, C.W. (1990-1991). The Social Ecology Model of Adolescent Substance Abuse: Implications for Prevention. *The International Journal of the Addictions*, 25(4a), pp. 435-463.

Ladikos, A. & Neser, J. (2003). An opinion survey on teenage substance abuse indicators: An application of the chaid analysis. *Acta Criminologica*. 16 (5), pp. 161-172.

Langa, M., Masuku, T., Bruce, D. & Van der Merwe, H. (2016). Facilitating or hindering social cohesion? The impact of the Community Work Programme in selected South African townships. *South African Crime Quarterly*, 0 (55): 41-48. Available from doi: <http://dx.doi.org/10.17159/2413-3108/2016/v0i55a159>.

Larson, J., Lochman, J.E. (2002). *Helping school children cope with anger: A cognitive-behavioural intervention*. New York: Guilford Press.

Leather, N. (2009). Risk-taking behaviours in adolescence: a literature review. *Journal of Child Health Care*. 3(3):295-304. doi: 10.1177/1367493509337443.

Leggett, T., Louw, A. & Parry, C.D.H. (2002). *Implications for drugs policy*. In Leggett T (ed), *Drugs and Crime in South Africa: A Study in Three Cities*. ISS Monograph No. 69, Pretoria, pp. 43-47.

Leoschut, L. (2009a). *Snapshot results of the CJCP 2008 National Youth Lifestyle Study*. Research Bulletin no. 3, September 2009.

Leoschut L, (2009b). *Running Nowhere Fast: Results of the 2008 National Youth Lifestyle Study*. Centre for Justice and Crime Prevention. CJCP Monograph No 6, Cape Town, 2009

Lezin, N., Roller, L., Bean, S. & Taylor, J. (2004). *Parent-Child connectedness: Implications for research, interventions and positive impacts on adolescent health*. Santa Cruz, CA: ETR Associates.

Liamputtong, P. (2011). *Focus Group Methodology: Principle and Practice*, SAGE Publications Ltd.

Lo, C.C. & Globetti, G. (2000). Gender differences in alcohol beliefs and usual blood-alcohol concentration. *Journal of Child and Adolescent substance abuse*, 9(3), p. 15.

Louw, A., Louw, D. & Ferns, I. (2007). In Louw, D. & Louw, A. (eds.). *Child and Adolescent Development*, p. 413. University of the Free State.

Louw, D.A., Van Ede, D.M., Louw, A.E. (1988). *Human Development*. (2nd ed.). Cape Town: Kagiso Tertiary

Madu, S.N. & Matla, M.Q.P. (2003). Illicit drug use, cigarette smoking and alcohol drinking behaviour among a sample of high school adolescents in the Pietersburg area of the Northern Province, South Africa. *Journal of adolescence*, 26(1), p. 121.

Maggs, J., Frome, P., Eccles, J. & Barber, B. (1997). Psychosocial resources, adolescent risk behavior and young adult adjustment: Is risk taking more dangerous for some than others? *Journal of Adolescence*, 20, pp. 103-119.

Mann, A. (2003). *Relationships matter: Impact of parental peer factors on teen, young adult substance abuse*. Available from: http://www.drugabuse.gov/NIDA_notes/NNVoll8N2/Relationships. [Accessed: 6 June 2010].

Maree, K. (Ed.) (2007). *First steps in research*. Pretoria: Van Schaik.

Mapumulo, Z. (2016). *Young kids crave dagga*. Cape Town: City Press, 13 November 2016. page 11 Available: <http://www.news24.com/SouthAfrica/News/young-kids-crave-dagga-20161112>

Marks, D.J., Miller, S.R., Schulz, K.P., Newcorn, J.H., & Halperin, J.M. (2007). The interaction of psychosocial adversity and biological risk in childhood aggression. *Psychiatry Research*, 151(3), 221–230.

Maseko, J., Ladikos, A. & Prinsloo, J. (2003). Learners' general attitudes and views on experimenting with drugs. *Acta Criminologica*. 16(5), pp. 136-171.

McDonald, R.M. & Towberman, D. (1993). Psychological correlates of adolescent drug involvement. *Adolescence* 28(112), pp. 925-36.

McDowell, U. & Futris, T. (2002). *Adolescents at risk: Illicit drug use*. Columbus, Ohio: The Ohio State University. [Online]. Available: [http:// www.hec.ohio-state.edu/famlife/](http://www.hec.ohio-state.edu/famlife/) [2011, November 02].

McIntosh, J., Gannon, M., McKeganey, N. & MacDonald, F. (2003). Exposure to drugs among pre-teenage schoolchildren. *Addiction*. 98(11), pp. 1615-1623.

Meghdadpour, S., Curtis, S., Pettifor, A. & MacPhail, C. (2012). Factors associated with substance use among orphaned and non-orphaned youth in South Africa. *Journal of Adolescence*, 35(5), pp. 1329-1340.

Meijer, P., Verloop, N. & Beijaard, D. (2002). Multi-method triangulation in a qualitative study on teacher's practical knowledge: An attempt to increase internal validity. *Quality & Quantity*, 36, pp. 145-167.

Merriam-webster.com/dictionary.Precursor (n.d.). Retrieved August 12, 2016, from <http://www.merriam-webster.com/dictionary/precursor>

Mertens, D.M. (2003). *Mixed methods and the politics of human research: The transformative-emancipatory perspective*. In A. Tashakkori & C. Teddlie (Eds.), *Handbook of mixed methods in social & behavioral research* (pp. 135-164). Thousand Oaks, CA: Sage.

Mohasoa, I.P. (2010). *Substance abuse among male adolescents*. Unpublished MA Dissertation. Pretoria: University of South Africa.

Mohasoa, I.P. & Fourie, E. (2012). Substance abuse amongst adolescents: A case study of Zeerust, North West Province, South Africa. *New Voices in Psychology*, 8(1), pp. 30–44.

Molgaard, V. & Spoth, R. 2001. *Strengthening Families Program for young adolescents: Overview and outcomes*. In: S.I. Pfeiffer & L.A. Reddy (eds). *Innovative mental health programs for children: Programs that work*, pp. 15-29. Binghamton, NY: Haworth Press.

Morojele, K. & Brook, J. (2006). Substance Use and multiple victimization among adolescents in South Africa. *Addictive Behaviours*, 31, pp. 1163-1176.

Morojele, N.K., Brook, J. & Kachieng'a, M. (2006). Perceptions of sexual risk behaviours and substance abuse among adolescents in South Africa; A qualitative investigation. *Aids Care*, 18(3), pp. 215-219.

Morojele, N.K., London, L., Olorunju, S., Matjila, M., Davids, A. & Rendall-Mkosi, K. (2009). Predictors of risk of alcohol-exposed pregnancies among women in an urban and a rural area of South Africa, *Social Science & Medicine*, 70(4), pp. 534-542.

Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: SAGE Publications.

Mudavanhu, N., Schenck, R. (2014). Substance abuse amongst the youth in Grabouw Western Cape: Voices from the community. *Social Work/Maatskaplike Werk*, 50(3); (4) 370-

391. <http://socialwork.journals.ac.za/pub>. Available: <http://dx.doi.org/10.15270/50-2-405> [Accessed 7 August 2016]

Mrug, S., Gaines, J., Su, W., Windle, M. (2010). School-level substance use: Effects on early adolescents' alcohol, tobacco, and marijuana use. *Journal of Studies on Alcohol and Drugs*, 71(4), 480-495.

Myers, M.D. (2009). *Qualitative research in business and management*. London: Sage

National Institute on Drug Abuse [NIDA]. (1997). *Preventing drug abuse among children and adolescents*. A research-based guide. National Institute on Drug Abuse.

National Institute on Drug Abuse [NIDA]. (1998). *Parenting IS Prevention: Resource Guide*. National Institute on Drug Abuse. Retrieved [Accessed August 03, 2011]. Available at: <http://www.nida.com>.

National Institute on Drug Abuse [NIDA]. (2003). *Prevention Drug use among children and Adolescents, Second edition*. Maryland, USA; NIDA

National Institute on Drug Abuse [NIDA]. (2005). *Brief strategic family therapy for adolescent drug abuse*. Available from: <http://www.nida.nih.gov/TXManuals/bsft/BSFT2.html>. [Accessed 7 November 2009]

National Institute on Drug Abuse [NIDA]. (2016). *Principles of Substance Abuse Prevention for Early Childhood*. Available from <https://www.drugabuse.gov/publications/principles-substance-abuse-prevention-early-childhood/index> [Accessed 12 August 2016].

Ndondo, B. (2016). *A review of Literature on Drug and Substance Abuse amongst Youth and Young Women in South Africa*. Soul City Institute for Social Justice. Available: <http://www.soulcity.org.za/research/literature-reviews/soul-city-institute-drug-abuse-youth-south-africa.pdf/view> [Accessed: 14 November 2016]

Needle, R.H., Glynn, T.J. & Needle, M.P. (1983). *Drug abuse: Adolescent addictions and the family*. In Figley, C.R. & McCubbin, H.I. (eds.) (1983). *Stress and the Family, Volume II: Coping with Catastrophe*. New York: Brunner/Mazel.

Neser, J.J., Ovens, M., Victor-Zietsman, M.M.J. & Ladikos, A. (2001). Views of learners on drugs and related matters: preliminary findings. *Crime research in South Africa*, 3(3), pp. 1-14.

Newcomb, M.D. (1992). *Understanding the multidimensional nature of drug use and abuse: The role of consumption, risk factors, and protective factors*. In: Glantz, M.D. and Pickens, R., eds. *Vulnerability to Drug Abuse*. Washington DC: American Psychological Association, pp. 255-297.

Nielsen, J.N. (2011). *Metaphysical Ecology Reformulated. Grand strategy and geopolitics from the perspective of the Pacific Northwest*. [Accessed: 08 August 2013]. Available from: <http://geopoliticraticus.wordpress.com/2011/03/22/metaphysical-ecology-reformulated/>

Oetting, E.R. & Donnermeyer, J.F. (1998). Primary socialization theory: The etiology of drug use and deviance. *Substance Use Misuse*, 33(4), pp. 995-1026.

Ojermark, A. (2007). *Presenting Life Histories: A Literature Review and Annotated Bibliography (November 1, 2007)*. Chronic Poverty Research Centre Working Paper No. 101. [Accessed 04 September 2014]. Available: <http://dx.doi.org/10.2139/ssrn.1629210>

Onya, H., Tessera, A., Myers, B. & Flisher, A. (2012a). Adolescent alcohol use in rural South African high schools. *African Journal of Psychiatry*, 15 (Spring), pp. 352-357.

Onya, H., Tessera, A., Myers, B. & Flisher, A. (2012b). *Community influences on adolescents' use of home-brewed alcohol in rural South Africa*. BMC Public Health. <http://www.biomedcentral.com/1471-2458/12/642> (Retrieved April 12, 2013)

Pagani, L., Boulerice, B., Tremblay, R.E. & Vitaro, F. (1997). Behavioral development in children of divorce and remarriage. *J Child Psychol Psychiatry*, 38(7), pp. 769-781.

Parker, M., Wills, G. & Wills, J. (2008). *Community in tension (CiT). Technical Report ECSTR-LSL08-002*, ECS, University of Southampton.

Parry, C.D.H., Morojele, N.K., Saban, A. & Flisher, A.J. (2004). Brief report: Social and neighbourhood correlates of adolescent drunkenness: a pilot study in Cape Town, South Africa. *Journal of Adolescence*, 27(3), pp. 369-374.

Parry, C., Pluddermann, A., Bhana, A., Harker, N., Potgieter, H., Gerber, W. & Johnson, C. (2005) (SACENDA). *Update 16 May 2005. Alcohol and Drug Abuse Trends: July December 2004 (Phase 17)*. Parow: Medical Research Council.

Patrick, M.E., Schulenberg, J.E., O'Malley, P., Johnston, L. & Bachman, J. (2011). Adolescents' reported reasons for alcohol and marijuana use as predictors of substance use and problems in adulthood. *Journal of Studies on Alcohol and Drugs*. 72(1), pp. 106-116.

Patton, M.Q. (2002). *Qualitative Research and Evaluation Methods*. Thousand Oaks, CA: Sage.

Petratis, J., Flay, B.R. & Miller, T.Q. (1995). Reviewing theories of adolescent substance use: Organizing pieces of the puzzle. *Psychological Bulletin*, 117, pp. 67-86.

Peterson, G.W. & Leigh, G.K. (1990). *The family and social competence in adolescence*. Gullotta, T.P., Adams, G.R., Montemayor, T. (eds.). *Developing social competency in adolescence*, pp. 97-138. Newbury Park, CA: Sage Publications.

Pinnock, D. (2016). *Gang Town*. Cape Town: NB Publishers.

Pierce, M., Hayhurst, K., Bird, S., Hickman, M., Seddon, T., Dunn, G., Millar, T. (2015) *Quantifying crime associated with drug use among a large cohort of sanctioned offenders in England and Wales*. *Drug & Alcohol Dependence*, 155: 52 - 59 Available: <http://dx.doi.org/10.1016/j.drugalcdep.2015.08.018> [Accessed: 07 August 2016]

Plant, M. & Plant, M. (1992). *Risktakers: Alcohol, Drugs, Sex and Youth*. London: Routledge.

Plüddemann, A., Dada S, Parry CD, Kader R, Parker JS, Temmingh, H., van Heerden, S., de Clercq, C., Lewis, I. (2013). Monitoring the prevalence of methamphetamine-related presentations at psychiatric hospitals in Cape Town, South Africa. *African Journal of Psychiatry*. 16(1): 45-9. DOI: <http://dx.DOI.org/10.4314/ajpsy.v16i1.8>. Available: <http://dx.DOI.org/10.4314/ajpsy.v16i1.8>. [Accessed 06 August, 2016].

Plüddemann A., Flisher, A.J., McKetin, R., Parry, C.D., Lombard, C.J. (2012). Methamphetamine Use and Sexual Risk Behavior among High School Students in Cape Town, South Africa. *Journal of Child & Adolescent Substance Abuse*. 21(2): 181-91. DOI:10.1080/1067828X.2012.662437 [Accessed 06 August 2016] Available: <http://www.tandfonline.com/doi/abs/10.1080/1067828X.2012.662437>

Plüddemann, A., Parry, C.D.H. & Bhana, A. (2008). *South African Community Epidemiology Network on Drug Use (SACENDU) update: Alcohol and drug abuse trends: July-December 2007 (Phase 22)*. Tygerberg: Medical Research Council.

Puljević. C. & Learmonth., D (2014) Substance abuse prevention in Cape Town's peri-urban settlements: local health trainers' perspectives. *Health Psychology & Behavioural Medicine*. . 2 (1): 183–197. Available: <http://dx.doi.org/10.1080/21642850.2013.878659>[Accessed: 17 May 2016]

Ramsay, M. & Partridge, S. (1999). *Drug Misuse Declared in 1998: Results from the British Crime Survey*. Home Office, London.

Reddy, S.P., Panday, S., Swart, D., Jinabhai, C.C., Amosun, S.L., James, S., Monyeki, K.D., Stevens, G., Morejele, N., Kambaran, N.S., Omdien, R.G. & Van den Borne, H.W. (2003). *Umthente Uhlaba Usamila – The South African Youth Risk Behaviour Survey 2002*. Cape Town: South African Medical Research Council, 2003.

Reddy, S.P., James, S., Sewpaul, R., Koopman, F., Funani, N.I., Sifunda, S., Josie, J., Masuka, P., Kambaran, N.S., Omdien, R.G. (2010). *Umthente Uhlaba Usamila – The South African Youth Risk Behaviour Survey 2008*. Cape Town: South African Medical Research Council, 2010.

Resnick, M.D., Harris, L.J. & Blum, R.W. (1993). *The impact of caring and connectedness on adolescent health and well-being*. National Adolescent Health Resource Centre, Minnesota, United States: University of Minnesota.

Resnick, M.D., Bearman, P.S., Blum, R., Bauman, K., Harris, K., Jones, J., Tabor, J., Beuhring, T., Sieving, R., Shew, M., Ireland, M., Bearinger, L. & Udry, J.R. (1997). Protecting adolescents from harm. Findings from the National Longitudinal Study on Adolescent Health. *JAMA* 278(10), pp. 823-32.

Richter, L. & Morrell, R. (2006). *BABA – Men and fatherhood in South Africa*. Cape Town: Human Science Research Council Press.

Roberts, G. & Ogborne, A. (2005). *Substance abuse program evaluation in Canada*. Paper presented at the Health Canada's Drug Strategy and Controlled Substances Programme, Ottawa, Ontario, Canada

Robertson, E. (n.d). *Risk and Protective Factors: Principals and Approaches to Drug Abuse*. Prevention Research Branch National Institute on Drug Abuse Prevention (NIDA). Retrieved from: <http://www.wcer.wisc.edu/fast/ppt/RPFactors.ppt>

Rocha-Silva, L. (1998). *The nature and the extent of drug use and the prevalence of related problems in South Africa: National surveillance*. Pretoria: HSRC Publishers.

Rocha-Silva, L. (2001). *The nature and extent of drug use among South Africa young people: A review of research conducted between the mid-1970s and the mid-1990s*. Pretoria: CADRE-Centre for Alcohol/Drug Related Research.

Rocha-Silva, L., De Miranda, S. & Erasmus, R. (1996). *Alcohol, tobacco and other drug use among black youth*. Pretoria: HSRC Publishers.

Rohner, R.P. (2004). The parental “acceptance-rejection syndrome”: Universal correlates of perceived rejection. *American Psychologist*, 59, pp. 830-840.

Roman, N.V. (2008). *Single and married mother-preadolescent relationships: Understanding and comparing the interaction between self-esteem and family functioning*. Unpublished Doctoral Thesis, University of the Western Cape.

Roman, N.V. (2014). *Parenting in a rainbow nation: A South African perspective of parenting*. H. Selin (ed), *In Parenting Across Cultures: Childrearing, Motherhood and Fatherhood in Non-Western Cultures*. Netherlands: Springer Publishers (ISBN 978-94-007-7502-2).

Rosner, R. (2013). (Ed). *Clinical Handbook of Adolescent Addiction*. New York: WileyBlackwell.

Santrock, J.W. (2000). *Psychology*, (6th ed.). United States of America: The McGraw-Hill Companies.

Sarah, W. (2006). Substance use and risk-taking among adolescents *Journal of Mental Health*, 15(6), pp. 633-643.

Science in Africa.(2005). *Tik, memory loss and stroke*.Online Science magazine for Africa. Available: <http://www.scienceinafrica.co.za/2005/june/tik.htm>. [Accessed 07 June 2005].

Sdorow, L.M. & Rickabaugh, C.A. (2002). *Psychology, (Fifth Edition)*.United States of America: The McGraw-Hill Companies.

Sigelman, C. & Rider, E. (2009). *Life span human development* (6th ed). California: Wadsworth Cengage Learning.

Seligman, M.E.P. (1992). *Learned optimism: how to change your mind and your life*. New York: Pocket Books.

Shenton, A. (2004). Strategies for ensuring trustworthiness in qualitative research projects.*Education for Information*22, pp. 63-75.

Silverman, D. (2001). [*Interpreting Qualitative Data*](#). (2nd Edition). Thousand Oaks, CA: Sage Publications.

Snedker, K.A., Herting, J.R. & Walton, E. (2009). Contextual effects and adolescent substance use: exploring the role of neighborhoods, *Social Science Quarterly*, 90 (5), pp. 1272-1297.

Sokol, J. (2009). Identity Development Throughout the Lifetime: An Examination of Eriksonian Theory. *Graduate Journal of Counseling Psychology*: Vol. 1: Issue. 2, Article 14, pp. 139-149. Available at: <http://epublications.marquette.edu/gjcp/vol1/iss2/14>

South African Community Epidemiology Network on Drug Use [SACENDU]. (2015). Available at: www.mrc.ac.za/sacendu/SacenduUpdateJune (retrieved on: 2 October 2015).

South Africa, Department of Community Safety. (2016). *Policing Needs and Priorities Report 2015/16*. Available: https://www.westerncape.gov.za/.../www.westerncape.../wcg_pnp_2015-16_web_lq_2 [Accessed on 30 September 2016].

South Africa, Department of Health [DOH]. (2003). *Systems Research, Co-ordination and Epidemiology Research Update*.5(2). Pretoria: Government Printer. Accessed 2011, June 07]. [Online]. Available from: [http:// www.doh.gov.za/docs/research/vo:5-2drugs.html](http://www.doh.gov.za/docs/research/vo:5-2drugs.html)

South Africa, Department of Social Development [DSD]. (2006). *National Drug Master Plan (NDMP) 2006-2011*. Pretoria: Government Printer.

South Africa, Department of Social Development [DSD]. (2013a). *National Drug Master Plan (NDMP) 2013-2017*. Pretoria: Government Printer.

South Africa, Department of Social Development [DSD]. (2013b). *Prevention and Early Intervention of Alcohol and other Drug Use Policy* no C24/12/13. City of Cape (CoCT). [Online]. [Accessed 25 July 2016]. Available from: <https://www.capetown.gov.za/en/PublicParticipation/Documents/Alcohol%20and%20Drug%20Abuse%20Policy%203%20April%202013.pdf>

South Africa, Department of Social Development [DSD]. (2013d). *White Paper on Families in South Africa*. Pretoria: Government Printer.

South Africa, National Youth Commission & the Youth Desk in the Presidency. (2009). *National Youth Policy, 2009-2014*, p. 1. Pretoria: Government Printer.

South Africa, The Children's Act No 38 of 2005. (Government Gazette No. 33076, GN R261, 19 June 2006). Pretoria: Government Printer.

South Africa, The Group Areas Act No 41 of 1950. Pretoria: Government Printer.

Spooner, C. (1999). Causes and correlates of adolescent drug abuse and implications for treatment. *Drug Alcohol Review*, 18, pp. 453-475.

Spoth, R.L., Clair, S., Shin, C. & Redmond, C. (2006). Long-term effects of universal preventive interventions on methamphetamine use among adolescents. *Archives of Pediatric Adolescent Medicine*, 160, pp. 876-882.

Spronck, W.E. & Compennolle, T.H. (1997). Systems Theory and Family Therapy: From a Critique on Systems Theory to a Theory on System Change. *Contemporary Family Therapy*, 19(2), pp. 147-175 [Online]. (Accessed: July 12, 2009). Available from: <http://www.ingentaconnect.com/content/klu/coft/1997/00000019/00000002/0>

Standing, A. (2003). *The social contradictions of organised crime on the Cape Flats*. Institute for Security Studies Papers. Pretoria, South Africa. [Online]. Available from: http://www.iss.co.za/index.php?link_id=26&slink_id=572&link_type=12&slink_type=12&tml_id=3 . [Accessed 10 August 2011].

Statistics South Africa [StatsSA]. (2011). *Annual Report 2010-2011*. Pretoria: Statistics South Africa. [Online]. [Accessed 12 February 2013]. Available from: http://www.gov.za/sites/www.gov.za/files/statssa_anrp_2010-2011.pdf

Steinberg, L. (1993). *Adolescence (Third Edition)*. New York: McGraw Hill Publishers.

Steinberg, L. (2001). We know some things: Parent - adolescent relationships in retrospect and prospect. *Journal of Research on Adolescence* 11(1), pp. 1-19.

Steinberg, L. (2002). *Adolescence*, (6th ed.). New York: McGraw-Hill.

Steinberg, L., Fletcher, A. & Darling, N. (1994). Parental monitoring and peer influences on adolescent substance use. *Pediatrics*, 93(6), pp. 1060-1064.

Steinberg, L. & Morris, A.S. (2001). Adolescent Development. *In Annual Review of Psychology*, 52(2001), pp. 83-110.

Stevens, A. & Schaller, J. (2009). Short-run Effects of Parental Job Loss on Children's Academic Achievement, NBER Working Paper No. 15480. [*Economics of Education Review*](#), 30(2), pp. 289-299.

Substance Abuse and Mental Health Services Administration (SAMHSA). (1998). *Parenting is Prevention: Resource Guide. Influence of Parents and Family on Children's Drug Use and Other Problem Behaviors: Review of the Literature*. (Accessed 04-02-2009) [Online]. Available at: <http://www.sahealthinfo.org/admodule/sacendu3.htm>

Substance Abuse and Mental Health Services Administration [SAMHSA]. Center for Behavioral Health Statistics and Quality. (2014). *The TEDS Report: Gender Differences in Primary Substance of Abuse across Age Groups* (April 3, 2014). Rockville, MD. Available at: <http://www.samhsa.gov/data/sites/default/files/sr077-gender-differences-2014.pdf> [Accessed 6/08/2016].

Tashakkori, A., & Creswell, J.W. (2007). The new era of mixed methods, *Journal of Mixed Methods Research*, Volume 1, Number 1, 3-7.

Tashakkori, A. & Teddlie, C. (2003). *Handbook of Mixed Methods in Social and Behavioral Research*. Thousand Oaks, CA: Sage

Trzesniewski, K., Moffitt, T., Poulton, R., Donnellan, M., Robins, R. & Caspi, A. (2006). Low Self-Esteem During Adolescence Predicts Poor Health, Criminal Behavior, and Limited Economic Prospects During Adulthood. *Developmental Psychology*, 42(2), pp. 381-439.

Tudge, J., Mokrova, A., Hatfield, B. & Karnik, R. (2009). Uses and Misuses of Bronfenbrenner's Bioecological Theory of Human Development. *Journal of Family Theory & Review*, 1, pp. 198-210

Ungar, S. (2001), Moral panic versus the risk society: the implications of the changing sites of social anxiety. *The British Journal of Sociology*, 52, pp. 271-291.

UNICEF (2003). *Life Skills-Based Education Drug Use Prevention Training Manual*. Available from: <http://www.unicef.org/lifeskills/files/DrugUsePreventionTrainingManual.pdf> [Accessed 16/10/2014].

United Nations (2011). *Men in families and Family Policy in a Changing world*. New York: United Nations.

United Nations Office for Drug Control & Crime Prevention [UNODC]. (2002). *Lessons learned in drug abuse prevention: A global review*. ODCCP Studies on Drugs and Crime Monographs. NY: United Nations.

United Nations Office on Drugs and Crime [UNODC] (2003). *Adolescent Substance Use: Risk and Protection*. Available at <http://www.unescap.org/esid/hds/pubs/2287/pub2287.pdf>. [Accessed 14 April, 2014].

United Nations Office on Drugs and Crime [UNODC]. (2012). World Drug Report 2012. [Online]. Available from: <https://www.unodc.org/unodc/en/data-and-analysis/WDR-2012.html>. [Accessed 2013, June, 25].

Vakalahi, H.F. (2001). Adolescent substance use and family-based risk and protective factors: A literature review. *Journal of Drug Education*, vol. 31, pp. 29-46.

Vakalahi, H. (2002). Family-Based Predictors of Adolescent Substance Use. *Journal of Child & Adolescent Substance Abuse*, 11(3), pp. 1-15.

Van Heerden, M.S., Grimsrud, A.T., Seedat, S., Myer, L., Williams, D.R. & Stein, D.J. (2009). Patterns of substance use in South Africa: Results from the South African Stress and Health study. *South African Medical Journal*, 99(5), pp. 358-366. [Accessed on 06 Jan 2014]. Available from: http://www.scielo.org.za/scielo.php?script=sci_arttext&pid=S0256-95742009000500025&lng=en&nrm=iso.

Van Manen, M. (1990). *Researching Lived Experience: Human science for an action sensitive pedagogy*. London, Ontario: Althouse.

Van Ryzina, M., Foscoa, G. & Dishion, T. (2012). Family and Peer Predictors of Substance Use from Early Adolescence to Early Adulthood: An 11-Year Prospective Analysis. *Addict Behav.* 37(12): 1314–1324. doi:10.1016/j.addbeh.2012.06.020.

Van Zyl, A. (2013), Drug Use amongst South African Youths: Reasons and Solutions *Mediterranean Journal of Social Sciences*, 4(14), pp. 581-589. Rome-Italy: MCSER Publishing.

Vanyukov, M. M., Tarter, R. E., Kirillova, G. P., Kirisci, L., Reynolds, M. D., Kreek, M. J., Conway, K.P., Maher, B.S., Lacono, W.G., Bierut, L., Neale, M.C., Clarke, D.B., Ridenour, T. A. (2012). Common liability to addiction and “gateway hypothesis”: Theoretical, empirical and evolutionary perspective. *Drug and Alcohol Dependence*, 123 (Suppl 1), S3-17.<http://doi.org/10.1016/j.drugalcdep.2011.12.018>

Velleman, R., Mistral, W. & Sanderling, L. (2000). *Taking the Message Home: involving Parents in Drugs Prevention @ a Briefing*, London, Home Office. *Drugs Prevention Advisory Service Paper, Briefing 5 (a summary of DPAS Paper 5)*, [On-line]. Available at: <http://www.drugs.gov.uk/ReportsandPublications/DPASPublications/1033750750/1033750786.pdf>; [Accessed 6/10/2014].

Velleman R., Templeton, L. & Copello, A. (2005). The role of the family in preventing and intervening with substance use and misuse: a comprehensive review of family interventions, with a focus on young people. *Drug and Alcohol Review*, 24, pp. 93-109.

Visser, M. (2003). Risk behaviour of primary school learners in a disadvantaged community - a situational analysis. *South African Journal of Education*, 23(1), pp. 58-64.

Walsh, F. (2003). Family Resilience: A framework for clinical practice. *Family Process*.42, pp. 1-18.

Walsh, F. (2006). *Strengthening Family Resilience (2nd edition)*. New York: The Guilford Press.

Walsh, F. (2012). *Normal Family Processes*. (4thed.). New York: Guilford

Ward, B.W. & Gryczynski, J. (2009). Social learning theory and the effects of living arrangement on heavy alcohol use: Results from a national study of college students. *Journal of Studies on Alcohol and Drugs*, 70 (3), pp. 364-372.

Werner, N.E. & Silbereisen, R.K. (2003). Family relationship quality and contact with deviant peers as predictors of adolescent problem behaviours: The moderating role of gender. *Journal of Adolescent Research*, 18, pp. 454-480.

Western Cape Department of Community Safety. (2016). *Policing Needs and Priority Report 2015/16*. Western Cape Department of Community Safety: Cape Town.

Whitesell, M., Bachand, A., Peel, J., Brown, M. (2013). Familial, Social, and Individual Factors Contributing to Risk for Adolescent Substance Use. *Journal of Addiction*. Vol 2013. Article ID 579310, 9 pages. doi:10.1155/2013/579310 Available at: <http://www.hindawi.com/journals/jad/2013/579310/cta/>; [Accessed 6/08/2016].

Willig, C. (2003). *Introducing qualitative research in psychology: adventures in theory and method*. Berkshire, United Kingdom: Open University Press.

Wilson, F. & Ramphela, M. (1989). *Uprooting poverty: The South African challenge*. New York: W.W. Norton and Company.

Winek, J.L. (2010). *Systemic family therapy: From theory to practice*. Los Angeles, CA: Sage.

World Health Organization [WHO]. (2002). *The World Health Report 2002: reducing risks, promoting healthy life*. Geneva: World Health Organization.

World Health Organization [WHO]. (2004). *Problems related to alcohol consumption*. Geneva: World Health Organization.

World Health Organization [WHO]. (2011). *Global status report on alcohol and health*. [Online]. [Accessed 12 October 2015]. Available at:
http://www.who.int/substance_abuse/publications/global_alcohol_report/msbgsruprofiles.pdf?ua=1

World Health Organization [WHO]. (2014) *Global Status Report on Alcohol and Health 2014*, Geneva: World Health Organization. [Online]. Available at:
http://www.who.int/substance_abuse/publications/global_alcohol_report/en/ [Accessed 08 October 2016].

Ziervogel, C.F., Ahmed, N., Flisher, A.J. & Robertson, B.A. (1997-1998). Alcohol misuse in South African male adolescents: a qualitative investigation. *International Quarterly of Community Health Education*, 17 (1), pp. 25-41.

Zucker, R.A. (2000). *Alcohol involvement over the life course*. In *National Institute on Alcohol Abuse and Alcoholism, Tenth Special Report to the U.S. Congress on Alcohol and Health: Highlights from Current Research* (pp. 28-53). Washington, DC: U.S. Department of Health and Human Services.

APPENDICES

APPENDIX 1: ASSENT/CONSENT LETTER

Dear Participant

I am a postgraduate student at the University of the Western Cape doing research on youth and drug abuse and have been granted permission to conduct research study at your Centre. The main purpose of the study is to explore your childhood and life experiences, parent-child relationships, and the reason(s) *why* you started using drugs. The aim of the study is to identify areas of need, risk factors, and reasons for drug-taking decisions. The research findings reported on could serve to inform the focus and development of meaningful prevention and intervention strategies.

The study will be conducted by means of a questionnaire which would provide me with some basic information regarding your lives and experiences. This will be followed by individual in-depth interviews that will be taped, or **alternately** you may volunteer to write about your life history and experiences leading up to your drug-using pathways. I will be available to provide assistance in understanding or completing the questionnaire and/or written life-history and account of your drug-taking pathway that can be written in the language of your choice- either English or Afrikaans. Feedback of results of this study can be made available to the institution in the form of a brief report, and will also be available for your perusal upon request.

The only criterion for participation is that you be between the ages of **14 and 19 years old**. Participation is **voluntary**, all information provided is strictly **confidential**, and pseudonyms or numbers will be used when reporting the findings. Please note that you may change your mind and withdraw from the study at any time you wish. Please tick **first** and **one** other block and sign:

A. Willing to participate and complete questionnaire:	
B. Willing to participate in an in-depth interview that will be taped:	
C. Willing to write about my life experiences prior to my drug-taking	
D. Willing to participate in a small focus group discussion:	

Name:..... Age:.....Signature:.....Date:.....

Parent/Appointed guardian:Signature:.....Date:.....

I thank you for your time and assistance. Your participation will be greatly appreciated. Please feel free to contact me on 021-9487382 should you need any further information.

Principal Researcher: **Edna Rich**

Signature:.....Date:

APPENDIX 2: STRUCTURED QUESTIONNAIRE

Name.....AgeWhere did you live before?.....

NEIGHBOURHOOD/SCHOOL: Did you like living in your area? (Yes/No?).....

Please give reasons for your answer (e.g. friends/gangs/safe/unsafe etc.).....

.....

Before coming here, did you still attend school?(Yes/No?).....Which grade?.....

If left, which grade left school?.....Did you start using drugs *before* or *after* you

left school.....What is the main reason(s) why you left school?.....

.....

FAMILY: Parents marital status? (married/unmarried/living together).....

Please list the *adults* you grew up with (e.g. mother/father/grandma etc.).....

.....

Who supported the family financially?.....

Would you say you had a happy, unhappy, or OK childhood?.....

Who was your primary caregiver at home? (mother, grandma etc?).....

Who monitored or supervised your activities in your free time?.....

Did you feel loved, cared for and wanted by your mother/caregiver? (Yes/No).....

Why do you say so?.....

.....

.....

Did you grow up with your father?stepfather?

Do you feel loved, cared for and wanted by your father/stepfather (Yes/No).....

Why do you say so?.....

.....

DRUGS: Age started?Illicit Drug type(s) started using.....

.....

Drug type(s) last used?.....

Who introduced you to drugs?

How many of your friends use drugs? (few, many, all? etc.).....

Who else in the *family* take drugs?.....

Who else in the family drink alcohol?.....

What happened in the home when they got drunk?.....

.....

SUPPORT: Who in the family, school or elsewhere spoke to you about the dangers of

drug-use?.....

Please name who you felt you could trust to share your drug-using problem with?.....

.....

Who at *school* did you tell of your drug-taking?.....

What then happened about it?

.....
If you did not tell anyone at school, why not?.....

Who at *home* knew about your drug-taking?.....

What was done about it at home?.....
.....

REASONS FOR USE: What do you think are the main reasons why you started using
drugs?.....
.....

Can you try to describe how you feel about yourself and your life?.....
.....
.....

Thank you for your participation

APPENDIX 3 SEMI-STRUCTURED INTERVIEW SCHEDULE

Please reflect on your family life and talk to me about important relationships especially your relationship and interactions with your parents as well as the significant events or experiences leading up to your drug-taking decisions.

A. HOME/CHILDHOOD EXPERIENCES:

- What was it like growing up in your home?
- As you were growing up, are there things that happened in your life that you wished had never happened?
- What would you have liked to change or wanted different about your life?

B. PARENT-CHILD OR SIGNIFICANT OTHER RELATIONSHIPS

- Whilst growing up who were the most important people in your life? And why?
- Who was your primary caregiver? (mother/ grandmother? etc.)
- What was your relationship with her like? (e.g. close, warm, loving? distant, cold uncaring?)
- Did you grow up with your father/ other father figure?
- What was your relationship with him like?
- Please tell what you did in your free time and over week-ends. Who monitored and supervised your activities? Was it done strictly? How were you disciplined at home?

C. DRUG USE:

• HOW DID YOU GET INVOLVED IN DRUG-TAKING BEHAVIOUR?

- Any significant events/experiences leading up to you starting to use drugs?
- How do you wish your life to have been different during that time?

• WHAT DO YOU THINK CAUSED YOU TO START USING DRUGS?

- What other factors could have contributed to your decision to use?
- Aware of negative consequences? Why did you still go on to use drugs?
- Why did you *continue* to use drugs after you started?

D. SUPPORT

- What type of support do you think would have helped prevent you from starting to use drugs? In the home? At school? Anywhere else?

Thank you for your participation

APPENDIX 4 LIFE-HISTORY GUIDE

Please reflect on your life-experiences and write a brief account of your life history up until your drug using behaviour. I would like to find out what was taking place in your life leading up to your decision to start using drugs. You may use the following themes to probe and guide your writing.

A. HOME/CHILDHOOD EXPERIENCES:

- What was it like growing up in your home? Were there things that happened in your life that you wished had never happened?
- What would you have liked to change or wanted different about your life?

B. PARENT-CHILD OR SIGNIFICANT OTHER RELATIONSHIPS

- Whilst growing up who were the most important people in your life? And why?
- Who was your primary caregiver? What was your relationship with her like?
- What was your relationship with your father or the father-figure in your life like?
- What did in your free time and over week-ends.

C. DRUG USE:

- **HOW DID YOU GET INVOLVED IN DRUG-TAKING BEHAVIOUR?**
 - Kindly recall any significant events/experiences leading up to you first starting to use drugs?
 - How do you wish your life to have been different during that time?
- **WHAT DO YOU THINK CAUSED YOU TO START USING DRUGS?**
 - What other factors could have contributed to your decision to use?
 - Why did you continue to use drugs after you started?

D. SUPPORT

- What type of support do you think would have **helped prevented** you from starting to use drugs? In the **home**? At **school**? **Anywhere else**?

Thank you for your participation

APPENDIX 5 CONSENT LETTER

SCHOOL OFFICIAL: LEARNER (DISCIPLINE) SUPPORT OFFICER

Dear Participant

I am a postgraduate student at the University of the Western Cape doing research on the drug abuse among youth. The main purpose of the study is to explore the reason(s) and riskfactors for drug youth among young people, and also to see how it can be prevented or reduced. The aim of the study is to identify areas of need and challenges in their lives of young drug users. The research findings reported on could serve to inform the focus and development of meaningful primary prevention and intervention strategies.

The study will be conducted by means of an individual in-depth interview that will be taped and can be conducted in the language of your choice- either English or Afrikaans. Feedback of the results of this study will be made available to you upon request.

Participation is **voluntary**, all information provided is strictly **confidential**, and pseudonyms or numbers will be used when reporting the findings. Please note that you may change your mind and withdraw from the study at any time you wish.

I am willing to participate in an in-depth interview that will be taped:

Name.....Age.....Signature.....Date.....

I thank you for your time and assistance. Your participation will be greatly appreciated. Please feel free to contact me on 021-9487382 should you need any further information.

Principal Researcher: **Edna Rich**

Signature.....

Date:

APPENDIX 6 SEMI-STRUCTURED INTERVIEW SCHEDULE

LEARNER DISCIPLINE SUPPORT OFFICER AT SCHOOL

A. REASONS FOR DRUG USE

- What is the drug-use situation among learners at your school like? And in the community?
- What do you think are the main causes for drug use among the youth?

B. PREVENTION OF DRUG USE AMONG YOUTH

- How do you think this drug-use problem can be prevented or reduced among our youth?
- What difficulties do you and/or the school experience in trying to reduce drug use of the learners?

C. SCHOOL DRUG POLICY/PROCEDURES

- Does the school have a formal drug policy in place? How is it disseminated to learners and their parents.
 - o What Life-skills education is provided to the learners at the school in terms of substance abuse education?
 - o What type of drug prevention education/activities happen at the school?
 - o How are learners' drug problems addressed? (Intervention procedures?)
 - o How is the family involved in the intervention process?
 - o What difficulties/challenges do you experience when implementing the school drug policy and procedures?
 - o How are learners, parents, and the larger community made aware of the existing school drug policy, procedures, and/or programmes?

Thank you for your participation

APPENDIX 7

SEMI-STRUCTURED INTERVIEW GUIDE: FOCUS GROUP DISCUSSION

Introductions and restatement of the purpose of the study, the ethical considerations etc. (Consent form was signed when you completed the questionnaire)

Reasons and risk factors for drug use among youth:

- How prevalent do you think drug use is among young people today?
- Why do you think young people start using drugs? Think about your own experiences and those of your friends and talk to me about what do you think are the main *reasons* for drug use among youth?
- What other factors could contribute to young people's decision to use? Or what conditions or life circumstances would put young people at risk for drug use?
- Were you aware of negative consequences of drug use? Why did you still go on to use drugs?
- Why did you continue to use drugs after you started?
- Is there anything else you can tell me to help me understand the reasons and risk factors for drug use among youth.

Thank you for agreeing to talk to me about drug use among youth.

13 January 2017

To whom it may concern

Dear Sir/Madam

RE: Editorial Certificate

This letter serves to prove that the thesis listed below was language edited for proper English, grammar, punctuation, spelling, as well as overall layout and style by myself, publisher/proprietor of Aquarian Publications, a native English speaking editor.

Thesis title

EXPLORING PERCEIVED REASONS AND RISK FACTORS FOR
ILLCIT DRUG USE AMONG YOUTH IN THE WESTERN CAPE:
IMPLICATIONS FOR PRIMARY PREVENTION

Author

Edna Grace Rich

The research content, or the author's intentions, were not altered in any way during the editing process, however, the author has the authority to accept or reject my suggestions and changes.

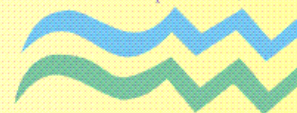
Should you have any questions or concerns about this edited document, I can be contacted at the listed telephone and fax numbers or e-mail addresses.

Yours truly,



E.H. Londt
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