

University of the Western Cape

Case Study Report

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**A case study examining the experiences of a methamphetamine addict
and its impact on the family relationships.**



In partial fulfilment of the Master's Degree in Research Psychology.

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Keywords: Amphetamines, methamphetamine, qualitative, case study, substance abuse, addiction, dependence, family relationships, family systems theory.

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ABSTRACT

Methamphetamine (MA) is associated with young people world-wide. In South Africa MA is considered to be responsible for the fastest growing addiction rates, especially amongst persons under the age of twenty. Research in this area is predominantly focused on providing surveillance information and neglects the experiences of the user and the family. The aims of this study were therefore to describe the personal experiences of a methamphetamine addict as well as the effects of this addiction on the family's communication and problem-solving abilities. A single, descriptive case-study methodology was employed in which a series of interviews and journal entries were used as multiple sources of evidence to corroborate converging lines of inquiry. The research findings identified clear associations between MA-abuse and violence and aggression in the user, as well as negative family effects such as compromised family processes and family dysfunction. The extent to which these associations are defining features and characteristics of MA-abuse, more so than any other substance, should be subject to further investigation as well as recommended for future research to inform more effective treatment approaches.

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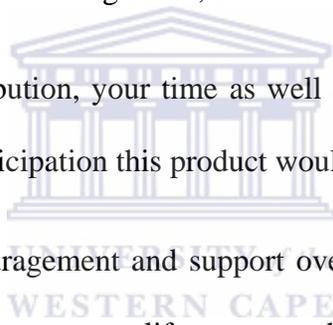
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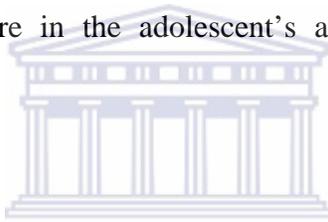


CHAPTER 1:

1. INTRODUCTION

1.1. Background information

Within the last ten to fifteen years the world-wide drug culture has evolved in dramatic and alarming ways (Emmett & Nice, 1996). Focused on younger customers, the availability of drugs has become widespread, and the prices of more popular substances have become more affordable and accessible to a greater number of individuals (Emmett & Nice, 1996; Alberton, Derlet & Van Hoozen, 1999). No longer viewed as an anti-social activity, the introduction of designer drugs has been widely accepted as an integral part of relaxation and pleasure in the adolescent's and young adult's social scene (Emmett & Nice, 1996).

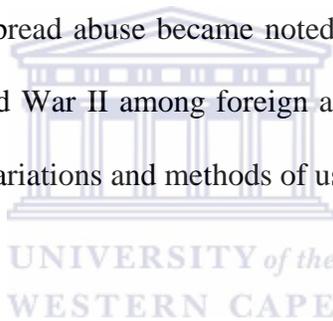


A variety of substances are available and easily accessible to users, of which marijuana, amphetamines, stimulants, and inhalants are always popular (Fields, 1998). Amphetamines are considered to be the third most popular drug associated with young people world-wide (Emmett & Nice, 1996), of which methamphetamine (i.e. “ice” or “crystal meth”) is considered to be its most potent form (Doweiko, 1999; Beebe & Walley, 1995). Methamphetamine (MA) is a powerful, synthetic, central nervous system stimulant that is relatively easy to produce, and is thought to stimulate the pleasure centre of the brain (Beebe & Walley, 1995). This drug is known to induce a powerful sense of euphoria, great strength and energy, increased activity without rest or food, an increased sexual appetite in its users (Emmett & Nice, 1996), as well as a sense of confidence or increased self-esteem (Halkitis & Shrem, 2006; Science in Africa, 2005). Long-term and

short-term adverse effects include for example great fatigue, heart problems, as well as physical and mental deterioration (Emmett & Nice, 1996; Doweiko, 1999).

1.2. History of methamphetamine

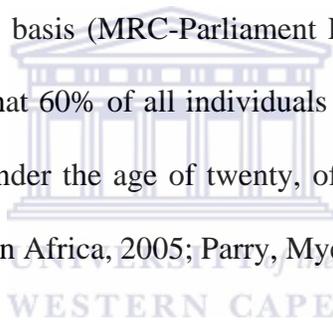
First synthesised in 1887, amphetamines and methamphetamines have a long history of abuse (Beebe & Walley, 1995). In 1932 these components were commercially available in a nasal spray for the treatment of asthma and in 1937 amphetamines were produced in a tablet form that was used as a treatment for narcolepsy (Beebe & Walley, 1995). Soon the substance's euphoric properties, stimulating effects, as well as appetite suppression were recognised and its widespread abuse became noted. Amphetamine abuse has also been documented during World War II among foreign armies (Beebe & Walley, 1995), and has developed into many variations and methods of usage over time.



1.3. Prevalence

It is estimated that approximately four million people in the USA are thought to have used methamphetamines (i.e. “ice” or “crystal meth”) at least once in their lifetime (Office of National Drug Control Policy, 1996; cited in Doweiko, 1999). Traditionally, MA use is associated with white, male, blue-collar workers throughout the US (Fields, 2001). However, this drug has spread throughout more diverse groups such as 1) men who have sex with men; 2) homeless and runaway youths; 3) both male and female commercial sex workers; as well as 4) young adults who frequent raves or private clubs (Fields, 2001). In general, methamphetamine-use is most popular among persons whose occupations demand long hours, mental alertness and physical endurance (Fields, 2001).

In South Africa, methamphetamine, or locally known as “tik”, is considered to be responsible for the fastest addiction rates ever seen by communities that have been historically associated with gangsterism (Science in Africa, 2005). For example, areas on the Cape Flats such as Mitchell’s Plain, Manenberg, Elsies River, Hanover Park and Retreat have been largely affected by the widespread increase in methamphetamine use (Science in Africa, 2005). A dramatic increase in patients at specialised drug treatment facilities in Cape Town has been noted, reporting 121 to 429 MA-related cases within a 12-month period between late 2003 and early 2004 (MRC-Parliament Report, 2005). Six out of 10 of these cases were under the age of 20, of which approximately 40% were reported to use MA on a daily basis (MRC-Parliament Report, 2005). In South Africa more broadly, it is estimated that 60% of all individuals that have “tik” as their primary substance of choice are also under the age of twenty, of which 91% are reported to be male and ‘coloured’¹ (Science in Africa, 2005; Parry, Myers & Plüddemann, 2004).

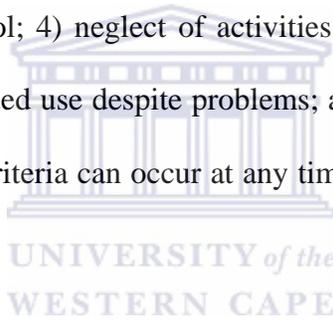


1.4. Addiction

Doweiko (1999) claims that not all drug users become addicted. Only a percentage of users actually become addicted to their drug of choice. Doweiko (1999) distinguishes between social *use* and substance *abuse*, defining the former as the “...rare or infrequent use of that drug, in a social setting”, and the latter as the “...use of a drug when there is no legitimate medical need to do so” (p. 13). There is no clear-cut way of defining addiction. However, it could be understood in three ways: 1) the *compulsion* or *loss of control*, whereby the individual will use more of the drug than they intend to, or will not be able to cut back or stop using; 2) *tolerance*, which refers to the individual building up

¹ An Apartheid classification of racial segregation.

a tolerance to the effects of the drug and has to use more and more to attain the desired effect, developing withdrawal symptoms when the drug is stopped; and 3) *impairment*, in which the chemical use has caused one of many medical, psychological, social, legal or vocational complications (Doweiko, 1999). Furthermore, this includes a preoccupation with the use of the drug whereby recreational activities are planned and centred on the chemical (Doweiko, 1999). According to the fourth revision of the *Diagnostic and Statistical Manual of Mental Disorders*, drug dependence can further be defined as a “maladaptive pattern of substance use, leading to clinically significant impairment or distress” that are manifested by three or more of the following criteria: 1) tolerance; 2) withdrawal; 3) impaired control; 4) neglect of activities; 5) time spent to recover from effects of substance; 6) continued use despite problems; and 7) compulsive use (Grant & Dawson, 1999, p.12). These criteria can occur at any time within a twelve-month period (Grant & Dawson, 1999).



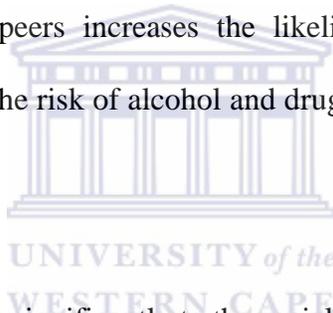
Fields (1998) argues that many individuals strive to alter consciousness by using drugs or alcohol, and that this tendency continues to increase in young people worldwide. This global phenomenon does not occur in isolation, and is influenced directly and/or indirectly by the social environment in which the individual is located.

1.5. Social environments that support substance abuse

Communities that are characterised by high levels of neighbourhood disorganisation are believed to contribute to the development of alcohol and drug related problems (Hesselbrock, Hesselbrock & Epstein, 1999). These include a high population density,

high levels of adult crime, physical deterioration, illegal drug trafficking (Hesselbrock, Hesselbrock & Epstein, 1999), as well as high levels of school truancy and gang activities (Seivewright, 2000). Furthermore families, schools, and peers are considered to be the most important units of socialisation that influence an individual both directly and indirectly (Hesselbrock, Hesselbrock & Epstein, 1999).

Young people spend an enormous amount of their time identifying and engaging with peers, and as result, they are significantly influenced by these individuals in terms of behaviour, values and attitudes (Hesselbrock, Hesselbrock & Epstein, 1999). Therefore, the association with deviant peers increases the likelihood of individuals accepting deviant behaviours, as well as the risk of alcohol and drug use (Hesselbrock, Hesselbrock & Epstein, 1999).



The family unit also contributes significantly to the socialisation of an individual and his / her likelihood to experiment and use substances. Poor parenting skills and high levels of family stress was identified as key factors that compromise the acquisition of conventional values and attitudes (Hesselbrock, Hesselbrock & Epstein, 1999). These dynamics encourage young people's association with deviant peers and therefore also increase their susceptibility to substance misuse (i.e. both alcohol and drugs) (Hesselbrock, Hesselbrock & Epstein, 1999). The family unit evidently plays an important role in the socialisation of young people and are therefore identified as the primary arena to prevent, intervene and treat substance use (Fields, 1998).

As family members are socialised *into* certain behaviours and attitudes, so are they socialised *by* its various members. The next section we will briefly illustrate how the addiction of a family member affects the family unit.

1.6. Addiction of a family member

It is common for an addict to experience difficulty in maintaining healthy relationships with family and others (Seivewright, 2000). This could be attributed to the emergence of an elaborate defence system, in which the addict employs methods like denial, intimidation, angry defensiveness, and manipulation to defend against 1) the severity of the using behaviour; 2) its harmful consequences; and 3) the reality of their situation (Sheehan & Owen, 1999). Furthermore, family members commonly find themselves engaging in enabling behaviours that perpetuates the addict's use of substances (O'Farrell & Fals-Stewart, 1999). Enabling behaviours can be understood as those behaviours that allow and even encourage the addicted individual to continue his / her drug using behaviour. It is also described as "an unhealthy doing *for*, or killing *with kindness*" (Fields, 2001:156). For example, family members may make it easier for the addict to engage in substance use behaviour by protecting them from the harmful, negative consequences associated with drug taking (O'Farrell & Fals-Stewart, 1999), and absolving the member from taking responsibility for his / her actions. This is done when the family assumes responsibility for the negative consequences of the drug-related behaviour (e.g. replacing or refunding stolen goods), and therefore exempting the addicted member from the negative consequences thereof.

1.7. Research on addiction and family

Few research studies explore how the addiction of one member affects the other members of the family (Doweiko, 1999). However, international as well as local studies focus on the family and addiction more broadly. For example, some investigated issues around family stability and its relationship with adolescent substance abuse (Stewart, 2003), as well as the effects of family -demographics and -influences on alcohol use among young people (Duncan, Duncan & Strycker, 2003). A study done by Caughlin and Malis (2004) looks at the demand/withdraw communication between parents and adolescents, in which they attempt to draw connections between self-esteem and substance abuse. Whereas another looks at the perceptions of family environment and how this influences youth behaviours such as running away from home and substance abuse (Slesnick & Prestopnik, 2004). A national survey in the USA focused on identifying patterns in youth substance use and found a relationship between adolescent participation in extra-mural activities and a decreased use of substances, regardless of the family's income status (NSDUH, 2007). A relationship between STD/HIV transmission and substance use amongst sexually active adolescents in rural areas have also been examined, and found that there is indeed an association between sexual-risk behaviours and substance use (Yan, Chiu, Stoesen & Wang, 2007).

In most of these studies mentioned, researchers investigate the family environment and how the family system and its characteristics/demographics influence substance abuse. Relationships between the individual's social environment, their behavioural tendencies as well as substance use/abuse are also examined. However, no reference is made to how

a substance/drug of choice affects the personal experiences of the addict and his/her relationship with the family. More specifically, a perusal of literature revealed no studies investigating the effects of methamphetamine abuse on the family. Available research were however focused on MA's association with 1) risky sexual behaviour and HIV/AIDS (e.g. Molitor, Ruiz *et al.*, 1999); 2) medical issues for example its association with cardiovascular disease (e.g. Alberton, Derlet & Van Hoozen, 1999; Beebe & Walley, 1995), and 3) special populations like homosexual substance abusers (e.g. Halkitis & Shrem, 2006; Boddiger, 2005).

In South Africa, research on substance-related issues focus on various issues for example, emerging trends in adolescent alcohol and other drug use (Parry, Myers, Morojele, Flisher, Bhana, Donson & Plüddemann, 2004), access to alcohol and other drug treatment for historically disadvantaged communities (Myers, Louw & Fakier, 2008), as well as a growing demand for heroin treatment in Gauteng and Cape Town alike (Parry, Plüddemann & Myers, 2005). Myers (2004) embarked on a cross-sectional audit of substance abuse treatment facilities in Gauteng and collected information on available treatment facilities in terms of the diversity of services provided, the facility's characteristics, the profile of clients served, as well as barriers to treatment entry, engagement, retention and service delivery. Others focused on providing surveillance information about the nature and extent of cocaine use in three metropolitan areas in South Africa namely Cape Town, Gauteng, and the Eastern Cape (Parry, Plüddemann & Myers, 2007).

However, in South Africa there remains a paucity of literature on methamphetamine. This has begun to be ameliorated by the South African Community Epidemiology Network on Drug Use (SACENDU) that was established in 1996 to address this vacuum in the knowledge base (Plüddemann, 2001). SACENDU consists of a network of researchers, policy makers, and practitioners from five areas in the country (Cape Town, Durban, Port Elizabeth, Gauteng, and Mpumalanga) that meets every six months in order to provide community-level public health surveillance of alcohol and drug use trends (Plüddemann, 2001). The SACENDU project was expanded in 2004 to include East London as well as implement related regional projects in Luanda (Angola), Kinshasa (DRC), Dar es Salaam (Tanzania) and Zanzibar (MRC-Parliament Report, 2005). Although this project reported surveillance information on 12 countries, this unit was the first to highlight the exponential growth of methamphetamine abuse in Cape Town from 121 to 429 cases between the second half of 2003 and the first half of 2004 (MRC-Parliament Report, 2005). A need to address MA-related problems in SA, specifically Cape Town, emerged and a growing concern for MA-popularity was stressed by a few scholars and media alike. Therefore, some South African publications addressed the need for drug policies regarding methamphetamine (Parry *et al.*, 2004), as well as the prevalence of illegal drugs in trauma patients (Parry, Plüddemann, Donson, Sukhai, Marais & Lombard, 2005) and drug-treatment facilities (MRC-Parliament Report, 2005).

1.8. Rationale

MA-abuse has been identified as a growing problem in South Africa, especially Cape Town. Dramatic increases in use based on the surveillance information available only

reflect those totals that seek treatment and enter the available facilities. These figures however reflect a dramatic increase in use within the broader population. Although research on methamphetamine use in SA is in its infancy, all of the studies mentioned above makes no direct reference to its influence on the personal experiences of the individual, as well as his/her relationship with the family. Surveillance information has been provided both nationally and internationally, without an in depth description of the effects of this addiction on family systems and outcomes. Treatment facilities in Cape Town are faced with growing rates of MA-users (MRC-Parliament Report), a drug that is commonly associated with a high relapse rate (Rawson, Anglin & Ling, 2002). Hence, in order to develop more effective treatment approaches, especially in terms of providing guidance and support to distressed family members of MA-addicts, an in depth investigation concerning the personal experiences of the addict as well as the effects of this addiction on the family is needed. Therefore, the present study aims to breach this gap in South African literature and provide an in depth look on MA-addiction and family life.

1.9. Aims of this study

This study broadly aimed to examine the personal experiences of an individual addicted to methamphetamine in a South African context; and describe how this specific drug affected the individual's relationship with the immediate family. More specifically, the research aims were to:

- a) examine the emotional, psychological, behavioural, and physical changes the participant has undergone since his addiction to methamphetamine; and

- b) describe the family's overall functioning in terms of its communication- and problem-solving processes. This was investigated by paying special attention to:
- a. the clarity and congruence in messages between family members;
 - b. emotional expression; as well as
 - c. collaborative problem-solving efforts within the family unit.

Bounded by time and place, this study therefore describes the in-depth experiences of an individual addicted to methamphetamine in the form of a single, descriptive case-study.

1.10. Chapter layout

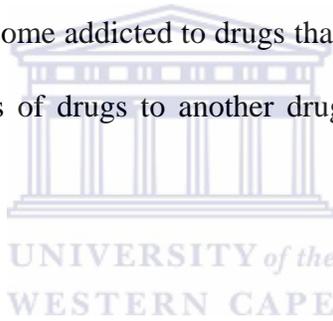
In this report, *chapter one* has provided an introduction of the research project and provided the reader with the aims and rationale of this study. *Chapter Two* presents an extensive literature review concerning the area of investigation, which includes the elaboration of the theoretical frameworks selected for this research. The method design and research methodology is discussed in *Chapter Three*, of which the techniques employed as well as issues arising throughout this research are stipulated. *Chapter Four* presents the results as well as a discussion of the case study findings. This chapter will contain both the descriptive analyses of the interview- and journal data. Lastly, *Chapter Five* concludes the case study report by presenting the emerging pattern in the findings, as well as the conclusions drawn from these.

CHAPTER 2:

2. LITERATURE REVIEW

2.1. Introduction

Cocaine and amphetamines are the most widely abused illicit stimulants in the world (Nordahl, Salo & Leamon, 2003). A world-wide drug culture has emerged whereby more and more young people today are seeking ways to reach alternative states of consciousness (Fields, 1998). This raises many questions such as: What are the motivations behind seeking alternative states of consciousness? What are the proposed function(s) of substances, especially illicit drugs? Why are some people more likely to become addicted to drugs than others? And lastly, what makes a user or addict prefer certain kinds of drugs to another drug of choice? These issues will be discussed in this chapter.



This chapter provides a review of recent literature, both South African and international, on substance abuse, families and addiction, and MA-related research. The discussion begins by highlighting possible motivations for substance abuse:

2.2. Why do people use substances?

“Many people are passive procrastinators and conflict avoiders. Our search for the magic pill or cure for the pain of the human condition has created a modern marketplace for alcohol and drug elixirs” (Fields, 1998: 3).

Throughout time, the human condition has expressed an ability to seek ways in achieving alternative states of consciousness (Fields, 1998). It is argued that human beings often avoid feelings of sadness, boredom, stress and loneliness as a way of circumventing the investment of time, effort and motivation involved in *actively* working through these emotions (Fields, 1998). Instead, there is a tendency to *passively* change what he or she is feeling through the use of substances. This is believed to be a learned behaviour acquired throughout the user's life and is more pertinent when there is an existing pattern of avoiding feelings, or a tendency to self-medicate emotions with substances (Fields, 1998). Therefore, in this sense, drugs and alcohol serve a particular function for its user and can be described in the following ways:

2.3. Functions of drugs

Fields (1998) describes five different functions a substance may serve to its user. These are 1) searching for the desired effect; 2) drug as a source of power; 3) a weapon of self-destruction; 4) seduction and sexuality; and 5) drugs as reinforcers.

(1) Searching for the desired effect

According to Fields (1998), the choice of drug is linked to the function it has for its user. In other words, people develop a drug of choice based on how that particular substance meets their desired effect. For example, the table below to illustrate Fields' (1998) interpretation of these functions:

Users of:	Function it serves:
Opiates (E.g. heroin, morphine)	<ul style="list-style-type: none"> • To kill physical and emotional pain; • Purposefully numbing the self towards life.
Central Nervous System (CNS) depressants (E.g. alcohol, tranquillisers)	<ul style="list-style-type: none"> • To decrease activity; • To calm or relax.
Stimulants (E.g. cocaine, amphetamines, methamphetamines, coffee, nicotine)	<ul style="list-style-type: none"> • To increase activity; • To excite, energise and stimulate.
Hallucinogens (E.g. marijuana)	<ul style="list-style-type: none"> • To change their view of the world; • Manipulate their perception of reality.

(2) Drug as a source of power

Since the use of drugs is frequently associated with feelings of power and superiority, the individual uses the substance as a way of achieving instant gratification for this desired effect. Fields (1998) furthermore argues that a drug of choice reflects both a conscious and subconscious symbolic meaning, for example where “getting high” is a symbolic representation of exceeding / excelling over another. Ironically, however the “individual in the cycle of addiction becomes powerless” to the substance he or she comes to rely on for their desired effect (Fields, 1998: 5).

(3) A weapon of self-destruction

When compared to non-users, addicts are more likely to express a desire for death as well as reflect on their own demise more positively than others do (Fields, 1998). In the discipline of psychology, addicts have been referred to as having “unconscious death wishes” whereby a sense of self-destructiveness results from the failure of the ego-functions to preserve, care and protect the self (Fields, 1998: 6). In essence, these ego-functions fail to protect the self from the

individual's unconscious need to destroy or repress underlying feelings of depression, guilt, and anxiety that generates from childhood (Fields, 1998).

(4) Seduction and sexuality

More often than not addicts describe drugs as aphrodisiacs whereby its use has symbolic meaning in terms of seduction and sexuality (Fields, 1998). However, this is believed to be an illusion many users are seduced by since no drug truly possesses these properties. Instead, drugs lower the individual's inhibitions and may therefore stimulate sexual arousal at low dose levels, hence creating the illusion of sexual potency and seduction (Fields, 1998). Contrary to this popular belief, drugs and alcohol are documented to *impair* sexual performance, especially with prolonged use (Fields, 1998; Nordahl *et al.*, 2003).

(5) Drugs as reinforcers

Lastly, drugs may function as a reinforcing attribute in which its continued use is strongly reinforced by the memorable feeling attached to the user's *first use* (Fields, 1998). It is believed that the first use of any drug "becomes the new and unforgettable awareness" in which the user attempts to recapture that original experience (Fields, 1998: 7). Since it is impossible to duplicate the memorable experience of the first use, a cycle of addiction is developed in which the individual compulsively chases after the first feeling. Fields (1998) contends that it is this strong reinforcing property of drugs that explains why so many addicts continue to use, even after the feeling and behavioural experiences associated with drug-taking has become negative and unpleasant. *Euphoric recall* is therefore common whereby the user has a subjective recalling

of positive feelings while forgetting the negative consequences and dangerous situations, associated with their use (Fields, 1998).

Therefore, these five functions of drugs discussed above are believed to perpetuate the use of drugs and lead to the potential addiction of its user.

2.4. Methamphetamine abuse

2.4.1. Methods and Use

Methamphetamine is a synthetically produced stimulant that is relatively easy to manufacture from legally purchased chemicals (Emmett & Nice, 1996; Doweiko, 1999). It is available in various forms, for example 1) in tablet form that is ingested; 2) a powder, which is dissolved in water or smoked; and 3) crystal or “ice” that is commonly smoked (Emmett & Nice, 1996). Popular methods of use range from injecting the substance (most popular), smoking its crystal form, to smoking the powder with a cigarette or cannabis (least popular and effective) (Emmett & Nice, 1996). Users tend to prefer methods that induce the drug’s effects immediately and most intensely. MA enters the brain more rapidly than any other central-nervous system stimulant and many of its users move to compulsive use soon after their initial exposure (Fields, 2001). Tolerance is known to develop quickly and the consistent increasing of dosages to meet the desired effect is argued to invariably lead to permanent brain damage (Fields, 2001).

Polydrug use (i.e. the use of more than one drug at a time) is very common among MA users, of which *alcohol* is identified as the most popular (Fields, 2001). Regardless of the method of use

alcohol is concurrently used with MA either to blunt some of the stimulant effects, or to assist the user to “come down”¹ after an extended period of use (Fields, 2001).

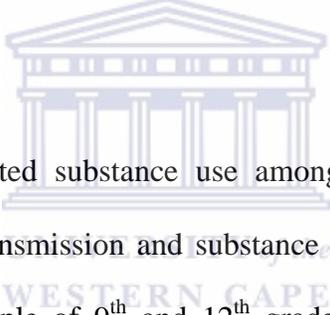
2.4.2. Effects and popularity

Methamphetamine, a dangerous child component of amphetamine, has increasingly gained popularity because of its relatively lower cost and its general availability when compared to other drugs, such as cocaine (Albertson *et al.*, 1999). This drug is considered to be a powerful drug that primarily targets the central nervous system (Beebe & Walley, 1995). Known to stimulate the pleasure centre of the brain (Doweiko, 1999), MA induces intensified emotions, an altered self-esteem, increased alertness and sexuality, irritability, as well as paranoia and hallucinations (Beebe & Walley, 1995; Doweiko, 1999; Emmett & Nice, 1996). Aside from the pleasurable effects of MA, its popular status among adolescents and young adults is believed to result from the drug’s ability to take immediate effect (i.e. resulting in an immediate high) (Albertson *et al.*, 1999), and to remain active for up to fifteen hours (Beebe & Walley, 1995). Adverse effects generally include great fatigue, hyperthermia (i.e. increase in body temperature), heart complications, psychological problems, and even extremely aggressive and violent behaviour (Emmett & Nice, 1996; Gans, 2007; ACDE, 2008). Physical dependence could occur within a short period of using, whereas the development of a deep psychological dependence could be viewed as most threatening to the individual (Emmett & Nice, 1996).

¹ “Come down” – means the opposite of “getting high”. In other words, it is a term used to describe the user deflating / disembarking from their sense of euphoria that results as an effect of a substance.

2.5. Recent international research on substance abuse

In the United States, a national survey was done in 2005 on young people ranging between the ages of 12 and 17 that investigated whether there is a relationship between youth substance use and activities they are involved in (NSDUH, 2007). Questions were asked about whether these young people were participants in school-based, community-based, church- or faith-based, or any other type of activity and compared to their self-reported habits concerning substance use and family income. The results revealed that, regardless of family income, young people who did not participate in any activities reported a higher rate of substance use within the past year, than those individuals that were active in at least four activities (NSDUH, 2007).



Yan *et al.*, (2007) also investigated substance use amongst adolescents and examined the relationship between STD/HIV transmission and substance use in sexually active teenagers in U.S. rural areas. A national sample of 9th and 12th grade learners across the country were selected, and a total of 5 745 participants completed the national Youth Risk Behaviour Survey. This survey gathered information on self-reported substance abuse behaviour (e.g. alcohol, marijuana, tobacco, and cocaine use) and was correlated to variables such as unprotected sex and the number of recent sexual partners. The findings revealed that there is an association between alcohol and drug use before sexual intercourse, especially in terms of binge drinking and cocaine use. Thirty-seven percent of participants that reported alcohol or drug use also reported having multiple sexual partners, of which the latter was significantly associated with binge drinking ($p < 0.05$) and cocaine use ($p < 0.0001$). Therefore, this study showed that there is indeed a

relationship between substance use and sexual risk behaviours, and that substance use may lead to unprotected sex as well as multiple partners.

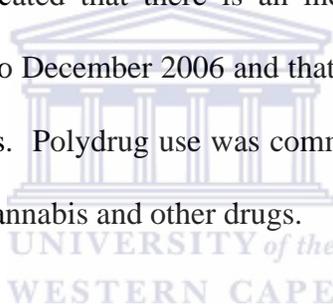
2.6. Recent South African research on substance abuse

Parry *et al.*, (2004) researched the emerging trends in adolescent alcohol and other drug use in three sites in South Africa, namely Cape Town, Durban and Gauteng. With the aim of providing surveillance information, this study gathered information from 1997 to 2001 from trauma units, specialist treatment centres, school learners, arrestees, as well as individuals who frequent rave parties. Alcohol use was reportedly the most common substance of abuse, especially amongst high school learners, and was followed by smoking cannabis. The information gathered from treatment facilities supported the data on cannabis and revealed that a large proportion of adolescents are undergoing treatment for this drug. The abuse of this substance was also found amongst trauma patients and arrestees, whereas ecstasy use was limited to parties and clubs. Cocaine and heroin use was identified as an emerging problem among adolescents in the metropolitan sites and highlighted a need for strategic interventions that are specifically targeted at young people in South Africa.

The emerging problem of heroin use amongst young South Africans were followed up in a study that investigated the increasing demand for heroin treatment in Cape Town and Gauteng (Parry, Plüddemann & Myers, 2005). With the purpose of providing surveillance information about the nature and extent of heroin use in South Africa, data were collected from 41 treatment facilities between January 1997 and December 2003. The results of this investigation revealed that there

is indeed an increase in heroin use amongst South Africans especially amongst (although not limited to) white, male individuals between the ages of 21 and 24. This identified the need to further monitor heroin-use patterns amongst young adults and develop strategic prevention strategies and interventions.

A study aimed at providing surveillance information on cocaine use in South Africa was completed in 2007 (Parry, Plüddemann & Myers, 2007). Sampling from three sentinel sites, data were collected from 56 specialist treatment facilities in Cape Town, Gauteng, and the Eastern Cape. The findings indicated that there is an increase in treatment admissions for cocaine abuse from January 1997 to December 2006 and that the majority of patients were male, white, with a mean age of 30 years. Polydrug use was commonly associated with this drug and included substances like alcohol, cannabis and other drugs.



Myers, Louw and Fakier (2008) examined access to substance abuse treatment facilities for historically disadvantaged communities in Cape Town. This study used key informants as their source of information and interviewed service treatment providers, local action committee members, as well as district social workers. Three structural barriers to equal service delivery were identified. These were 1) challenges in developing and implementing strategic plans; 2) limitations in essential resources needed to function optimally; and 3) difficulties resulting from providing a fragmented service in the treatment of alcohol and other drugs. In essence, this study identified a need for a serious transformation in the South African social welfare system that is responsible for adequate treatment service delivery to all communities.

Substance abuse is a phenomenon that does not occur in isolation and affects the individual as well as broader social systems like the family. Although family research and addiction/substance abuse is a well-researched area that dates back to the 1980s, the most recent studies in this area are discussed below:

2.7. Family research on substance abuse

2.7.1. Family environment and substance-related behaviour

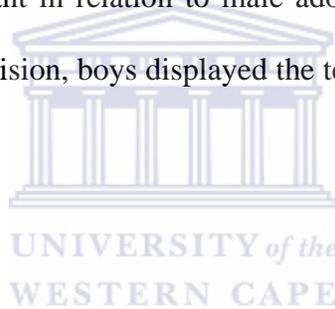
Accepted as an individual's first social setting, the family environment is generally understood as the basis of key attachments in an individual's life (McArdle *et al.*, 2002). For these reasons the family environment exerts considerable influence on individual behaviour, especially in terms of substance use. However, as these authors contend, it is still unclear which specific aspects directly and indirectly affects substance use. Bahr *et al.* (1995) argues that 1) strong family attachments or bonds; 2) feelings of closeness and intimacy; 3) perceived monitoring; as well as 4) communication and engaging in joint activities, are negatively associated with substance use (Cited in McArdle *et al.*, 2002). Also, these findings are found to be stronger among female adolescents than in their male counterparts.

A study conducted in Europe by McArdle *et al.* (2002) investigated the roles of family structure, function and gender in relation to adolescent substance use. Examining 3 984 pupils aged 14-15 from Newcastle, Tyne, Dublin, Rome, Bremen and Groningen, this study's aims were to explore the family structure and family functioning in relation to substance use and establish if these relationships differed in terms of gender. The findings suggest that adolescents, both male and female, who are living with both biological parents display reduced levels of drug use than their

counterparts. This did not however apply to regular alcohol use. Polydrug use (i.e. the regular use of more than one type of drug) was also common.

Furthermore, the ability of adolescents to confide in at least one parent, especially the mother, proved to have a decreasing effect on drug use, especially polydrug use. This strongly suggests that attachment to parents, especially the mother, is key in regulating substance use behaviours in adolescents (McArdle *et al.*, 2002). However, this protective factor was counteracted when a delinquency variable like general anti-social behavioural tendencies was added.

Parental supervision also proved to have a decreasing effect on drug use (McArdle *et al.*, 2002). This appeared to be more important in relation to male adolescent participants because it was found that in the absence of supervision, boys displayed the tendency to increase their drug using activities more so than girls.



This study, therefore, highlights the significance of family life and relationships in substance use behaviour. It also directs special attention to the strength of the adolescents' relationship with the mother and the extent to which parental supervision is available. These conditions have been identified as influential in the extent to which adolescents engage in substance using behaviours and how gender differences are indeed a consideration when approaching substance-related issues.

2.7.2. Parent-adolescent interaction, self-esteem and substance abuse

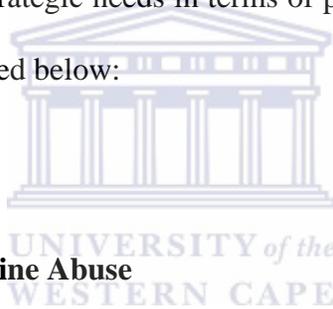
Caughlin and Malis (2004) studied the association between demand/withdraw communication between parents and adolescents, and self-esteem and substance abuse. This research set out to determine why some conflict between parents and adolescents are associated with negative health outcomes, and others not. Their main findings suggested that there is indeed an association between demand/withdraw communication (especially parent-demand / adolescent-withdraw) and low self-esteem and increased alcohol- and drug use.

Although there is some evidence to suggest substance users/abusers have low self-esteem, there is very little to suggest that low self-esteem ‘causes’ a strong affiliation with substances (Swadi, 1999). In fact, one should be cautioned not to overlook the possibility that low self-esteem and substance-related problems may be attributed to a common aetiology such as peer rejection, depression, family breakdown and dysfunction, and/or continuous exposure to any form of victimisation (Swadi, 1999).

Trends in research have shown that the social environment of the individual acts as a powerful mediator of risk for, or protection against, substance use (Graham, Marks & Hansen, 1991; Karelsen, Rogers & McCarthy, 1998; and Swadi, 1999). Although the family plays a crucial role, society’s attitude toward drug use, as influenced by the effects of media, can also determine various features of substance abuse (Swadi, 1999). Other factors such as the availability of drugs, as well as the religious and cultural norms within the immediate environment also contribute to this phenomenon. These factors are powerful influences on the individual and play

a significant role in aetiology and prevalence of substance use, as well as the patterns of use and treatment approaches (Swadi, 1999).

After a perusal of literature, no studies were found that focuses on methamphetamine use and the family. However, research on methamphetamine-related issues is available both internationally and in South Africa. Abroad, studies investigate broader issues relating to its abuse and focus on areas such as gender trends in usage, social costs and neuropsychological effects of chronic MA-use. Research in South Africa predominantly provides surveillance- and prevalence-information and address broader strategic needs in terms of policy development. The findings of these research studies are highlighted below:



2.8. Research on Methamphetamine Abuse

2.8.1. MA-use linked to depression

Chronic users of methamphetamine have been found to experience symptoms of depression (ACDE, 2008; Gans, 2007) and anhedonia (Fields, 2001). *Anhedonia* is a “condition marked by a general lack of interest in living, in the pleasures of life, [and] a loss in the ability to enjoy things”, and is regarded as a defining feature of depression (Reber & Reber, 2001: 35). In a study examining the association between MA-use and self-reported ratings of depression it was found that 73.2% of participants (n = 162) rated their depressive symptoms as mild and higher in severity, where 28.5% reported scores ranging between moderate and severe (Peck, Reback, Yang, Rotheram-Fuller & Shoptaw, 2005). Others have identified depression as a common

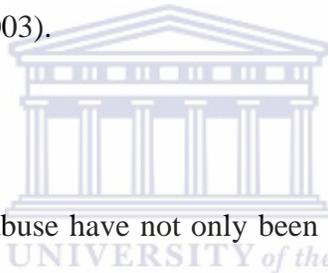
symptom of MA-withdrawal (Busko, 2007; Gans, 2007), and have identified MA-users as a potential risk-group for suicide (Busko, 2007).

2.8.2. MA-use related to psychotic symptoms

A study done by McKetin, McLaren, Lubman and Hides (2006) has investigated the prevalence of psychotic symptoms among regular methamphetamine users. Using a cross-sectional design, 309 (16 years and over) participants were recruited from Sydney, Australia, that used methamphetamine (MA) at least monthly during the last year. By means of structured face-to-face interviews and the administration of screening instruments the participants were assessed in terms of drug use, demographics, and the presence of psychotic symptoms within the past year. The findings of this study showed that 13% of participants screened positive for symptoms of psychosis, 23% of the sample had experienced clinically significant symptoms (e.g. suspiciousness, hallucinations, and unusual thought content), and even after controlling for a history of psychotic disorders, dependent MA-users were three times more likely to have experienced psychotic symptoms than persons in the general population in Australia.

These findings support what Nordahl et al. (2003) reported in an earlier study that investigated the neuropsychological effects of chronic methamphetamine use on neurotransmitters and cognition. According to these researchers, a growing sense of suspiciousness develops into a full blown paranoid psychosis that is indistinguishable from acute paranoid schizophrenia. The psychosis may extend well beyond the duration of intoxication and have the potential to become chronic despite abstinence from the drug. Compulsive repetitious behaviour, such as skin-picking (i.e. where the user compulsively picks their skin – sometimes picking through their own

skin), has also been noted and is usually accompanied by tactile hallucinations and delusions of parasitosis. Alterations to the brain is reported to occur in days of initial exposure and have been found to persist for months and even years (Nordahl *et al.*, 2003). However, some inconsistencies were found in the brain's dopamine system where some evidence suggests that there is no irreparable damage sustained and that normalisation of this system may take place over time. On the other hand, some cognitive deficits following the normalisation of the dopamine-transporter binding valves have indeed been found. Therefore, in summary, it was found that MA abuse *do* cause damage to multiple transmitter systems distributed throughout the human brain but whether the damage is permanent or not, or reversible over time, has not yet been determined (Nordahl *et al.*, 2003).



The effects of methamphetamine abuse have not only been linked and limited to the individual but is also associated with broader social -problems and -costs.

2.9. Social costs of methamphetamine use and addiction

Beyond the user and his/her immediate environment, MA has been paired with significant costs incurred by and/or result of 1) entering medical and psychiatric treatment facilities; 2) lost productivity in education and the workplace; and 3) criminal behaviour associated with this drug (Brecht, *et al.*, 2004). Medical and psychiatric treatment facilities are overwhelmed with the demand for innovative treatment approaches for methamphetamine-dependent users. It has been found that these patients are not only resistant to treatment, but they tend to have a) poor engagement rates; b) high drop-out rates; c) severe paranoia; d) high relapse rates; e) ongoing

psychotic episodes; as well as f) prolonged dysphoria² and anhedonia (Rawson, Anglin & Ling, 2002). Furthermore, MA-users commonly demonstrate unwillingness or an inability to recognise the extent of their drug use as problematic (Rawson, Anglin & Ling, 2002). These pose significant challenges for treatment programmes and become a huge barrier for successful treatment and recovery.

In terms of lost productivity, individuals dependent on methamphetamine are less productive in their daily lives due to the debilitating effects of distorted thinking (e.g. paranoia, hallucinations and delusions), behavioural changes (e.g. violent behaviour), as well as problems with the law, finances and work (Brecht, *et al.*, 2004). The costs are not limited to their physical, emotional, and psychological well-being but also add an economic dimension as well. Many turn to illegal means of financing the drug, which may range from stealing goods in exchange for money to manufacturing the drug itself (Brecht, *et al.*, 2004). This has implications for the criminal-justice system in terms of managing crime rates, as well as the consumer who runs a loss due to theft and replacement costs. Therefore, the effects of this drug reach far beyond the scope of the individual and penetrate the broader social- and economic environment of the user and his/her community.

2.10. Gender differences in MA-use

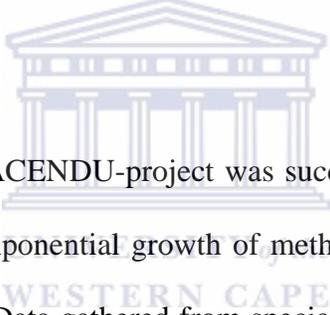
Gender differences in substance use behaviours have been documented as well. In their study, Brecht, O'Brien, Von Mayrhauser and Anglin (2004) describes the differences between male and

² *Dysphoria* – “A general term for any language dysfunction involving speech sounds or phonation” (Reber & Reber, 2001: 223).

female methamphetamine (MA) users in terms of their drug use history, MA-initiation and motivation for its use, as well as MA-related problems, its acquisition, distribution, manufacture, and gender-specific treatment characteristics. Using a cross-sectional design, 350 former clients of a public treatment system in Los Angeles (U.S.A) were recruited. In line with previous studies (e.g. Baskin-Sommers & Sommers, 2006; Halkitis & Shrem, 2006; Molitor *et al.*, 1999), these researchers found a general tendency for MA-users to engage in 1) polydrug use (i.e. using more than one particular drug at a time); 2) risk-taking behaviour (e.g. unprotected sex, and sharing needles); 3) criminal behaviour; and 4) a high relapse rate (i.e. 58% relapse rate within the first six months being released from rehabilitation). More specifically, males had a greater tendency to use more drug types (polydrug use), use drugs intravenously, as well as steal or cook the drug themselves if they are not able to purchase it, than females were (Brecht *et al.*, 2004). After initially experimenting with the drug, female participants were more likely than their counterparts to transition to the regular use of methamphetamine. They also made this transition much faster than that of the male participants. No gender differences were found, however, in their reports of violent behaviour and exchanging sex for money or drugs (Brecht *et al.*, 2004). The majority of participants, irrespective of their gender, reported an array of MA-related problems ranging from work-, financial- and legal problems to sleeplessness, paranoia, and hallucinations. Reports of violent behaviour and significant weight loss were also very common for both men and women.

2.11. South African research on Methamphetamine abuse

In South Africa, Parry *et al.*, (2002) embarked on an epidemiological drug use study that aimed to describe the trends and consequences of alcohol and other drug use from January 1997 to December 1999, as well as outline relevant policy implications for this country. This massive project was called the SACENDU-project (i.e. South African Epidemiology Network on Drug Use) and consisted of a network of researchers, policy makers and practitioners from five areas in the country (Plüddemann, 2001). Gathering information from treatment facilities, trauma units, school learners and arrestees, this study was able to provide surveillance data on substances most frequently abused in this country.



Expanded in the year 2004, the SACENDU-project was successful in being the first to provide information that highlighted the exponential growth of methamphetamine abuse in Cape Town (MRC-Parliament Report, 2005). Data gathered from specialised treatment facilities in this city indicated a dramatic increase in MA-related admissions (121 to 429 cases) within a 12 month period from the latter half of 2003 to the first half of 2004 (MRC-Parliament Report, 2005). These findings served the purpose of alerting health care professionals about this growing problem.

An editorial written for the South African Medical Journal substantiated the findings for the study mentioned above. Parry, Myers and Plüddemann (2004) reported that there is a dramatic increase in clients seeking treatment for MA-related problems across the country, however the extent of MA-use was most pronounced in Cape Town. Describing the increasing popularity of

MA-use amongst young people in Cape Town as “the new public health threat”, raising awareness as well as the accurate provision of information to the public and policy makers became the focal point for these researchers (Parry, Myers & Plüddemann, 2004: 964). They advocate for the development of urgently needed drug policies for methamphetamine, which will lead to the development and implementation of specific, science-based interventions that target both individuals and their communities.

2.12. Limitations of scholarship

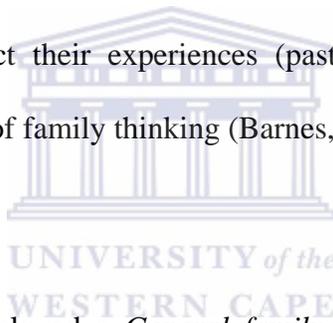
Most of these studies reviewed were largely quantitative and have relied heavily on correlational data. A major limitation of this is its inability to describe the in-depth experiences of the individual, and therefore restricts the study’s ability to cover contextual conditions that may be highly pertinent to the phenomena being studied, especially in terms of developing appropriate as well as effective intervention strategies and treatment techniques.

2.13. Theoretical frameworks

For the purpose of this study, three theoretical frameworks were employed to assist the investigation as well as the interpretation of the information collected, namely the *General family systems approach*, *Family Resiliency Framework (FRF)*, as well as the *Substance abuse Maintenance Model*.

2.13.1. Family systems theory

This study was mainly situated within a family systems theoretical framework. According to this approach, individuals in families are intimately connected (Barnes, 1998) and could be viewed as components of a system that function in an integrated and coordinated way to maintain a sense of stability (Dallos & Draper, 2000). A system could be defined as “any unit structured on feedback...made up of a set of interacting parts which mutually communicate with and influence each other” (Dallos & Draper, 2000, p.24). This theoretical approach was commonly used with studies of substance abuse in families (e.g. Slesnick & Prestonik, 2004; Caughlin & Malis, 2004); as it is an ideal means of describing familial experiences because it looks at the language within which the family construct their experiences (past and anticipated), and how these descriptions illustrate the nuances of family thinking (Barnes, 1998).



More, specifically, this study employed a *General family systems* approach. This approach contends that one cannot begin to understand a particular family without knowing how the family functions as a whole unit (Sharf, 2000). Each family is seen as part of a larger system (e.g. a neighbourhood), which in turn is part of an even larger system (e.g. a town) (Sharf, 2000). Therefore, “if any part of the system changes, the whole system reflects a change” (Sharf, 2000: 503).

This particular theory understands the communication pattern within the units of the system via the use of two main concepts, namely *linear-* and *circular feedback*. According to these, a *linear causality* refers to communication within the family flowing in a single direction, whereas

circularity results when a change in one unit affects or triggers a change in any of the other units (Sharf, 2000). It should be noted that in families, circular feedback is mostly observed with an emphasis on the *process* rather than content.

Another concept relevant to this theory is that known as *homeostasis*. This term refers to the “system’s tendency to seek stability and equilibrium”, as well as attempt to regulate itself once an imbalance is detected (Sharf, 2000: 504). According to this author, feedback functions as the primary process by which homeostasis is maintained, and can be classified as either positive or negative feedback. Contrary to conventional understandings of *positive* and *negative*, in line with this theory, these terms carry very different meanings. Positive feedback, in this sense, means that a change has occurred in the system, and this may have a destructive impact on the family itself (Sharf, 2000). On the other hand, *negative feedback* refers to when equilibrium is achieved. Therefore, in systems theory “positive and negative feedback are related to changing the system or maintaining stability in the system, respectively” (Sharf, 2000: 505).

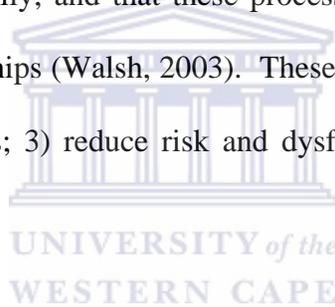
These concepts are employed in the analysis of the case study data and are useful in terms of understanding the family as the context of the behaviours and events under investigation.

2.13.2. Family resilience framework

Based on a systemic view, this framework is built on theory and research on family stress, coping and adaptation (Walsh, 2003). Combining ecological and developmental perspectives on family functioning, this approach incorporates the broader socio-cultural context when assessing

how families deal with adversity, and focuses on family strengths rather than shortcomings (Walsh, 2003).

According to this framework, *resilience* is understood as “the ability to withstand and rebound from disruptive life challenges”, and also “involves key processes over time that foster the ability to ‘struggle well’, heal from painful experiences, and go on to live and love fully” (Walsh, 2003: 399). Essentially, this approach extends beyond the individual and concentrates on the family as a functioning unit. Therefore, the family resilience approach contends that challenges and crises have an impact on the whole family, and that these processes mediate the recovery of family members as well as their relationships (Walsh, 2003). These processes allow families to 1) rally in times of crisis; 2) buffer stress; 3) reduce risk and dysfunction; and 4) support adaptation (Walsh, 2003).



This framework identifies *family belief systems*, *organising patterns* and *communication and problem-solving processes* as the three primary domains of family functioning. For the purposes of this study, *Communication and Problem-solving processes* was selected as the domain under investigation. Focussing on *clarity*, *emotional expression*, and *collaborative problem-solving*, the premises of these concepts are understood in terms of the following:

- 1) **Clarity and congruence in messages** between family members. This is believed to assist in effective family functioning;

- 2) **Open communication.** This is believed to reflect mutual trust, empathy and tolerance for differences, as well as promoting the sharing of a wide range of feelings; and
- 3) **Conflict resolution and negotiation.** This is measured by the family's ability to resolve conflict and engage in shared decision-making and negotiation (Walsh, 2003).

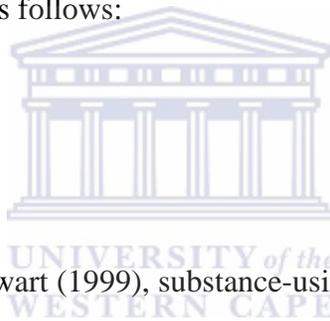
Therefore, this approach was ideal for the purpose of this study as it assessed family functioning within its context, as well as considered the family's (i.e. the research case) values, resources and life challenges (Walsh, 2003).

2.13.3. Model of Maintenance of substance abuse

This model provides a framework in which the maintenance of drug-using behaviour is understood by the interplay of biological, environmental, individual, interpersonal, social, and familial factors (O'Farrell & Fals-Stewart, 1999). Family characteristics such as poor-communication and problem-solving skills, arguing, and heightened family stress are identified as common antecedents to, and consequences of, substance abuse by family members (O'Farrell & Fals-Stewart, 1999). Drawing from a social learning perspective, this approach posits that substance abuse occurs in relation to a variety of antecedents and consequences (both positive and negative) that ultimately reinforce substance-abusing behaviour (O'Farrell & Fals-Stewart, 1999). For example, when family members of the substance user avoids conflict when he/she is under the influence of alcohol or drugs, it may serve as a positive consequence to the substance user and may therefore act as reinforcement to the substance-using behaviour. A negative consequence may include the negative remarks or comments made to the substance user when he or she is using (O'Farrell & Fals-Stewart, 1999). These remarks are usually made by

surrounding family members and can be considered a normal reaction to the disapproval of the family member's substance-using behaviour. However, negative feedback of this nature is considered counter-productive (O'Farrell & Fals-Stewart, 1999).

This model provides an integrated approach to understanding why and how substance abuse within a family is maintained. It also provides a framework from which to assess and identify reinforcing antecedents as well as consequences to substance using behaviour. The basic premises of this model is conceptualised as the Stimuli-Organismic-Response-Consequence (S-O-R-C) model, and is understood as follows:



2.13.3.1. The S-O-R-C model:

According to O'Farrell & Fals-Stewart (1999), substance-using behaviour like drinking and drug use is a *response* (R) to environmental stimuli (S). The latter may vary considerably, and may not be limited to factors such as 1) the time of day; 2) day of the week; 3) persons in the environment; and 4) social- and geographical surroundings. Furthermore, the influence of the environmental *stimuli* (S) on substance using behaviour is mediated by *organismic* (O) factors. These may include organismic phenomena such as a) cravings; b) the effects of withdrawal symptoms; and/or c) negative affective states such as anger, depression or anxiety. The drinking or drug using behaviour is maintained by positive *consequences* (C) of using. These may include, but are not be limited to, the cessation of withdrawal symptoms and the temporary alleviation of negative affect (i.e. emotional states).

These three theoretical frameworks were used to describe the experiences of the participants during their struggle, as a family, with methamphetamine addiction. The following chapter will discuss the methods employed, and challenges experienced throughout this research.



CHAPTER 3:

3. METHODOLOGY

3.1. Introduction

The nature of this research called for an in-depth investigation of a qualitative nature. As an investigation bound by time and place (Creswell, 1998), this study describes a contemporary phenomenon within its real-life context. The case study method is therefore deemed ideal especially when the boundaries between the phenomenon and its context are not clearly defined (Yin, 1994; 2003).

Many researchers have critiqued the case study method as inadequate in terms of providing a basis for scientific generalisation (Yin, 1994; 2003). However, these critiques have been addressed as misguided prejudices that undermine the value the case study method has as a qualitative methodology. Yin (1994; 2003) argues that case studies, just like the single scientific experiment, do not aim to be statistically generalisable. In stead, it finds its strength in its ability to *generalise to theoretical propositions*. Formally known as *analytical generalisation*, this technique allows the case study investigator to generalise its findings to predetermined theoretical propositions and/or a policy orientation, in stead of universes or populations (Yin, 1994; 2003). Therefore, adding value by expanding and transferring theoretical understandings that enable the exploration, explanation, or a rich description of other cases that are similar in context and conditions (Yin, 1994; 2003).

The case study method can therefore be divided into three variations in which 1) explanation-building; 2) description; and 3) exploration is its essential function. Yin (1994; 2003) refers to these as explanatory-, descriptive-, and exploratory case studies. Since this study's initial aim was to provide a description of individual family members' experiences with

methamphetamine addiction, a single-descriptive case study method was employed in which a single family came under investigation as the research case. The rationale for the use of the case study method stems from its potential to contribute to existing knowledge through active engagement in theory-building (Yin, 2003). Therefore, this method awards researchers with the opportunity to help refocus future investigations in the necessary directions within this particular field.

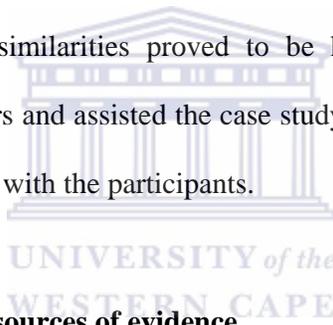
3.2. Case selection and sampling methods

Due to the nature of the research area, finding and recruiting willing participants proved to be problematic. Many individuals, who are using methamphetamine, do so without the knowledge of their immediate and extended family. In cases where the family is aware of the drug use of a family member, many are not willing to be part of a study that investigates such a sensitive issue. Therefore the selection of a case for this particular study has proven to be extremely difficult. The most appropriate sampling method for this particular study was non-probability sampling, specifically *purposive sampling*. This method does not follow the principle of statistical randomness, and selects potential participants in terms of accessibility (Terre Blanche & Durrheim, 1999). Hence, participants were purposively chosen because they possessed the specific qualities / experiences needed for the investigation, and because they were extremely difficult to reach (Terre Blanche & Durrheim, 1999).

Knowledge about the study and the need for a participant was spread via word-of-mouth. A mother of an individual who has been struggling with methamphetamine-abuse has heard about the study and indicated that she and her son are interested to participate in the research. The grandfather of the core participant, who resides with the family, was also identified as a

potential participant. However as time progressed, this individual's participation did not materialise. Written consent for all the relevant participants was obtained.

Due to the fact that the core participant 1) has been using the drug extensively and over a long period of time; 2) has been residing with his family; and 3) the family is aware of his usage / addiction, he was considered ideal for the purpose of this particular investigation. Furthermore, members of his family indicated that they were willing to participate and articulate their experiences in living with his addiction. The case participants selected and the case study investigator also shared important attributes like language (i.e. both speak English and Afrikaans), similarities in residing neighbourhoods, and come from similar cultural backgrounds. These similarities proved to be helpful in minimising cultural-, contextual- and linguistic barriers and assisted the case study investigator to establish rapport and a good working relationship with the participants.



3.3. Data collection: Multiple sources of evidence

The strength of the case study method lies in the use of *multiple sources of evidence*, in which more than one method of data collection is employed for the purposes of triangulating data (Yin, 2003). Multiple sources (e.g. documents and interviews) are used to collect data, of which the objective was to encourage the development of converging lines of inquiry. Corroborating data in this sense therefore increased the accuracy of the research findings and added value in terms of the trustworthiness of data (Yin, 2003).

For the purpose of this research, two main sources of evidence was collected namely interviews and personal documents. The use of semi-structured interviews was the main means of data collection and was complimented by the analyses of a personal journal. All

participating family members were therefore asked to keep a journal as a research requirement.

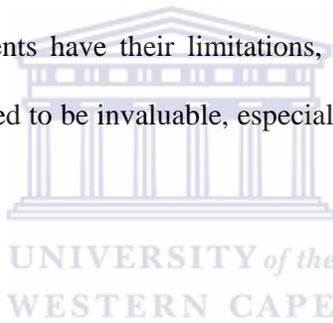
3.4. Strengths and weaknesses of the sources of evidence selected

The use of interviews as a data collection tool was ideal for gathering information from participants and had the advantage of being targeted and focussed directly on the issues under investigation; it provided the opportunity to gain insight into specific areas; and it enabled the case study investigator to seek immediate clarification on particular issues raised during the interview (Yin, 2003). Therefore, this source of evidence was invaluable for the purposes of this investigation. However, traditionally this method was not without its limitations. Interviews' are usually plagued by its potential for response biases (Yin, 2003). For example, the interviewees may have manipulated their responses in such a way as to please the investigator in the search for information. In other words, respondents may find themselves in the position where they tell the investigator what they believe the investigator would want to hear. Furthermore, information gathered via interviews is often subjected to the inaccuracies of poor recall. In this sense the information provided by respondents is limited by poor- and/or selective memory as well as unintentional or intentional deception (Yin, 2003).

According to Yin (2003), the use of documents as a source of evidence can prove to be advantageous because this source is stable and can be reviewed repeatedly, it is unobtrusive, it is exact in its provision of details and specifics, as well as it offers a broad range of coverage that captures time, events and environments over a long period of time. The limitations of this source however include reporting biases, retrievability, and accessibility (Yin, 2003). Reporting biases are commonly reflected in the selection of particular

documents (e.g. the use of a journal) in favour of others (e.g. notes from the social worker). This invariably reflects the inclusion of certain documents for analyses, at the exclusion of others. The retrievability of the documents also introduces bias in the evidence due to the incompleteness of certain documentation. When the document collection is incomplete for any reason it creates a low, biased selectivity. The final limitation of this source relates to the accessibility of the documents required. For example, the research participants have received counselling from a social worker assigned to this case. The counsellor's notes would therefore add considerable value to the inquiry. However, these notes are of a confidential nature and accessibility to these was prohibited by conventional ethical standards.

Though interviews and documents have their limitations, their use as multiple sources of evidence for this study has proved to be invaluable, especially for the purposes of developing converging lines of inquiry.



3.5. Data analysis

Interpretative Phenomenology acknowledges the role of the investigator within the research process itself. According to Willig (2001), this approach recognises that the investigator's own view of the world, as well as the nature of the interaction between the investigator and the participant, produces an *interpretation* of the participant's experience (Willig, 2001). Formally known as *Interpretative Phenomenological Analysis (IPA)*, this approach is considered ideal for analysing semi-structured interviews, as well as diaries/journal entries (Willig, 2001). This kind of analysis was therefore best suited for this descriptive case study, due to its ability to "capture the quality and texture of the individual experience" (Willig, 2001:53).

Following Willig's (2001) approach to Interpretative Phenomenological Analysis a series of steps were employed to analyse the interview and journal data. Firstly, the transcripts for each participant was carefully read and re-read. Reflection notes capturing my perceptions, observations, and my interpretation of what the participant was reporting were made. Secondly, themes emerging from the participants' narrative were identified. The emerging themes were listed for each interview for each participant. A combined list of themes for the two participants was then generated. Thirdly, clusters of themes were created by grouping together related themes under the rubric of a master theme. Each cluster consisted of a master theme and its sub-themes organised into meaningful clusters of themes that served the purpose of describing various aspects of a selected theme. The fourth step involved developing a summary list for all the identified themes for each transcript, along with their sub-themes and page numbers. This was documented to ease the process in identifying themes later on, especially as a source of referencing for the purposes of writing up the analysis and discussion. Summarising the themes for each transcript furthermore allowed the integration of the various themes into an organised structure, in which the themes that captured the participants' experiences more closely/accurate were retained, and others that did not were eliminated. This process of retaining and rejecting themes was informed by my own interpretation of the themes and how they related to the focus of the study. The four steps were repeated for every transcript. The compiled summary lists for each of the transcripts were then analysed and compared (i.e. the mother's themes were compared to the son's themes) to identify common themes between the two participants. Therefore, this final step resulted in the identification of clusters (i.e. master- as well as sub-themes) of common/shared themes between the participants that were retained and then discussed as the research findings.

3.6. Reflexivity

In employing a method like Interpretative Phenomenological Analysis (IPA) that utilises interpretation as a vehicle for describing individual experience, it was important for the case study investigator to remain self-aware of her own views, preconceptions, and biases. Therefore a reflective journal was kept throughout the research process. This journal documented all views, impressions, events and occurrences throughout the research process. These included any encounters, dates of events, preconceived ideas, notions, and personal difficulties in terms of the designing, planning, organising, execution, as well as the analyses and write-up of the study. A summary of this reflexivity journal is included in the case study database as a source of reference

3.7. Ethical considerations

In conducting ethical research, the welfare and the rights of all participants were protected at all times (Terre Blanche & Durrheim, 1999). The participants were fully informed about the nature of research, its area of inquiry, the aims and objectives of the study, as well as the intended procedures (Terre Blanche & Durrheim, 1999). Therefore voluntary and informed consent was ensured. The individual's right to anonymity was respected at all times and was reassured of complete confidentiality. Any limitations to confidentiality was made clear to the participants, informing them of who may have access to the data (e.g. research supervisors) and what their intentions are with the findings. Permission was obtained for the audio-recording of interviews, and participants were aware of their right to terminate the research process at any given time. In the event of the participants experiencing distress and needing counselling, provision was made to make this service available to them. A research journal was kept throughout the data collection and data analysis processes to address issues around researcher reflexivity.

3.8. Criteria employed for judging the quality of the research design

There are four tests case-study researchers use to judge the quality of their designs, namely *trustworthiness*, *credibility*, *confirmability* and *data dependability* (Yin, 2003). For the purposes of a descriptive case study, the quality of the research design is only measured through testing trustworthiness (i.e. construct validity), confirmability (i.e. external validity), and data dependability (i.e. reliability), since credibility testing (i.e. internal validity) is only deemed applicable to explanatory studies that engage in explanation-building and identifying cause-and-effect relationships (Yin, 2003). Therefore the 3 testing criteria selected were applied in the following ways:

3.8.1. Trustworthiness (Construct Validity)

To establish data trustworthiness, the following tactics were employed:

1. *The use of multiple sources of evidence*

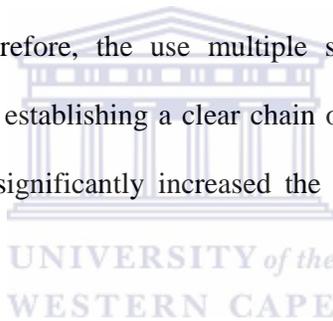
Multiple sources of evidence were collected during the data collection phase by use of semi-structured interviews and personal documents (i.e. journal). The information collected through these multiple sources assisted in establishing a clear chain of evidence.

2. *Establishing a chain of evidence.*

The evidence collected from each case was justified in terms of its operational value. For example, the use of the participants' journals as well as collecting data via semi-structured interviews, proved to be valuable in terms of 1) identifying recurring themes in the information provided by the participants; 2) collaborating narratives of participants in terms of understanding events and perspectives; as well as 3) identifying themes pertinent to the family's dynamics and functioning. Therefore the operational value in selecting these sources of evidence was crucial in developing converging lines of inquiry that described the influence of methamphetamine use/addiction on family functioning.

Another way of establishing a clear chain of evidence was to provide the research participants with the opportunity to review a draft of the findings during the composition phase of the case study report. The intended rationale for this was to allow the participants to add any additional comments as well as to enable the case study investigator to gain clarity on certain issues that was missed during the interview. However, this approach was not successful as receiving feedback from the participants (in general) proved to be a difficult task.

These processes set the stage for the development of the research findings and its conclusions. Thus by linking the initial research questions to the conclusions, a clear chain of evidence was established. Therefore, the use of multiple sources of evidence to develop converging lines of inquiry and establishing a clear chain of evidence between the research questions and its conclusions, significantly increased the data trustworthiness of the case study.



3.8.2. Confirmability (External validity)

For the purposes of a case study design, the *replication logic* was used to establish the domain to which the findings can be generalised. Research findings are considered valid when it can be said to be applicable beyond the boundaries of the immediate case (Yin, 2003). Case study research has been severely criticised for its inability to generalise from a single or few cases to the rest of the population. Therefore statistical generalization is impossible. However, case studies rely on *analytical generalisation* where the investigator strives to generalise a particular set of results to some broader theoretical proposition or policy orientation. Confirmability (or external validity) can therefore only be determined once the case study findings are replicated in another case or cases, where the research

propositions specify the same results to occur. Due to this fact, a case study protocol was kept to document in detail *how* the case study was practically executed. Therefore, if this study is to be replicated on another case where its research propositions specify the same results to occur, and similar findings are found, the confirmability of this case study significantly increases in terms of its ability to analytically generalise its findings. This test can therefore only be done once this particular study is repeated on a similar case in the future via use of the case study protocol provided in Appendix A.

3.8.3. Data dependability (Reliability)

Judging the dependability of the data generated the case study findings have to withstand the test of reliability. In other words, data can only be deemed dependable when, following the exact same procedures and conducting the study in the exact same way (i.e. on the same case), a later investigator finds the same findings and conclusions. The case study investigator was therefore required to meticulously document the procedures followed during the study. Tactics employed that facilitated this enormous task was the development of a *case study protocol* and a *case study database*. The latter is a way of organising and documenting the data collected for the case, and consisted of personal documents (i.e. the journals), interview transcripts, the reflexivity journal, as well as the case study investigator's notes.

Therefore, to facilitate a data dependability test as well as to endure the test of confirmability, a detailed and completed case study protocol and a case study database are available for review.

3.9. Reflexivity issues

3.9.1. Feelings of disbelief, suspiciousness and scepticism

During the interview process, the core participant spoke about his criminal behaviour in using methamphetamine. He revealed that although he engaged in drug-dealing activities, he never stole from his family members. At this time I was reminded of my own family, in which a cousin of mine is struggling with an addiction to heroin. When interacting with my cousin he would deny all allegations of his involvement in stealing money and goods from his immediate family and neighbouring community members. He would find ways to justify his claims and shift blame to his accusers, dismissing their allegations as misguided and unfair. However, when interacting with the accusing family members and neighbours they were able to provide proof as well as eye-witness testimony linking him to these crimes. Therefore, when the participant reported that he never stole anything from anyone I was faced with an overwhelming sense of disbelief, as I was reminded of my cousin's dishonesty. My personal experience with my cousin evoked feelings of suspiciousness and scepticism towards the participant and led me to question whether he was indeed telling me the truth. Furthermore, the content of his disclosure reminded me of my aunt and uncle's plight and sadness when their son was accused by neighbours and friends for stealing goods to sell for the purchase of drugs. I remember thinking that the participant's mother may have felt great embarrassment and sadness (as my cousin's immediate family did) learning that her son is selling drugs as a means of financially supporting his habit. Hence I felt my frustration and resentment toward my cousin emerging toward the participant. I had to be very careful not to convey these feelings and thoughts to the participant in the questions that followed, as I did not want to alienate him in any way.

3.9.2. Feelings of discomfort and judgement

In our discussions about the effects of MA-abuse on the family both participants revealed the ever-presence of violence and aggression in their daily interactions. When the core participant was sharing some of the details about his violent outbursts and heated arguments with his mother, siblings and grandfather I felt a great sense of discomfort. As he was describing incidents where he broke household items in a violent rage, and verbally abused his grandfather and mother I felt an emerging sense of judgement towards him. The events he was describing made me uncomfortable because as a child I was raised to show respect towards my elders, especially not to raise my voice. Physical fighting and violence in the home was also something I was never exposed to and raised to oppose. Therefore, as the discussion progressed I developed sympathy towards the recipients of his abuse as well as a growing feeling of resentment towards him for his disrespect and destructiveness. I made sense of these feelings by becoming aware of my personal values and previous socialisation, as well as the possibility that this ambivalence comes from my pre-conceived notions of how a family should interact and engage with one another. This growing sense of judgement towards the participant's disclosure was therefore understood within its context as becoming aware of my own prejudice assisted me to not voice these feelings to him in any way.

In both these occasions I felt I needed to share some of these personal experiences with the participant. I shared some events and incidents relating to my cousin's drug-related behaviour and also disclosed how my cousin's behaviour influenced the rest of his family. I was able to relate my own experiences to that which he was reporting and through doing that, I was able to establish whether or not we indeed shared the same feelings and experiences. Therefore, my disclosure served two purposes namely 1) to reflect my own interpretation of what he was reporting; and 2) to verify or refute whether my interpretation was accurate in

terms of the participant's experiences. This was indeed a very successful strategy of verification and occasionally led to the participant disclosing more personal feelings and experiences. I believe this may have been due to him relating to certain events as well as the relief of him knowing that his experiences are not isolated from other users/people.

3.10. Challenges experienced

3.10.1. Finding willing participants

The biggest challenge in doing this research was finding a willing family to participate. Recruiting via word-of-mouth, I was referred to a family who later indicated that they were interested to participate in the study. However, upon entering the data collection phase I was informed by this family that their son (the MA-addict) has disappeared from their home and has not returned in months. Since this was a very unpredictable situation, I was forced to look for another family. This was a considerably difficult task as many adolescents and young adults who were introduced to me came from families where their addiction is unknown, or denied. However, after two months of searching I was approached by a mother who heard about this research and indicated that her family is willing to participate.

3.10.2. Maintaining contact

I experienced considerable difficulty contacting the participants (especially the mother) to make appointments. Cell phone calls to the mother was seldom answered, and also text messages (sms) and voice messages were never responded to. However, she would answer the cell phone after a few days of trying. When family members answered the home's telephone they would frequently excuse their mother's absence as being unavailable or out working. I soon discovered that she took my calls when I sms'd her the previous day announcing why I want to speak to her.

Arranging interviews with the core participant (addict) was also met with some difficulty. For each interview I had to call numerous times in order to (1) arrange an appropriate time for him to meet with me; (2) confirm appointments well in advance as well as on the day; and (3) to reschedule (repeatedly) cancelled or postponed appointments. These difficulties persisted from early June to mid-December 2007 (i.e. seven months).

3.10.3. Difficulties retrieving journals

Participants were asked to keep a journal throughout the entire data collection process, of which there was a minimum requirement of at least one entry per week. Notebooks were delivered to each participant after the research contracting phase, and various attempts to encourage writing and reflecting in these books were made. For example, occasional sms' were sent to remind them about the journals, also feedback on their progress was requested whenever I made a house visit or telephone call. However, upon each request I was informed that they have not started yet but that they do intended to start soon. After approximately 9 months it was brought to my attention that they had lost the notebooks and new ones had to be supplied. Again, I made numerous calls to the participant to arrange dates in advance to have the journal / reflection notes done and ready for submission. By this time, I have accepted that the journals will not be the product that was initially desired (i.e. reflecting on issues in their daily lives over the data collection period) and changed the focus of the journals as a mere reflection exercise of the last 6 to 12 months. After supplying them with a new set of notebooks, the due date to hand in the journal reflection notes has extended six times. After which, the core participant was able to deliver an eight-page journal that provided a very broad reflection on his experiences with methamphetamine addiction. The mother's feedback concerning the submission of her journal revealed various inconsistencies,

and hence led to the conclusion that she did not start the journaling process. I was thus forced to continue without this potentially valuable source of information.

As discussed above, making contact and arranging interview appointments with both participants was an extremely difficult and lengthy process. Retrieving the journals proved to be an even longer and demanding task. These challenges therefore led to an extended data collection period that stretched over a total period of 16 months. Furthermore, the mother's failure to submit a journal as well as the manner in which the core participant's journal was documented has potentially compromised the trustworthiness of the information analysed. Due to this fact, the amount of information collected was less than anticipated and the quality of information used to find corroborating lines of inquiry were therefore reduced.

3.11. Significance of the study

This study breaches a gap in South African literature in describing and analysing the experiences of a methamphetamine addict, as well as those of family members. A descriptive case study of this nature could be viewed as a revelatory case because it allows the opportunity to study a phenomenon, previously inaccessible to scientific investigation (Yin, 1994). Therefore, this study will significantly act as a prelude to future research and provide valuable insight into this phenomenon.

CHAPTER 4:

4. ANALYSIS AND DISCUSSION

4.1. Case background information:

4.1.1. Core participant: Nicolas

For the purposes of anonymity and assuring the protection of the participant's identity, his name will be changed and will hereon be referred to as Nicolas.

At the time of the interviews, the core participant was twenty-four years old, unemployed, and lives with his mother, stepfather, grandfather and three other siblings (i.e. one sister and two younger brothers). According to this participant, his mother was forced to adopt the role of both mother and father, as his parents have been divorced for approximately eight years. However, his mother has recently remarried. In the year 2000, he failed two of his matric subjects and hence attended a technikon where he started a trade in electrical engineering, which he has not completed yet. Living the student life, along with an old neighbourhood friend, he regularly attended classes and enjoyed making new friends in his new environment. Adapting and engaging with his new surroundings, he made his first contact with people experimenting and using methamphetamine (MA). His neighbourhood friend showed a particular liking for the drug and hence introduced the substance, as well as the various techniques in which it is used, to Nicolas on his twenty-first birthday.

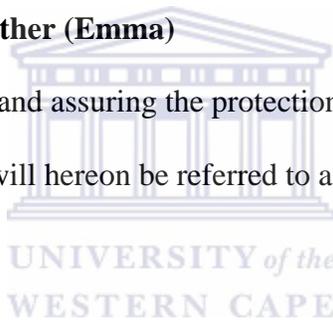
After becoming an adept user himself, Nicolas started engaging with very different social groups and found himself socialising more and more with other methamphetamine users.

This is how he further developed his substance-using career and also discovered that two of his younger siblings at home have been moving in these drug-circles long before he has. However, he claims he never engaged with them in any drug-related activities, nor did he confront them on their secret.

Nicolas has been addicted to methamphetamine for approximately four years now, of which he has been abstaining from any substance use for less than six months. He has never been to a rehabilitation centre and is attempting sobriety without professional help.

4.1.2. Family Participant: Mother (Emma)

For the purposes of anonymity and assuring the protection of the participant's identity, her name will be changed and will hereon be referred to as Emma, or as the participant's mother.



Emma is a well-educated, assertive woman that was an active member in her community. She was previously involved in voluntary work that aided the development of her community, as well as the support of members in need of aid and guidance. The forty-four year old mother of four (i.e. three boys and one girl) has recently been remarried after a tumultuous divorce. Before her recent remarriage, she was her family's only source of income and hence worked two jobs to maintain their livelihoods. Therefore, she spent very little time at home and was not able to provide her children with the needed parental guidance and supervision.

Being the mother of three methamphetamine-addicted children, her roles of primary caregiver, financial provider, as well as part-time student has become increasingly difficult to maintain under the current family demands. Therefore, she was forced to resign from her work and attend to her family in crisis. Hence, this participant was an unemployed, stay-at-home mother at the time of the interviews.

Above a brief description of the core participant- and his mother's background has been provided, as well as contextual information that was relevant to the particular time of the interviews. The following section will identify and discuss the emerging themes from the interview data, and will thus describe the experiences of a methamphetamine addict as well as that of a co-habiting family member.

4.2. Common themes between core participant and family member

4.2.1. Methamphetamine-use developmental path & Polydrug use

Both participants revealed that the aetiology of Nicolas' experimentation with substances is related to a past traumatic experience in which he was physically assaulted with an axe. According to these beliefs, Nicolas started using substances as a way of coping with the emotional difficulties associated with surviving this violent assault. Nicolas describes how the incident happened and how he is aware that this pushed him towards methamphetamine use:

“One day hey, out (unclear) my friend's sister was hit by the police's drug squad...and as result we had an argument with them man. Then we told them that it is not right to hit a woman like that. Then they asked us, who are we? They would have taken the both of us but instead they just took me...and they hit me with an axe (showing the scar across his skull). And from that day onwards...that was before my 21st. A few weeks before that.

And it was from that that I had started with this drug. With that trauma...I will never forget that. And so it went on” (P1:Int1:11).

His mother confirms his report:

“But the eldest one, Nicolas, started substances when he had an encounter with the police. They actually hit him with an axe... And from there he just went the opposite way of doing right. That’s from the age of 20....that he started” (P2:Int1:04).

The mother also reveals other plausible factors that she believes may have influenced her son’s aetiology of substance use. She reveals that her son was trying to cope with a lot of changes in the family, for instance, his parents’ divorce and not having an available father figure. Furthermore, he had to learn to adapt to new emerging problems in the family such as financial insecurity, as well as his mother’s increased absence from the home due to her having to work two jobs:

“I think he needs his father. He needs a proper father figure. In terms of that, is actually lacking...He’s struggling mostly not just with the divorce but because where it all started. In terms of that, he is struggling with a lot today” (P2:Int2:22).

“Because also what I believe in, the breakage of my marriage, the the debt that I was in um...the the factors that brought this on...there wasn’t always something for them to eat because you need to cover debt. When I got paid the 15th because the father didn’t contribute to them...it was difficult. You know, getting where you at and maintaining what you had. It’s not so much to get things but to maintain what we had. I had to get some, I had two jobs. And um, it was difficult. Coming from the one job out of the day-shift, right into the other job. To try and keep the family together. But you could only keep it together because you needed to have finance” (P2:Int1:14).

According to Nicolas, his addiction to methamphetamine was not immediate, but a gradual process of experimenting with various other substances before his introduction to, and subsequent preference of, methamphetamine. He reports that he started using

alcohol (his gateway drug), after which he used ecstasy. Cigarette smoking was only initiated after his introduction to methamphetamine.

Interviewer: Now, with what substances have you started with? I know the tik was one but with what did you start off with?

Participant: Alright, wine.

Interviewer: Wine. And cigarettes?

Participant: I did not smoke, I never smoked. Just afterwards yes. But now I have stopped smoking. I was merely a casual smoker.

Interviewer: Okay.

Participant: Before tik I popped e's.

(P1:Int1:12)

Being introduced to methamphetamine by his close friend on his 21st birthday, he acquired the skill to self-administer the drug, developed a liking for it and gradually started using it more and more. Nicolas' journal supports this description of his first use, as well as his gradual increase in use, and liking for, methamphetamine.

“When I went to technikon ne, halfway through it, with this friend of mine, but we grew up next each other, grew up in front of each other. (unclear). Then he introduced me to this...And on my 21st. I will never forget it...Yes, and I was willing and up to anything. Then afterwards, then it was about this, then we explain to each other, this is how it's done, then it goes around, then he holds it for me again...Yes, it is first the big lollie then the small one. But okay, now he shows me. Like this he shows me. Then after a while, then I started doing it myself...” (P1:Int1:03).

“When I am with him (i.e. best friend)...then we party....It went every weekend...It went, once a weekend and then I ended up going to him during the day as well...Becoming more and more and then it became an everyday thing. Then we end up sitting there whole day...through the night.” (P1:Int1:14).

Reportedly, methamphetamine was almost always used with other substances, for

example alcohol, marijuana, and ecstasy.

Interviewer: Now when you mixed your drugs, what have you mixed before? With tik that is?

Participant: That was all...and then we smoked marijuana as well. But with him, I just did that when I “dubed” with the friends (i.e. smoke weed).

Interviewer: So most of the time it was marijuana that was used with tik? Alcohol?

Participant: All the time.

(P1:Int1:12).

The above was further substantiated by the events described in his journal, in which he listed the use of various drugs such as rocks, mandrax, heroin and ‘magic mushrooms’.

The participant also recalls an occasion where using more than one substance at a time has had a negative effect on him and caused him to hallucinate.

Participant: Now, that day that I used the tik, something told me to take e’s, like the ecstasy pill...now they first give you a half...

Interviewer: To check if you are okay afterwards.

Participant: Yes, then they see if you can cope, okay you cope nicely. But that, then afterwards then we did this, then we tik...

Interviewer: At the same time?

Participant: E is, e’s are a double drop. Then that evening, then I don’t know what happened but I started to hallucinate. But I know for a fact that I was not right, I started seeing things. (P1:Int1:11).

The mother reveals that she is convinced that her son started his drug career on heavy substances and has suspected him of polydrug use. Also, she could not accurately name the substances he used on his substance development path, she was aware that he was on a mixture of substances.

“I think he started off with heavy things. Like um dagga, marijuana. Your LSD. I’m I think he was on tik. Because I could have, I could’ve seen the mixed behaviour...I think the gateway drug, when he had started, on, it could have been on on on heroin, or

anything...but when he talked I could hear he was on a mixture of things” (P2:Int1:05).

The evidence presented above shows that methamphetamine use was frequently paired with different substances, especially alcohol. This finding is in line with other research as polydrug use is very popular among methamphetamine users, of which alcohol has been identified as the most common substance paired with this drug (Fields, 2001; McArdle *et al.*, 2002).

Literature suggests that peers are one of the most important units of socialisation to influence an individual both directly and indirectly (Hesselbrock, Hesselbrock & Epstein, 1999). Evident from the findings, the participant has revealed that his close friend introduced him to methamphetamine, and spending increasingly more time with this friend and their peers, has gradually increased his acceptance of their drug-using behaviour as well as progressively lead to his addiction to, and preference for, methamphetamine. Therefore, this finding substantiates Hesselbrock, Hesselbrock and Epstein (1999)’s argument that an individual’s continuous association with deviant peers increases the likelihood of accepting deviant behaviours, values and attitudes, and therefore increases the risk for substance use.

4.2.2. Effects of Methamphetamine use on the user

Various effects of methamphetamine use have been reported by both mother and son. These effects range from behavioural, emotional and cognitive changes to negative physical effects.

4.2.2.1. Behavioural changes

Nicolas and his mother both noticed drastic changes in his *behaviour* in terms of aggressiveness and violent outbursts. The participant reflects on these experiences: *“Your behaviour....You become very aggressive. When someone says something to you, before he even says it, then (unclear)...then just say something wrong then...no, then you’re on your high-horse! Then you become rude man. You say things...that you don’t want to say but okay, you will say it... But if you do fight, then there is no stopping it”*

(P1: Int1: 06).

“I won’t say they are being on purpose, but you are so far gone in your mind hey. It’s almost like you know that you are the one who done that thing but there is just no point of return when you go off” (P1: Int2:02).

The mother substantiates these reports of aggressive outbursts by reflecting on her experiences of living with a methamphetamine user:

“Yes very much a behavioural change. From the softest child that I know, like he is now...that... He was a quiet child, you could tell him anything before, and he wouldn’t moan and groan. And he would accept what you had to say. But with the incident that happened when he went to court, you could see definite, he was the complete opposite of what he was. More aggressive, more shouting, more domineering. More, more of everything” (P2: Int1:06).

Interviewer: Was there any cases of violence that came with that?

Participant: Yes, yes, yes. It became like that, first from that was the verbal aggression, then it went to the physical where my stuff was taken and thrown. I had beautiful stuff. You know, my glass table was broken down, my ornaments. You could have seen, he even once wanted to take the TV and throw it against the wall... (P2: Int1:06-07).

“I feared most of the time, like em, violence. They would, they they very violent. More than anything, there was a lot of violence” (P2: Int1:12)

Nicolas reveals that the use of this drug leads to the lowering of his inhibitions and decreases his ability for self-restraint:

Participant: You will just say what is on your mind at the time, you won’t prevent it from coming out. You will say it just as it is. Whether you are going to like it or not. Or what the next person...

Interviewer: So there is no restraint?

Participant: There is no restraint. You just maybe, for your grandfather that you have more respect for...you will scold at him. Say: "No, huh-uh you, you won't tell me! Like that man.

Interviewer: So it kinda changes your whole personality?

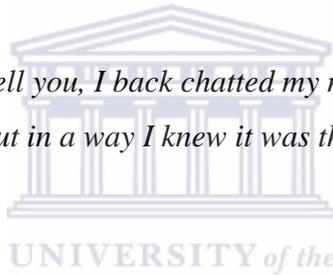
Participant: Hey, totally. You carry on like a wild, wild animal. (P1: Int2:11).

4.2.2.2. Cognitive effects and changes

According to Nicolas, he was in a constant state of denial where he believed he was in control of his usage, and that the changes he was going through was not due to his substance use:

"I will tell you straight man, this drug is a thing that...it corrupts your whole life. You are in denial at all times" (P1: Int1:09).

"Yes, with the scolding, I will tell you, I back chatted my mother yes. And screamed: Yes! Yes! It is not the drugs! But in a way I knew it was the drugs...you are lying to yourself man" (P1: Int2:04).



He also noticed certain changes in his thinking whereby his thoughts were gradually consumed more and more by thoughts of wanting the drug:

"The drug turns your whole mind, your way of thinking. Everything you do, you do differently. You become smart...first thing, it helps you stay awake to study. Thereafter, then it becomes such a habit. Then it's a pattern in you, it takes you...then...then...then you have to have it" (P1: Int1: 06).

Emma also noticed certain changes in his reasoning and thinking. It became apparent that he argued from a viewpoint where he believed that 1) she does not understand anything he might be going through; 2) she should not tell him what to do; and 3) that *she* is the source of the problem:

"His reasoned like, you don't understand, you don't know what I'm going through. It's like we don't know. He's the only one that knows. It's like, we don't understand, you don't know...like don't you be telling me because I am telling you this! I am telling you

that! Things like that. It's always not them, it's always you. It's never them. It's never them it's only you" (P2:Int1:11).

Nicolas admits that his use of methamphetamine has affected his way of thinking and has compromised his sense of reasoning, especially towards his family:

"...but sometimes you are so consumed by the drugs that...you cannot blame the drugs but it makes you...your mind, how can I say, your whole attitude...changes. Anything can happen. You can be very unreasonable. You can lose your temper. But you will not be unreasonable with your friends that do drugs with you. You adopt them as your family" (P1: Int2:15).

4.2.2.3. Emotional changes

Aside from behavioural and cognitive changes, the participant as well as his mother reported significant shifts in his **emotional state**. Firstly, they report that he has been indifferent towards things around him:

"But then then you become retarded, you don't worry anymore. Yes, you hang loose. Then you don't worry" (P1: Int2:02).

"I became never-minded man....the drug hey makes you neglectful. You don't feel like doing this thing. You don't feel like doing that thing. You do now what you feel like doing. And those ways are not the right ways" (P1:Int2:09).

Nicolas's journal, as well as the description of his mother substantiates that he became indifferent:

"I started to care less about things" (P1:Journal:05).

"They didn't care about the world around them. He wouldn't know from Monday to Tuesday. He lost complete sense and input of time" (P2:Int1:10).

Secondly, both participants noticed a dramatic change in his mood and described it as fluctuating between being depressed, irritable, and 'edgy'. Emma describes the changes she noticed in all three of her addicted children, including Nicolas:

"Well, he was very awkward. You could see he was like his normal self, almost, but you could see also that that that they're edgy. They want to go, they want to go, they want to get something. Like they say, their feet are itching!" (P2:Int1:11-12).

"Very irritable. Very irritable. They very moody as well. But not so much in aggression" (P2:Int1:12).

"Ja, they were very depressed. They were feeling down" (P2:Int1:12).

Nicolas reflects on his own experience:

"Your moods change" (P1: Int1:08).

"You will, for yourself ne, you know that you are not like that, but you will start saying things to each other, curse and scold and fight. You will be unhappy about something. Anything. It's just that, especially on your comedown. You just not in the mood ne. You will say you just don't feel for all of this hey. There is a moodswing with that. You're just...nobody should say anything wrong now...." (P1:Int2:04).

4.2.2.4. Physical effects

Several physical effects of the drug were also identified by both the mother and her son. The mother reported more noticeable effects like weight loss, disturbed sleeping patterns, and cravings for sweet things:

"...he lost a lot of weight" (P2:Int1:16).

"He was just sleeping, then he was eating, I must just provide. Its like, he sleeps sometimes for 4 to 5 days. No, not straightforwardly. He would sometimes get up to go to the toilet. They use to eat. Sweet tooth. Oh, sugar stuff didn't last long. They very sweet toothed. What I, I think the people that are on drugs they crave a lot of sweet

things” (P2:Int1:10).

Nicolas, on the other hand, describes other effects that include severe headaches, involuntary movements, and a decrease in appetite:

“Sometimes you have involuntary movements man” (P1: Int1:22)

“Your sleeping habits. That is the first thing that is disrupted. Yes. Some nights you sleep through it. But then you feel the same way when you wake up the next morning. Or you get severe headaches” (P1:Int1:24).

“You don't have an appetite. (unclear) then I didn't eat because when I was there all I ate was drugs. And that 50c chips ne” (P1:Int1:24).

These descriptions were all reflected in Nicolas’ journal as well.

He furthermore describes how a tolerance for methamphetamine developed as time progressed where he found himself having to administer the drug twice in order to feel the same effect he initially felt when starting off with one hit:

“It’s nice...nice and...you’re going to go twice on one hit to feel that” (P1:Int2:10).

In his attempts to decrease his usage, Nicolas reports that he has experienced some rather unpleasant withdrawal symptoms:

“I will tell you...crystal meth is not something that just goes out of your body. Joh, I will tell you, there are some days that I had bad cramps” (P1:Int2:06).

Various effects of MA-use have been reported by both the participant and his mother. The behavioural changes identified by both these participants can be summarised as a noticeable increase in aggression, violent outbursts, as well as a lowered sense of inhibitions and self-restraint. Dramatic changes in the user’s emotional state have also been reported and have been identified as being overly depressive, irritable, and ‘edgy’. These findings are consistent with previous research on the effects of methamphetamine

use where this drug has been correlated with intensified emotions, irritability and altered self-esteem, as well as extremely aggressive and uncontrollable violent behaviour (Beebe & Walley, 1995; Doweiko, 1999; Emmett & Nice, 1996; Plüddeman, Myers & Parry, 2007). Depression in MA-users has also been earmarked as a common side-effect of chronic use (Fields, 2001; Plüddeman, Myers & Parry, 2007).

According to Sheehan and Owen (1999), *denial* amongst addicts are one of the most common methods of defence against the severity of the using behaviour, its harmful consequences, and the reality of their situation. Nicolas's denial of his addiction to methamphetamine sheltered him from acknowledging that he had a substance-use problem, as well as the reality of the effects of his addiction on his family. Denying that he has a problem could be viewed as (1) a result of the cognitive changes and irrational thinking induced by methamphetamine; as well as (2) a contributing factor to sustained use of the substance. Therefore in terms of the *Model of maintenance of Substance abuse*, Nicolas' denial of his addiction can be interpreted as a powerful *antecedent to*, as well as *consequence of*, prolonged methamphetamine use. This psychological phenomenon can therefore be seen as the mechanism by which his MA-using behaviour is maintained.

It was also reported that Nicolas experienced an increased tolerance for the drug as time progressed, and found himself in a position where he needed to increase his usage in order to gain the desired effect. This substantiates Fields' (2001) assertion that many of methamphetamine users develop a tolerance quickly and hence start using more compulsively soon after their initial use.

Decreased appetite and severe weight loss is usually associated with methamphetamine use (Plüddeman, Myers & Parry, 2007). Weight loss has been marked by both parties but the mother did not notice a decrease in appetite, in fact she noticed the complete opposite in which she witnessed her son (and her two other addicted children) consume large quantities of sweet things. This can be explained by the fact that when the participant is away from home during his drug-binging periods he does not eat for days, whereas when

he is back home he eats (perhaps sweet things) in abundance. This is where his mother witnesses an increase in his appetite without knowing about his loss of appetite during his periods of use.

4.3. Effects of methamphetamine use on the family unit

Both participants report that the use of this particular drug has significantly influenced the family, their family relationships, as well as their relationships with people outside of the family unit. The evidence suggests that methamphetamine abuse breaks down family life and evokes feelings of failure.

“But at the end of the day I saw that I was working towards nothing. I was just bringing myself down. And that which I saw at home, you just break the house down even more. It affects the whole family. I will tell you that it pulls down the whole family. And do you know how long it takes? It’s only now that things are going nicely but it is still hard. I am not going to tell you it’s easy” (P1: Int2: 08).

Nicolas reveals that the existing trust and respect between family members is broken as result of his drug-related behaviour. The loss of this sense of trust and respect is reportedly very hard to restore:

“The damage hey, to think, you’re already pushing your family away from you hey. The trust and whatever, what you had with your family, you break that. And to get that back again...it is...it takes you much more time to get it right again” (P1: Int2: 08).

At the end of the day...your own mother will lose her respect for you. And to regain that respect again...you have to...you still have a lot to prove to her so that you can get it back. (P1: Int2: 11).

This participant also reflects on the effects of this addiction on the existing family bond and previous relationships with family members.

“Your bond with your family that you had...all these things go down the drain” (P1: Int2: 09). “ Okay, emotionally it makes you feel...joh...the person I use to look up to most...I cant look up to her anymore. Because I disappointed her. And because I

disappointed her, I disappointed myself. Now you know I sit with a.... a double load. Of yourself and the thought that you don't have that same...you can't just confide in them anymore because all what she once stood for, I went and weakened and taken away" (P1:Int2:12).

Methamphetamine use has also been linked to creating a dysfunctional environment in the home where issues cannot be addressed constructively, and where the family struggles to function as a unit. The participant also describes a sense of ownership in creating disequilibrium in his family system.

"I will tell you, we, I will tell you as a family, we have our problems but...it was major but with the, the drug problem, it makes it, it becomes, it makes everything chaotic. Things get so out of hand...that you sit with a problem that you cannot tackle now because you cannot tackle it without your family. Because now firstly you need to re-group them...to help with the problems. We did not see that at first. Now that's what the drug does. Really. In order for the family to recover, they firstly now need to help you. If you want to be helped" (P1:Int2:16).

"But everything you do, it is something that, it's a setback in life man. For yourself, for your family. It avoids your family to go forward because why, they trying to build up, and you break down" (P1: Int2: 19).

A recurring theme throughout the interviews was that concerning the high level of family disputes and fighting that has resulted from the frequent use of methamphetamine. Reportedly, family fights would usually originate from minor squabbles like siblings teasing each other, and would escalate to a physical fight:

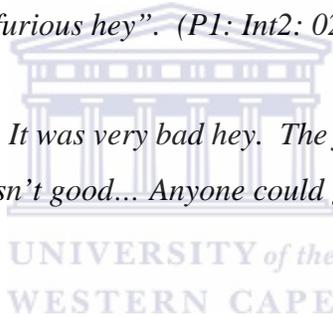
"When we're arguing with each other. Usually it starts with something small. Like my little brothers start arguing. They are playing in a way...but now...then you step in and tell the one to stop it now. But the one will continue to tease the other one. But now at the end of the day they start to fight. Now of course the older one is not going to lose. Then it comes down to me having to break them apart. Cause now the teasing, it gets ripped out of proportion...that you don't want to hit the one. But to break them apart,

you have to stop them from fighting you see? Now it becomes a whole story. Now the other one also gets involved” (P1: Int2: 01).

High levels of aggression as well as violent interactions have also been reported where family disputes are concerned:

“Now, you become frustrated. Now you begin to become aggressive. Not that you want to. You’re trying to avoid but it eats at you. It eats at you. They just say something, and so it goes on. Now they’re also doing their thing here on the side. Now we interact. Now we at each other’s throats. Now it becomes a situation where my mother, she cannot get involved. But she is always in the middle. It causes big problems hey. I’m not talking about normal cat-fights at home, not just this of arguing amongst each other. It gets worse you see. I have a...my mother could just have said something then I get onto my high-horse. Then I’m furious hey”. (P1: Int2: 02-03).

“I will tell you now it was bad. It was very bad hey. The fighting amongst each other was already something that wasn’t good... Anyone could get hurt at that time... We fought a lot...” (P1: Int2: 03).



“Everyone should just steer clear of me, then it will all be alright ... You are not the person you truly were before. You are in another state of mind. In your own world. And in that world you do not want anyone to be in your way. They should just steer clear. Even though it is your mother. You have to survive by her rules you see? But you want your own rules...And, I will tell you, my mother has called the cops already”. (P1: Int2: 04).

The mother also reflects on the high levels of aggression and violent interactions in the household:

“No no no, that was, that was very aggressive. Like very in a, like in a very, whirlpool...it always landed up in a fight between the two that you have to be in the middle of the two. It gets physical then you have to keep the two apart from each other. Because I am the mother and I can’t see them fight. Sometimes the conflict is between

two of them, sometimes when I argue and then the one hear and say “but hy’s ombeskof met mammie¹” and you know, that type of thing, then they two are at it. Then it’s away from them, then you have to get them out of there and you have to be the mediator on both sides saying “you can’t handle it like this, you can’t handle it so” ...it really is like two, three roles at a time. You have to be the peacemaker, you have to be the arbitrator, you have to be the judge...” (P2: Int2:10).

A recurring theme that emerges from family disputes is that of evading. According to the mother, the siblings who are in conflict with each other display the tendency to avoid taking responsibility for their actions, and they are also not accountable for their role in initiating or aggravating the dispute.

“They are always pointing it to the other side. Like they would say: Why are you not talking to that child of yours hey? Now you want to come and talk to me!? You know it’s like always bringing in the other one that is doing wrong but then I would say that your name is Nicolas, or your name is Peter. I’m speaking to Nicolas, I’m not speaking to Peter! You see you need to make, you constantly have to remind them that you not speaking to him, you’re speaking to him”. (P2: Int1: 11).

Also, the mother reveals that her addicted children also tends to divert attention away from their own dysfunctional behaviour and target her parenting skills as the cause of conflict.

“...it’s more when they’re on drugs. We would always fight or disagree about that I am actually handling the whole situation the wrong way. They would target me. They would target me in the sense that I would be to be blamed...” (P2: Int2:01).

“We will always fight um, that you on tik. ‘No but I’m not!’ You know, always that type of thing. ‘But you don’t look right. Now how do I look? It’s just the way I know you...you don’t look the way you should behave’. And then that’s the way we end up fighting. Then the other fight would be that I’m taking everybody else’s part. Never theirs. So, that is the fight most probably that I’ve been coping and struggling a lot.

¹ “but hy’s ombeskof met mammie” – Afrikaans for “but he is rude to mommy”.

When I speak to the one, the other one would say but ‘he’s doing it and you are not telling him what he is supposed to do. You are not telling him what is happening’”. (P2: Int2:02) “So it was always the thing that you talk to him about, was always reversed to another child. It was like...it was like...it was like a nightmare”. (P2: Int2:03).

Nicolas reports that when he was using, he spent long periods of time away from home, roaming the streets:

“Basically I live here ne...but when I was on that...tik...I was basically roaming the streets. Two, three days, maybe afterwards it starts going into weeks...Because after a while you get tired of...um...then you come home, just to rest a while. And when you’re done resting then you just go out again” (P1: Int1: 01).

This was also reflected in Nicolas’ journal and revealed that, when his mother kicked him out of the house he would go and live with the drug dealers:

“My mother chucked me out of the house because she knew I was on drugs plus on top of this I was also working for them. I took my clothes and I went to live by them” (P1:Journal:05).

He reports that although he knew his mother’s intentions were to bring peace to the home environment, it actually stimulated his drug-using.

Interviewer: “How has this influenced your drug-using? Did you move more towards it?”

Participant: “Yes. Then you would say: Yes, I will rather go there [to friends to go do drugs].” (P1: Int2: 18).

The above evidence describes the effects of methamphetamine-use on family functioning. Both participants reveal that daily interactions between family members are characterised by conflict, high levels of aggression, and violence. It was also shown that the introduction of methamphetamine use in the family leads to a 1) deterioration of interpersonal relationships within the family unit; 2) a breakdown in effective communication; 3) dramatic increase in levels of aggression, physical violence and

temperament; as well as 4) evading responsibility and inappropriately assigning blame. These findings are consistent with previous research that indicates that well-known adverse effects of methamphetamine use include extremely aggressive and violent behaviour (Brecht, et al., 2004; Emmett & Nice, 1996), as well as experiencing difficulty in maintaining healthy relationships with family and others (Seivewright, 2000). It also reflects Sheehan and Owen's (1999) understanding of substance-related behaviour where an elaborate system of defence emerges from these individuals for example denial, intimidation, angry defensiveness and manipulation. These defence methods are usually used to defend against the severity of the using behaviour, its harmful consequences, and the reality of their situation (Sheehan & Owen, 1999).

Habitual family conflict clearly poses a major challenge to the family system in terms of achieving and maintaining *homeostasis*. Its prevalence is symptomatic of family dysfunction and therefore causes difficulty in the system's attempt to regulate itself (Sharf, 2000).

According to O'Farrell and Fals-Stewart (1999)'s *Model of maintenance of substance abuse*, the maintenance of drug use can be understood as an interplay of various factors, which in this case, inter-personal conflict and family dynamics are most relevant. Frequent family disputes and physical fights can be seen as powerful antecedents to, and consequences of, substance abuse. Emerged from the evidence presented above, family disputes are usually a result of the mother accusing her children of being under the influence of methamphetamine. It was also reported that family fighting resulted from the children being more temperamental and aggressive as result of this drug, and hence resulting in disputes amongst each other. Therefore, family fighting was a *consequence of* substance use. The findings also indicate that family fighting was a powerful *antecedent to* substance use where the participant admits being pushed towards more drug use when he leaves his house as result of family fighting. Being out of the house for days at a time locates the participant in a rife drug-using environment in which his substance-using behaviour increases dramatically, and therefore encourages and maintains his addiction.

4.4. Criminal Behaviour

Both participants marked an association between methamphetamine use and criminal behaviour. Although Nicolas does not admit to stealing things from the home to sell for the purchase of drugs, he does however report this behaviour in his friends and siblings: *“I was tikking and tikking and all this stuff. But I have never taken stuff...Yes. I will tell you, I do not know, I will tell you those days that a man don’t have money for tik, then it is a temptation. Then you think, how much will I get if...here’s a jeans, here’s a TV. But I never did that though. I have never gone that far. I was glad for that. But my other friend...he stole his mother’s cupboards bare...and all those kinds of things...But I will tell you one thing, I have never...towards my mother...how can I say? Some children will stand here against their mother’s throat with a knife or something for money for the drug, or steal things” (P1: Int2:05).*

Furthermore, he reveals that he was falsely accused of stealing from the home by his mother because he was the only known methamphetamine user in the home at the time. His mother was not aware that two of her younger children were using as well.

According to Nicolas, these siblings were stealing from the home in order to acquire the needed funds to support their habit. Therefore, he recalls numerous incidents where his mother falsely accused him of stealing valuable objects from the home:

“Now part of the reason was that I did not know why things disappeared around here. But now my mother was blaming me all the time...Then I saw only at a later stage, intentionally if I do say so myself. That’s that because it was the other children you know. But my mother still does not want to believe that. She does not know that the other children do wrong things as well you see” (P1: Int2:05).

“Yes, yes, and then I found out. By that time they have stolen my mother’s things...and sold it for this stuff (i.e. methamphetamine)” (P1: Int1:04).

According to Nicolas, he was enraged by the fact that his mother falsely accused him of stealing and did not want to believe him when he pointed out the other siblings’ addiction

as well. Therefore, he recalls this one incident where he was furious after another false accusation and then stole his mother's old geyser to justify her claims:

"It's because I started to scold about it. Hey, then I was furious ne. (unclear). But I did once, neverminded. They put in another geyser, then I stole the other one. But okay, not because I had to do it...but I just figured...they blame me anyway..." (P1: Int2:05).

Aside from this isolated incidence where he stole from his mother, he discloses that he moved from using the substance to selling it as well. These activities are confirmed by the descriptions in his journal:

"But as things goes on and on, there is this guy, a whitey, that sells the stuff. Then I thought, I can also do that..." (P1: Int1:05).

"You work for the merchant². They give you what you want but you just have to do what they tell you to do..." (P1: Int1:08).

His mother believed that he was stealing from her and that this resulted from him being under the negative influence of his friends:

"The friends was already there. Doing these things and selling off things. And that just took the opportunity of grabbing him" (P2: Int1:05).

She also recalls various objects she has lost due to theft that were sold for money to buy drugs:

"Joh, I will tell you one day (unclear) I was making me a cup of coffee or tea, and when I got to the next morning I was looking for the kettle!...Oh, in terms of of losses, I've lost all my jewellery that I have accumulated through all the years. I've lost...a lot of things. A lot of things. But in terms of that, they tend to steal" (P2: Int1:12).

The mother's belief that all her children, including Nicolas, has stolen from her is evident from her testimony. This is in direct opposition to Nicolas' account that he never stole

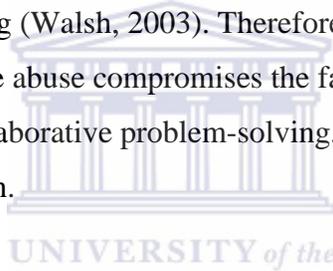
² "Merchant" – Drug dealer in South African lexicon.

from her during the period of his substance usage. This is however with the exception of the one incident where he stole the old geysir in reaction to the false accusations. Except for its association with stealing, MA-use has also been linked to other illicit behaviour such as drug-dealing. The participant entered the drug market by working for a local merchant in the selling and distribution of illicit substances. Selling illegal substances became a means of generating a lucrative income and acquiring financial stability in order to sustain his habit; as well as allowing free access to methamphetamine and other desired substances for his personal use. Working for a drug merchant therefore placed the individual in an environment that is conducive to continuous substance use, and therefore enabled him to maintain his addiction. Therefore, these environmental factors can be viewed as powerful antecedents to, as well as a consequence of, his substance abuse (O'Farrell & Fals-Stewart, 1999). Employing the S-O-R-C model from the *Model of maintenance of substance abuse*, the participant's employment is the stimulus (*Stimuli*) that supplies his physical need and cravings for methamphetamine (i.e. *Organismic* factor) in terms of continuous exposure, access and availability. Nicolas responded (*Response*) by sustaining his substance usage through continuing to work for the merchant in return for money and access to drugs. Therefore, he maintained his addiction through the positive consequences of using (*Consequence*). These positive consequences are, for example (1) the pleasure-stimulant effects of MA-use itself; (2) free and unlimited access to various illicit stimulants in exchange for his labour; as well as (3) access to a drug-using environment where he can use ("get high") without interruption or judgment.

The discrepancy between the mother and the participant in terms of objects being stolen from the home also reflects a compromise in the family's ability to communicate and problem-solve effectively. The mother is not able to accurately determine who is responsible for the theft in her home and assumes it is Nicolas, as he was the only known MA-user at the time. Her perception is later changed when her son brings it to her attention that two of her other children are also using methamphetamine. In light of this knowledge, the mother (in collaboration with the rest of the family) is unable to effectively eliminate the problem of stealing from the home since three of her children

(i.e. half of the household) are under the influence of methamphetamine. Therefore, in relation to the *Family Resiliency Framework*, this family is not able to 1) creatively brainstorm ideas on how to effectively solve this problem; 2) negotiate terms in which this behaviour will be monitored and actively discouraged; and 3) engage in effective conflict resolution (Walsh, 2003) that could minimise the negative interactions between the mother and the participant.

When Nicolas defended against the accusations of stealing, he reported that his mother did not believe him. Therefore, in reaction to these events he recalled an incident where he stole his mother's old geyser to ultimately justify her claims. By stealing the geyser, the participant's response to the false accusations reflects his inability to appropriately express his emotions, as well as the family's ability to find clarity in messages through truth-seeking and truth-speaking (Walsh, 2003). Therefore, the evidence presented above suggests that methamphetamine abuse compromises the family's ability to effectively engage in constructive and collaborative problem-solving, as well as sustain an open and clear channel of communication.



4.5. Steps taken to discourage Methamphetamine use

The mother has taken various steps and actions to discourage her son's drug use. For example, she gave him an ultimatum in which he was to cease his drug-use or leave the home. Hence he was frequently kicked out of the house and subsequently allowed to return. This cycle became characteristic of the drug-use in the family for the past three years.

"...I chucked him out, I chucked him out with a court order. And he was in and out of there for about three years. Till he come right yes. He comes right then he comes back and then off the wagon again, and then I throw him out again. Then he comes right, then he comes back and then he starts and then we throw him out again. And it was like that for quite some time" (P2: Int1: 09).

Her son, Nicolas, substantiates her claims:

“Then I come home, my mother kicked me out everyday. Not because she wants to, but because she does not know me like this” (P1: Int2: 09).

Drastic measures were also taken in the household itself to discourage drug-use in the home.

“And if you look through the house you’ll see there is only one door, that’s my door (i.e. on her bedroom). I took their doors off...” (P2: Int1:13).

Also, the mother never accepted money or gifts her son brought home from his illicit activities:

“...I never use to take money from him when he was doing those things. Because I didn’t...I believe that parents encourage things. You can de-courage a child or you can encourage the child. Although you’re tempted because you see that money and you need it, you know what I’m saying?” (P2: Int1:15).

Being a working mother before, Emma reveals that she wasn’t at home enough to provide her children with the necessary supervision. As a means to discourage their drug-use during this time, she made some drastic changes concerning her employment status and her physical presence in the household. She believes that this decision has encouraged her children to change as well.

“I needed to get away from the 7-7 job...because that was actually keeping me away from home. But I couldn’t just sit at home. I had to do something. Studies was always on my mind. Having also a 9 to 5 job would’ve been very nice. Because there was no money coming in, according to them their mother was never here, out there in the morning. So in terms of my changes, it made them also change”. (P2: Int2:14).

Lastly, the mother spoke to members of the extended family and informed them about the substance-using problems they are experiencing, instructing them not to give her son any money.

“I said to my sister, “you don’t give him money”. That is one thing you must do for me...” (P2: Int2:22).

These findings illustrate the steps the mother has taken to discourage substance-use in the family unit. The evidence presented here reflects some processes that mediate the family's recovery to crises, especially in terms of Walsh's (2003) understanding of family resiliency where *organising patterns*, and *communication- and problem-solving processes* are concerned. In terms of family *organising*, the mother resigned from her place of employment (leaving her husband as sole breadwinner), which freed her time to attend to her family in the time of their crisis. This enabled her to provide the necessary supervision to her children and focus more directly on the substance-related issues within the family. Therefore, rearranging the social and economic resources to such an extent that the family unit could achieve a balance between their economic needs and family strains (Walsh, 2003). In terms of *communication and problem-solving processes* in this family system, the mother took active steps towards fostering collaboration from the broader family. She approached members from the extended family to 1) inform them about the substance-using problems within her family unit, and 2) instruct them not to give her son any money as this would encourage his drug-use. Therefore, the mother attempted to forge alliances with extended family members in terms of managing the *antecedents* to substance use, and build structures for collaborative problem-solving. These attempts, however, have not been successful as the mother reports receiving no support from the broader family, friends and other social networks.

4.6. The Road to Self-recovery

The participant stopped using methamphetamine without the assistance of a rehabilitation program. According to Nicolas and his mother, he did not need to go to a rehabilitation centre since he was strong enough to fight his addiction on his own.

“Rehab is one thing but it does not help like that...I just told myself...I am done now...I will tell you...I will tell you that I was addicted yes. But I got myself off it man”
(P1:Int2:06).

Aside from believing that formal rehabilitation programs are ineffective, the mother believed that it is her son's responsibility to get himself off the drugs since he was responsible for becoming addicted in the first place:

"...I'm not going to send this kid off to rehab. They've gone on it, they will get over it then" (P2:Int1:10).

"Because I didn't see it as an option. He got himself on it, he needed to clean himself. Yes, he needed to do it himself. And he did it basically himself" (P2:Int1:18).

Nicolas and his mother both reflect a very strong religious affiliation and attribute their current progress in fighting his addiction to these convictions:

"I became a religious person. I go...Sundays I go to church...(unclear) so go sit in church. But I have not forgotten. That's one thing that keeps me strong. But I know I am a very strong person. But there are a lot of people that aren't" (P1:Int1:09).

"Then with all this happening to me I felt alone, but always know God was with me through all of this. I always acknowledge GOD as my everything" (P1:Journal:07).

"...So I also believed that I had to pray to God, and ask him to help and assist me. And through the grace of God...it's not me...it's through His grace I got Nicolas now" (P2:Int1:18).

"And I believe God has, God has got a reason for this. And I am thankful to the Almighty Father, our creator. And he has seen the hurt and the pain and everything. And through Him, he [Nicolas] could actually change. So spiritually, it was the point of our lives and everybody else's life" (P2:Int2:08).

Nicolas' reflects on his journey to self-recovery and reports that it was not an easy one. He started reflecting on his life and the consequences of his actions and decided that he no longer wants to live a life of substance abuse. This decision became apparent when he realised the negative consequences of selling drugs to others:

"The turning point was when I started to realise. It was that day that I saved that guy's

life. I was the one, although they did not buy it, I sold it. You see? Thereafter, for me, it was about, I did, how my actions affected other people's children (unclear), or whatever it was. I will tell you. That is where it turned around. (unclear)” (P1:Int1:19).

He realised that he had a problem and needed to ask for help. Turning to his mother for help, he reports that she has been a helpful agent of support and that he has learned to abstain from substances:

“I saw that I needed help. I told myself: I need help. Although I knew I could stay off it. But I didn't want to just stay off it for a little while... Then I told my mother...she...stood by me this whole time. (unclear). Then they tell me: But what are you doing? That is how I started realising that this is not for me. This is not my life” (P1:Int1:20).

“...I will tell you that my mother has handled it very well hey. Because if she had to quit, then we all would have quit...she kept everything together” (P1:Int2:17).

The mother confirmed that Nicolas reached out to her and admitted he needed help in overcoming his addiction. She also verified that his journey to self-recovery has not been easy and that she sees how much he struggles to maintain his sobriety and cope with his decision to turn his life around. However, she believes that he has better control over his impulses now than what he had before.

“He actually said, you know mommy, I can't anymore. He couldn't understand himself..We talked a lot. There was a lot of skelling³. It wasn't just like smooth understanding. Even now sometimes you can see the aggression coming out. Even in his, in his good state, you could see he's struggling. But he has control over it” (P2:Int1:14).

He is also pleased by his family acknowledging the change and telling him that they are proud of him.

“Well, my family...how can I say...they are disappointed. But alright, not that it is a problem but they all have come to me already and said that...we can see that you have

³ “Skelling” – Afrikaans term that means ‘scolding’.

changed a lot. And that they are proud of me. That has also made me feel proud. But I was mostly proud for myself” (P1:Int2:26).

He found himself gradually moving away from his substance-using friends and more toward his old friends. The latter noticed a change in his demeanour and welcomed his return.

“My own friends. They come to me again, they come to me again...and now they say they are sorry. Do I want to go with them. Then I go out with them. Then I sit with them but then people will always be people and say...look here’s Nick now, he was first verdallah⁴. Then I say to them: Yes, it’s not something to be ashamed about. I was” (P1:Int1:16).

The mother substantiates these claims and reports that he has made significant changes in his life, especially where his values are concerned.

“We are not down anymore, Nicolas is also working two jobs now. Saturdays he does mechanical jobs, and during the week he does... So he feels worthy. Although it’s not much, but okay you know it’s not the amount that matters... It’s the fact that your working, and seeing to yourself, and the fact that you actually coping... with the money that you earning... He’s sees life when earning with the drug lord, there he earned big bucks but here he is mos earning what he earns in a month, he earned there in a day. He’s learning the value of honesty...” (P2:Int1:15).

Emma also describes a marked difference in the way they communicate with each other:

Interviewer: How has the communication with him changed?

*Participant: It has changed a lot. He is totally off from it. He changed his friends, the stuff he’d do, like go dancing and stuff like that. It all changed.
(P2:Int1:13).*

More significantly, the mother reports that he has been much less aggressive than he was

⁴ “Verdallah” – a slang Afrikaans term meaning ‘run-down’.

when he used methamphetamine. However, his aggression resurfaces when he consumes alcohol. When she shared this observation with him, she was moved by his decision to terminate drinking as well:

“He’s much more calm. Not so aggressive anymore. But also gets on certain points, he would get aggressive. From June till now I can say he got aggressive five times. It’s like, it’s like a major change with him compared to what he used to be. But I also see, being aggressive when he’s not maybe on tik but he goes and have a beer or a drink, it is also affecting him. We spoke about it and he is now said “no mommy if that is now how I am which I don’t see myself, then I don’t want to touch that”” (P2:Int2:13).

When he stopped using he noticed a shift in his focus toward his family. He reports helping out more at home, as well as constructing new boundaries with friends:

“Yes. Either I go to work, or I take care of my grandfather that is sick. Then I help him. When my mother comes home from work then the house is clean. I cook...This is what my mother has taught me since I was young. And that is what is for me...my friends still come around to me. But they know they should not come around here with that stuff though” (P1:Int1:21).

Another important contributor to his progress is the value he attaches to truth-speaking. He argues that if the family is to recover from this crisis, he everyone has to be open and honest.

“That, now, is point number one if you want things to come right. Everything is basically laid out on the table here at home” (P1:Int2:11).

He also found that it is very hard to regain his mother’s respect now that he’s sober. However, the family is now learning to rebuild and restore respect for each other and break away from their destructive ways of interacting.

“At the end of the day...your own mother will lose her respect for you. And to regain that respect again...you have to...you still have a lot to prove to her so that you can get it back” (P1:Int2:11).

“Through all of this we learnt to respect each other. Like normal people man. Like normal people should be. Saw each other as, this is my sister and I have to respect her, and so on. No matter what she says wrong, it’s alright, leave it. You can tell me this now but I am going to be the bigger person. You see. I will just be the bigger person, Scolding, swearing. (unclear), whatever. Because, that always followed you see (unclear) where the little one wants to watch TV and the other one wants to watch this. There is only one TV now, now there the TV falls broken. For example now ne, I am busy by the stove or by the microwave. Now the one comes and plugs the one out and puts the kettle in, you see? Now, conflict. Little things. Now there’s big problems. Now things are not that way anymore” (P1:Int2:17-18).

The mother also reports that the family members are in the difficult process of rebuilding trust in their relationship with one another. She also argues that forgiving each other for their past transgressions is perhaps even harder than rebuilding trust. However, they are actively working on their relationship with each other and find it useful to erect boundaries between the family unit and members from the outside.

“...It’s also that trust relationship that you have to rebuild. And that is the difficult part...It’s very difficult. And the forgiveness is sometimes even more difficult. Because a lot of things is being reminded from the outside and from the inside. They do not want to be reminded and I also do not want to be reminded, so there’s always a clash where that is concerned. I think that will always be there...because we are still working on a lot of our relationships” (P2:Int2:04).

The road to self-recovery was reportedly not an easy one for Nicolas and his family. Nicolas does not describe all of the events that lead him to make the decision to change his behaviour and abstain from methamphetamine. However, he reports that he entered a process in which he started to realise the negative consequences of his actions. Though there may be many factors involved in his decision to fight his addiction and stop using methamphetamine, Nicolas described how he came to the realisation that he indeed has a problem and that he needs help. When approaching his mother with this decision and asking for her help, she responds by offering her support and mobilising the family to

encourage and reward his decision. Nicolas and his mother report that they relied heavily on their religious beliefs and convictions to motivate them through this difficult time. These religious views were described as a source of strength to persevere as well as a reference of how to live, which Nicolas strived towards.

Due to the support of his mother and the strength of their faith, Nicolas reports that he was able to cease his substance use as well as his drug-related behaviour. Both participants reported a noticeable change in his behaviour, his way of thinking and relating to his environment, as well as his emotional state. Family members noticed significant changes in the way he communicated on a daily basis, the friends he associated with, and the way in which he spoke more openly about his feelings and understandings. Nicolas moved away from his drug-using friends and shifted his focus towards his recovery and his family. Consequently, he found himself spending more time helping out at home and encouraging other users to stop as well. His mother, as well as the rest of the family, noticed that he was significantly less aggressive and more able to express himself in appropriate ways. Therefore, members in his family acknowledged the positive changes they saw in him, and commended him for his hard work. Nicolas favourably recalls his family members coming to him and telling him how proud they are. This had a reinforcing effect on his decision to stop the methamphetamine use and his drug-related behaviour and therefore encouraged him to sustain his abstinence.

The above discussion reflects a process of *circular feedback* within this family system. According to Dallos and Draper (2000), circular feedback occurs via a process of feedback between individual components that results in changes in the family system. This can be seen in the process by which the negative effects of methamphetamine use on the family have been changed by Nicolas' decision to quit his drug-related behaviour. For example, communication between Nicolas and his mother has improved and is significantly less aggressive than when he was using. More specifically, the process of feedback described above indicates how this family achieved equilibrium via their encouragement and support (i.e. positive reinforcement) of Nicolas' decisions and

behaviour. The feedback in this circular process can therefore be classified as *negative* feedback because it reflects a process in which equilibrium is achieved, and results in this family reaching a point of homeostasis (Dallos & Draper, 2000).

Although this family describes significant changes in their family system, they still experience some difficulty in rebuilding their relationships with one another. According to the mother, they are actively working on rebuilding trust and respect. More so, she described forgiving each other for past mistakes as the biggest challenge the family is facing. However, the mother's role and focus on actively rebuilding family relationships reflect this unit's ability to reorganise, as well as mobilise, the family's social resources towards a common goal. Therefore, these active attempts to improve and rebuild existing family relationships reflects positive processes in *family resiliency*, especially in terms of their organisational patterns (Walsh, 2003).

4.7. Social support and the role of the extended family

According to the mother, the family unit have received minimal social support from friends, her former place of employment, religious institutions, as well as from members of the extended family. Feelings of disappointment in extended family members emerge as well as a sense of abandonment and isolation:

“Interviewer: So you were, you did receive some kind of social support?”

Participant: From the workplace no. But from certain, say about from two of my colleagues at work yes. Um, from church none. From family, none”
(P2: Int1:07).

“I couldn't depend on my own family. Not on my own church people, it was always people from outside that I could depend on” (P2: Int2:03).

“Your actual blood is actually the most disappointing factor in your life um...because they are more closer and because you expect to get help from them, but it is always the opposite” (P2: Int2:04).

Aside from these feelings of isolation and not being able to rely on the extended family for support, the mother reveals that she was in constant conflict with persons outside of the family unit:

“I...you would be constantly in conflict with people. Especially family. And the church people” (P2: Int1:17).

In response to the conflict-ridden relationship with extended family members, the mother erected boundaries between the family unit and its extended social networks as a means of coping with the family crisis:

“We cutting everybody out from the outside. Nobody comes in here and talk anything. You want to say something, you do it outside. This is our home. We decide here. And by doing that, it’s more into a...build of our relationships here...There’s no more open boundaries” (P2: Int2:05).

Since the mother has erected these boundaries the conflict has not ceased, however, it has increased and is affecting her family in a negative way.

“In fact, there is even more arguments now. And the arguments, it is more, it is not from inside here. It’s from outside here. Ever since we’ve put up these boundaries...it still comes into the house but it affects the kids in a more different way. Some see they are interfering, some is just passive about it. And I just said, this is where is draw the line. You people don’t come into my house like this” (P2: Int2:05).

Lastly, the mother admits that she blames the extended family for the problems they are experiencing as a family, and that she carries a lot of resentment towards certain family members for encouraging her children in doing the wrong thing. She believes that because her extended family undermined her authority in their interactions with the addicted children, they compromised her attempts to handle the crisis and resolve the problem.

“I feel if they would not have interfered and like assisted the kids that was in the wrong doing, and neglected to assist me...because their focus was helping the kids while saying I was the wrong person or that I dealt with it in the wrong way. You know like blaming me for like doing things the wrong way” (P2: Int2:18).

“...that’s what was happening. Even now it is still happening. Like I’ve said to my sister here the other day; “you’ve never been like a sister to me. When your children came to talk about you and your husband and how you dealt with your things, I said to your son keep quiet. What your mom does, it’s their minds it’s their way of doing things. You don’t come and talk about your family here”. So I never gave their children ground to come and speak bad. So but they always undermined me. If they had said the same way, they would have assisted me in actually to resolve the problem much quicker” (P2: Int2:18).

The evidence presented here reflects an array of external factors that influence the family system. A lack of social support as well as continuous conflict with the extended family members has created difficulties in the mother’s attempts to manage her family during this crisis. Since every family is seen as part of a larger system (Sharf, 2000), the friction experienced with the extended family members negatively effects the members within the family unit as 1) feelings of resentment and isolation has emerged; as well as 2) attempts to regulate the family system (i.e. homeostasis) are compromised. These effects are reportedly brought on by the extended family members undermining the parental influence of the mother when addressing drug-related behaviour within the children. In other words, the extended family members undermined the authority of the mother by a) indirectly encouraging the children in their drug-using behaviour; b) providing a space for the children to discredit her parenting strategies; and c) openly questioning her ability to manage the family drug crisis. Therefore, these external influences from the extended family resulted in the development of disunity within the family unit, as well as creating a difficult environment for the mother to exert an influence over the addicted child’s behaviour. Hence, a circular process of *positive feedback* between the mother, her

children and the extended family has occurred, in which a destructive change within the family system is maintained (Sharf, 2000).

In response to this destructive impact on the family, the mother attempts to reorganise the family's patterns of interaction by what Walsh (2003) refers to as 'bouncing forward'. According to the Family Resilience Framework (FRF), *bouncing forward* refers to the family's ability to be flexible in times of crisis and reorganise its interactions to meet new challenges, and therefore develop a new sense of family normality (Walsh, 2003). 'Bouncing forward' in this family is therefore reflected by the mother's decision to erect boundaries of interaction between the family unit and members of the extended family. This was done as a means of counterbalancing stressful changes between these systems, and to achieve a sense of homeostasis within the family by preventing external influences having further destructive effects on daily family functioning. Therefore, the mother's reorganising of their interaction patterns can be understood through a process of *negative feedback*, where equilibrium is achieved in the family unit (Sharf, 2000).

4.8. Noticing dramatic changes in themselves

Nicolas and his mother reflect on the changes they have noticed in themselves, especially in terms of their behaviour and attitude when living with addiction. Nicolas talks about the time he was using and notices that he has changed in various ways, for example, he started to neglect himself and deemphasised his physical appearance to the point where old friends started noticing the difference:

"You are not the person you truly were before" (P1: Int2:04).

"I did not even recognise myself anymore. I went to my friends that weren't addicted and then they told me. And then I had too much pride for myself, dressed nicely, but slowly it affects you...Yes, I was always very neat. It all just...I like started giving my clothes away to people you see" (P1: Int1:08).

This made it harder for him to visit friends that weren't using methamphetamine and therefore he progressively spent less and less time with them:

“I could not go to their houses anymore. I was welcome there, but it’s just, I was not the type of person anymore that they expected to see...Yes, they did not know Nicolas like this. I did not feel welcome...You can feel it man. Something is not right, there is a definite change. Something is not in place, something is missing...Your friends, all moved away from you...” (P1: Int1:10).

This was substantiated in his reflections in his journal:

“Everybody looked at me as the bad person. My friends started to ditch me because I lost myself in drugs...” (P1:Journal: 04).

The mother noticed some definite changes in herself as well since her prolonged exposure to the behaviours of three methamphetamine addicts in her home. She reports that, in retaliation to Nicolas’ verbal abuse and violence, she has become verbally abusive towards him as well in order to maintain a position of strength and not be mistaken for being weak:

“How do you deal with this situation? What are you going to do? You try and plan but no plan in your mind that you make seems to be working. You become verbally abusive. You become them. To be honest with you, you know like the same mind? It become like that. Always striving toward retaliation, because when he says, ag I can’t (unclear), when he says something then you retaliate by saying something like hey jou ma se die⁵ (laughing) although you swearing at yourself (laughing) yes its true. This is what I mean. Because you needed to show him that you not a weakling. You had to fight on his level” (P2:Int1:01).

She describes her experience in living with her son’s MA-addiction and how it has created a personal shift in her way of being, when compared to her behaviour before her children became addicted:

⁵ “Jou ma se die” – Afrikaans slang that is used as profanity to cuss at a mother.

“It was like...it was like...it was like a nightmare. And you know what, it created so much within me. It changed me to a a person which I am still trying to get the swearing out of me. Because you still struggle to lose it” (P2:Int2:03).

“Yes, you started to swear. And you are still working on your own self. But if I look at myself and what I’ve been when they were smaller, meek mild with no swearing...and what I have become...it’s like wow” (P2:Int2:03).

“Through all these things, every child, character...and mannerism, I’ve changed in a lot of ways. It’s difficult getting to understand certain things with your old self” (P2:Int2:03).

During this time she has become more fearful as a mother. She reports that she found herself fearing for her children’s safety when they left the house, and she could only find peace when they were sleeping at home:

“... but it’s difficult because there is a lot of fear with you as a mother. And there is a lot of fear where their safety is concerned. And there is a lot of fear with oh, what have they done now again. So constantly your mind is always in a whirlpool, where you don’t know exactly what is happening. When they’re sleeping here inside then I feel so much more at ease” (P2:Int2:04).

These experiences reflect how individuals in a family are intimately connected. According to a family system’s approach, individuals within a family function as components of a system that strive towards maintaining a sense of stability via integration and coordination (Dallos & Draper, 2000). Changes within one of these components may influence a change in another through processes of interaction and feedback (Dallos & Draper, 2000). Since the family is viewed as a system that is based on interacting parts that influence each other (Dallos & Draper, 2000), a change in one system (or component) will reflect a change in another (Sharf, 2000). Therefore the effects of Nicolas’ dramatic change in his behaviour and attitude when under the influence of methamphetamine, and its influence on his mother’s behaviour as the primary caregiver, are evident from the evidence presented above.

Nicolas' behaviour in the family system was characterised by violent outbursts, physical violence amongst his siblings, as well as verbally abusive attacks on his mother and other family members. These dramatic changes in his behaviour influenced the way in which his mother communicated and interacted with him. Describing her experiences in engaging with Nicolas, she argues that she gradually became verbally abusive towards him as well. This signified a personal shift for her as she reports that she compromised her passive nature by engaging in verbally abusive exchanges with her son in an attempt to not appear weak in his eyes. She believed that communicating with him in this manner was the only way of strengthening her position in the home and effectively communicating with him. However, her reaction to his behaviour did not have the desired effect and instead strengthened his abusive behaviour towards her. In other words, her abusive behaviour stimulated his misconduct instead of discouraging it.

According to the *general family system's approach*, feedback that creates a change and leads to a destructive impact on a system is known as *positive feedback* (Sharf, 2000). Therefore, the type of feedback between Nicolas and his mother can be classified as positive feedback, whereas the *process* involved in this communication system can be understood in terms of its *circularity* (or circular causality). This means that the feedback of the change in his behaviour created a change in her behaviour, and consequently the feedback concerning the change in her behaviour stimulated the negative change in his behaviour. Hence, the process involved in the feedback between these two individuals can be classified as of *circular feedback*, whereby a change in one unit affects or triggers a change in any other of the units (Sharf, 2000).

Aside from the effects of MA discussed in previous theme, Nicolas noticed that he started neglecting his physical appearance. His friends, who were not using methamphetamine reportedly noticed the change as well and confronted him on his looks. This made him feel uncomfortable being around them and hence he felt less welcome and started limiting his visitations to them. As result, he found himself spending less time with his non-substance using friends and more time with MA-users. Therefore, placing him (Organism) in an optimal environment (Stimulus) for increased substance-use (Response)

and thus maintaining his methamphetamine addiction (Consequence). Hence, the maintenance of Nicolas' methamphetamine-using behaviour can be understood via O'Farrell and Fals-Stewart (1999)'s S-O-R-C model.

4.9. Open emotional expression: Mutual Empathy & Pleasurable Interactions

Nicolas reflects on how he has changed since he stopped using methamphetamine. When he was using, he did not feel comfortable talking to his family and only expressed himself to his other substance-using friends. However, he has learnt to express himself more openly with his family and finds that it is more useful in overcoming challenges:

“You're ashamed of it, you don't want to talk about it. You think for yourself, you will rather talk here amongst your... when you were still busy with the drugs here with your friends... Now, how can I say, when I opened up to my family, it has helped me to climb out of the hole. And to close that” (P1:Int2:21).

The mother reports that it is very difficult for her to express herself emotionally to her family members:

“It's a bit difficult for me, I can tell you now. It's very difficult telling them. This is the fear factor that I have here. It's difficult. Even for everyone. Fear is always something that is never easy to handle” (P2:Int2:19).

She recalls having expressed her emotions to one of her sons once before and says that this was an anomaly. This made her feel uncomfortable and she was overcome with doubt and a sense of vulnerability:

“I've only done it once with my second eldest son...” (P2:Int2:19).

Interviewer: How does this make you feel, having opened up to him?

Participant: It makes you feel like um...it makes you feel like a a fool man. So stupid. Like I say fool I feel like emotional...did I do the right thing now? Um, what are the consequences going to be of what I said now?

Interviewer: So you have a sense of vulnerability?

Participant: Yes. You feel like are they going to use this against you. You know stuff like that. I think also where I always kept my mouth is just for protection. For myself. (P2:Int2:19).

4.9.1. Mutual empathy

In terms of possessing a capacity for empathy, the participant and his mother reported some ability to empathise with each other and understand why they react in a particular way, at a particular time. This is a significant change in their relationship as this ability to empathise with another was not evident during Nicolas' substance using period. Nicolas, for example, shows a capacity for empathy and understanding towards his mother when she came home from work to find that certain chores have not been performed. He describes potential reasons for her frustrations:

“Say for instance my mother comes home from work. Alright, I know she has, I don't know what goes on there at her work. She might not have had a good day so she has frustrations. Sometimes people come home with their frustrations. Not like they want to take it out at home but it just takes...it only takes each of us to do our part” (P1:Int2:01-02).

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When reflecting on the family's ability to empathise with her as a mother, Emma reports that almost half of the members in her family are not able to understand what she endures and the emotions she is challenged with:

Interviewer: Do you think your family understands what you feel and what you are going through during these times?

Participant: Um...maybe my son. Susan a little bit. Now yes, completely. But two to three members within my family. Even my husband, doesn't really understand. He understands 50% but not completely. What I would say is yes, he does understand but not in the whole sense of 100%. (P2:Int2:17).

However, she believes that she understands the behaviour of her children and their motivation behind their reactions:

Interviewer: In your opinion, do you think you understand why your sons or daughter may be behaving or reacting to things the way they do?

Participant: Yes, sometimes. 90% yes. (P2:Int2:18).

Learning from her experiences in living with methamphetamine addiction in her family, she believes she understands her children better than before, and that she has learnt how to behave when dealing with them. She reports that she is better equipped to identify what triggers Nicolas' substance-use and therefore learnt to act accordingly:

“Yes, he [her husband] would say that “jy laat hulle wegkom met dinge⁶”. But I understand why I sometimes keep quiet. Cause I now knew what triggered what or...the wrong do and what triggered off the right do. I started to learn how to treat them each like a person. With the new drug...you learn to understand them. You tend to understand them” (P2:Int2:20).

4.9.2. Pleasurable interactions

According to Nicolas, he is able to have pleasurable experiences with his family and reports, like all families, they do have their good and bad days:

Interviewer: Okay. When you are not fighting with your family members, have you at ever felt that you actually like interacting with each other?

Participant: Yes, hey! Yes. Then it's like...we have our ups and we have our downs... (P1:Int2:23).

His mother also reports that they are able to share pleasurable experiences with each other when they are not in conflict. However, she feels that there is something missing from their relationship with one another:

“Yes, sometimes yes. But you still find that, there is that...the circle is not closed... Yes there is still conflict. It's just a feeling that yes, you are my friend but something is...is not right...Yes. You know, something is not right. You come into the room, or in the

⁶ “jy laat hulle wegkom met dinge” – Afrikaans for “you let them get away with things”.

office and you know man...something is not right. It's just a feeling but you can't say what it is" (P2;Int2:23).

As established in previous themes, this family is challenged by many issues and family processes. Along with their identified need to rebuild trust in their family relationships, the evidence provided above suggests that this family experiences difficulty in openly expressing their emotions as well. Nicolas describes that when he was using, members of his family (himself especially) were unable to constructively share 1) points of view; 2) pleasurable experiences with one another; as well as 3) their feelings, hopes and dreams. Instead, their family interactions were characterised by a disregard for household rules, frequent- and extreme conflict situations, behaving in self-serving ways, and defending their own needs and desires above that of other family members. Therefore, these behavioural tendencies that were prevalent during Nicolas' MA-use reflect an inability to act empathically towards one another. Hence, the behaviours associated with methamphetamine use sustained a climate in which open emotional expression between family members were compromised by a lack of trust, empathy, and tolerance for difference (Walsh, 2003).



After Nicolas decided to cease his substance use and work collaboratively to rebuild the trust in his relationship with this family, the communication and interaction between him and his mother has reportedly improved. The evidence presented above also show how both these members have developed a capacity to be empathic in their reasoning towards one another, and share pleasurable interactions. Even though communication has improved, these participants still face a challenge in terms of expressing their emotions openly and freely. Although Nicolas reports that he is more willing to share his feelings, hopes and dreams with his family members than when he was using, his mother on the other hand reveals that she experiences immense difficulty in being emotionally expressive. She describes it is a process that makes her very uncomfortable and leaves her feeling vulnerable and exposed. This inability to openly share emotions with her family members therefore reflects the level of mistrust within this family system, and restricts a capacity for effective communication between members. With these

limitations in a family system, as well as an uneven climate for open communication, Walsh (2003) predicts an environment in which family members will experience considerable difficulty in meeting challenges and managing conflict situations that are brought on by future crises. Furthermore, it is argued that when intense emotions are not shared with family members (especially loved ones), there is an increased risk for substance use, depression, conflict and self-destructive behaviours (Walsh, 2003). Hence the family's ability to communicate effectively, show resilience in times of crises, as well as share meaningful and pleasurable experiences with one another, are undermined (Walsh, 2003).

4.10. Clarity and Collaborative Problem-solving: Truth-speaking & Unresolved issues

4.10.1. Truth-speaking

According to Nicolas, he always spoke the truth irrespective of being under the influence of methamphetamine or not. However, he does admit that he indulged in omitting certain things from his mother instead of lying to her deliberately:

“I did talk, nay, I did speak the truth. If I had to lie...I was always trying to keep it real...I don't bother lying to her because tomorrow she will hear about it. So I did not say anything instead. I rather kept quiet” (P1:Int2:26).

His mother, on the other hand, does not feel there is a lot of honesty in between family members and that they (i.e. all her addicted children) are withholding a lot of information (truth) from her:

Interviewer: Do you feel, broadly that is, do you feel that in the family itself there is a lot of honesty in what is said to one another? Including yourself that is.

Participant: No. I feel, I just get this feeling that they...they still getting a lot away from me.

Interviewer: In terms of what?

Participant: In terms of not hurting my feelings. In terms of...not wanting me to know what they are doing. (P2:Int2:24).

She also feels that the honesty currently expressed in the family is superficial and only relevant to less serious issues:

“In terms of...when they make jokes and laugh yes. But in terms of the serious things, of what has been said...no” (P2:Int2:24).

4.10.2. Unresolved issues in the family

Nicolas recalls how difficult communication between family members was when he was using methamphetamine. When under the influence of MA, he strived to avoid any confrontation and hence issues were never resolved:

“But, how can I say, it is not easy to talk about problems with substances man. You just want to avoid... And leave...things aren’t that easy. That is where all the scolding and fighting comes from. Fighting...Nothing gets resolved” (P1:Int2:13).

He describes how communication has changed since he has ceased his substance use. They are now able to sit and talk about things, and there is more room for negotiation / suggestions than there was before in their family interactions:

“We can now sit and talk about things like grown-ups. What is said now, you should know, that’s how it’s going to stay. It’s not about what you say...It’s not just about what my mother says anymore. Why? Cause when we don’t feel good about something, we should be able to tell her about it. But I tell my mother, alright if it’s not like this then? Mommy, I can tell her what but mommy, would it not be better if it were like that?” (P1:Int2:14).

The mother feels that there are many family issues that have not reached resolution:

“There’s a lot that is not resolved” (P2:Int2:08).

Furthermore, she feels that there is no fairness in the way that the family interacts with each other and that there is no room for negotiation since each member strives to be right. Although Nicolas believes that there is more room for negotiation since substance use has diminished, his mother disagrees and believes that these problems still persist today:

Interviewer: Do you think there is a fairness in the way each person interacts in such a situation?

Participant: No. Never.

Interviewer: Okay, let's say in a typical conflict situation between the family members, in your opinion, do you think there is room for negotiation when you are trying to solve a problem?

Participant: I think in my family, no. Because everybody wants to be right.

Interviewer: So it's still like that today?

Participant: It's still up to today. They never see your point. (P2;Int2:11).

More so, the mother believes that her children are not in a position to negotiate since they have a long way to go in terms of understanding their responsibilities and the household rules:

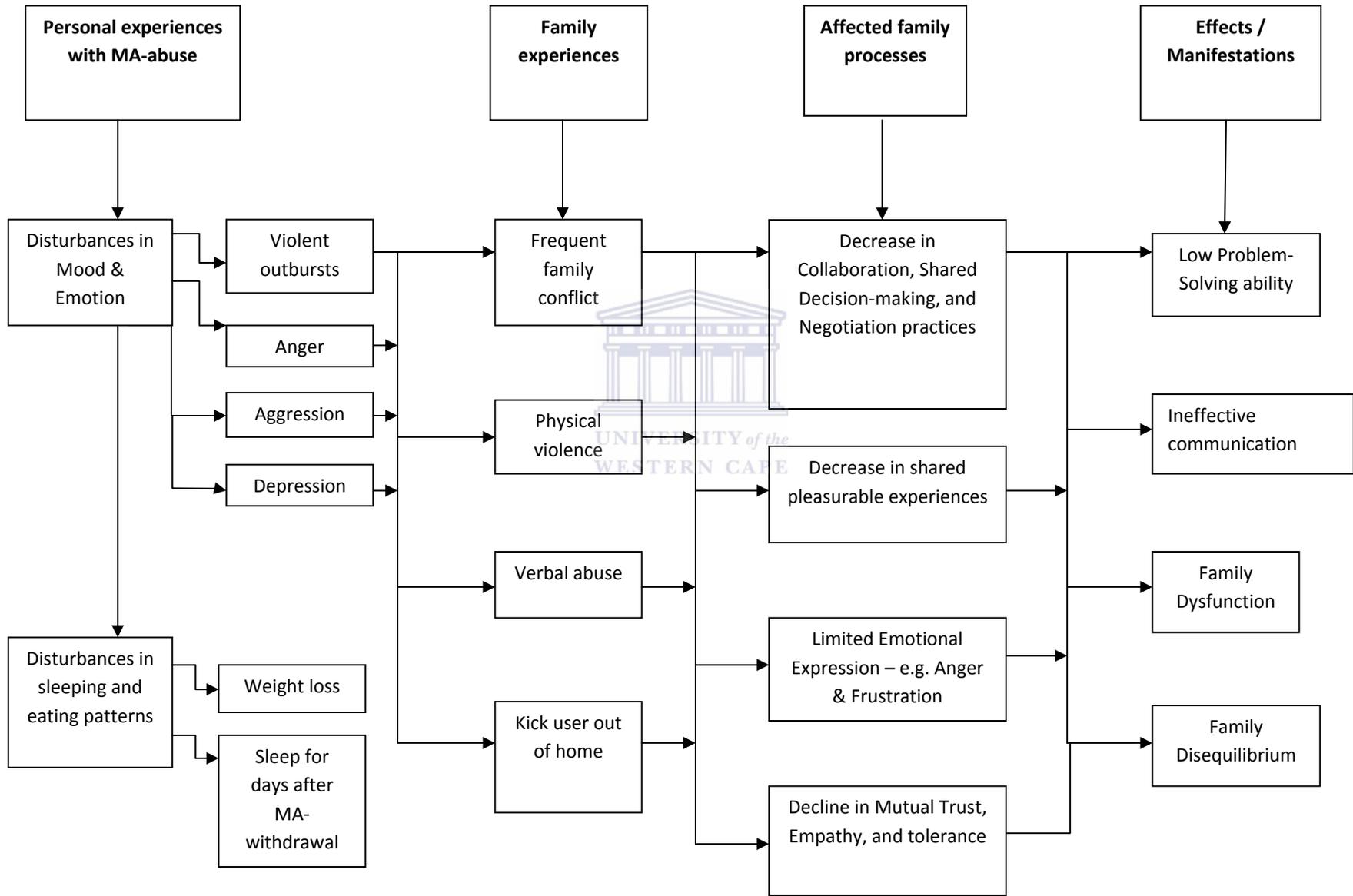
"In terms of negotiation in in my house...there's very little room. Because I feel like still that I am not reaching them and making them understand what is their responsibility and what is want and...um.....understand the rules..."(P2;Int2:12).

Based on the evidence presented above, truth-speaking in this family is described as a selective activity. When under the influence of methamphetamine, Nicolas reports that he was truthful in his interactions with his mother. However, he admits to his tendency to omit the truth at times as a possible means of preventing conflict. His mother, on the other hand, believes that truth-speaking in this family only applies to superficial issues and that Nicolas (and her other children) are still withholding information from her. These issues described here reflect an inconsistency in messages and actions between family members. There is no evidence that suggests that these members actively engage in truth-seeking activities and therefore it could be argued that the current family environment sustains selective truth-speaking practices. Hence, fulfilling the need for clarity and congruence in messages between family members could effectively improve family functioning, and as result, enhance family resilience in terms of 1) informed

decision-making; 2) finding meaning in interactions; 3) authenticating relations with one another; as well as 4) increasing closeness and understanding (Walsh, 2003). However, in the absence of truth-seeking activities as well as clear, open communication, family resiliency is not actively encouraged.

Due to the limitations in clarity and congruence in communication, this family also reflects a weakness in their collaborative problem-solving ability. Nicolas revealed that when he was using methamphetamine, his relationship with his family was conflict-ridden and that there was no room for negotiation in his interactions with his mother. Since his cessation, this situation has changed where there is some room for making suggestions and negotiating alternatives with his mother. However, his mother feels that there is very little room for negotiation between her and her children as they do not understand their responsibilities, and have a long way to go in terms of respecting household rules. These beliefs are informed by this participant's experience in living with substance-related behaviour and are sustained by their efforts to rebuild trust in their family relationships. Therefore, the above issues reflect a family environment that is not conducive to collaborative problem-solving and where family members are restricted in terms of brainstorming innovative ideas and pooling resources to collectively attain goals. The family's ability to engage in shared-decision making practices are therefore limited, and may experience difficulty in adopting a proactive stance to prevent future problems and challenges (Walsh, 2003). However, since the evidence suggests a slight shift in current negotiation practices (however minute), it reflects a potential for this family to develop more constructive and collaborative problem-solving practices as time progresses.

Diagram of findings: *Figure 1*

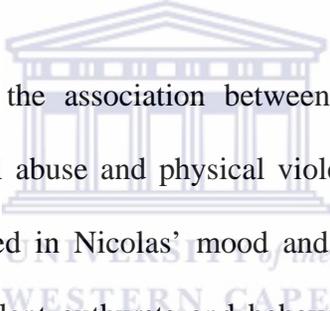


CHAPTER 5:

5. CONCLUSION

5.1. Summary of findings and conclusions

In describing the personal experiences of a methamphetamine addict and his family, an array of themes have emerged. Negative changes and transformations have been reported in both their personal lives as well as their family setting. Although many themes emerged from this study, some themes were more salient than others. The purpose of this chapter will therefore be to highlight these themes and postulate potential implications and future recommendations.



Emerging from the research, the association between methamphetamine abuse and features like aggression, verbal abuse and physical violence has been most prominent. Negative changes were reported in Nicolas' mood and temperament as he frequently experienced uncontrollably violent outbursts and behaved in antagonistic ways toward members of his family. His display of anger and hostility facilitated a family environment that was not conducive to effective communication, open emotional expression, and negotiation. Members of his family were forced to adapt to a precarious environment, in which the threat of violence became an everyday part of family life.

The second most prominent theme was MA-abuse's association with criminal behaviour. Although the participant only acknowledged one incident where he was involved in theft, he has however disclosed his involvement in illicit activities concerning the distribution of illegal substances. Working for a drug dealer and selling drugs became his primary

source of income whereby he gained financial support as well as free and unlimited access to his substance of choice.

These two predominant themes were instrumental in the deterioration of family relationships as the presence of aggression and violence as well as a strong association with criminal activities led to a conflict-ridden, dysfunctional family system. The frequency of violence and high levels of aggression in the family environment has been identified as potentially crucial elements involved in the breakdown in communication between family members, as well as the difficulties experienced in collaboratively addressing family issues and challenges. This trend leads to the conclusion that there is a relationship between MA-abuse and an increase in violence and aggression in its user.

Furthermore, the effects of these drastic (negative) behavioural changes expressed in the family environment were shown to lead to the gradual deterioration in family functioning. The findings of this study revealed significant limitations in 1) sharing pleasurable experiences; 2) the free expression of emotions; 3) mutual empathy; 4) congruence and clarity in messages between family members; as well as 5) collaborative problem-solving, when MA-abuse was rampant. This however improved considerably when the core participant entered MA-cessation periods. According to Walsh (2003), families experiencing difficulties in open-communication, emotional expression, and problem-solving abilities find it extremely difficult to manage family crisis situations as well as 'bounce back' from internal and external challenges. However, once the MA-abuse (and all its effects and influences) has ceased, the subsequent decrease in violent

outbursts led to the gradual improvement of communication between family members as well as their problem-solving abilities. Therefore strengthening the family's level of resilience and increasing their ability to ward off challenges associated with family substance abuse. The evidence presented thus leads to the conclusion that the effects and consequences of MA-abuse compromises vital family resiliency processes such as open communication and problem-solving abilities. Furthermore, it suggests that MA-abuse plays a central role in the gradual breakdown of family systems and may have a fundamental role in family dysfunction.

Aside from MA's association with increased violence and aggression in its user, as well as its negative effects on family functioning, the rehabilitation of the user was strongly associated with immediate family support. According to the research findings, the addict as well as his immediate family members received poor social support from the extended family and members from broader social networks. However, the user's success in maintaining his abstinence from MA was attributed to the support provided by his immediate family members. This phenomenon therefore identifies the family unit as a potentially crucial site of intervention and rehabilitation. Although the family environment has formerly been identified as fundamental in its ability to encourage, enable and sustain substance-related behaviour (Fields, 2001), the findings of this study suggest that the family unit, with all its processes and dimensions, are instrumental in the rehabilitation of a MA-addict. Therefore, in conclusion, this study suggests that immediate family support plays a crucial role in the MA-addict's continued abstinence as

well as sustaining the transition from MA-abuse to MA-cessation, to recovering addiction.

5.2. Recommendations for future research

Based on the findings of this study a need to examine the link between MA-abuse and negative behavioural tendencies was identified. The extent to which MA is associated with violence and aggression, more so than when under the influence of any other substance should be subject to further investigation. Establishing whether anger, aggression and violence is indeed a defining behavioural feature of methamphetamine will prove invaluable in developing more effective treatment approaches, especially considering the high relapse rate already associated with this drug.

Secondly, the findings suggest that the association between MA-abuse and family dysfunction be investigated in future research. The evidence presented here does not account for all the processes involved in maintaining family resiliency, especially when facing extreme family challenges during a period where communication and problem-solving attempts were limited, and even dysfunctional. During this period of crisis, the family still managed to maintain a sense of homeostasis even though it was dysfunctional. In other words, the family system did not disintegrate entirely and therefore suggesting the influence of processes not specified in this particular study. Therefore, for the purposes of informing more effective treatment approaches in assisting families with addiction, these issues are in need of further investigation. The processes involved in strengthening family resilience, especially when fighting the effects of

addiction should be identified as well as show *how* and *to what extent* these family processes can be strengthened via strategic family treatment approaches for MA-abuse. Additionally, the psychological processes as well as the environmental factors involved in the addict's decision to shift from MA-abuse to cessation have been beyond the scope of this research. This information is needed to inform the recovery process and assist families struggling with the addiction of a family member in initiating changes that will facilitate 1) the addict's desire to discontinue his/her substance abuse behaviour; 2) the family and addict to enter and participate in a process of rehabilitation; as well as 3) maintain and reinforce sobriety and effective family functioning.

5.3. Limitations of this study

Although the interview method proved to be a valuable source of evidence as well as a successful data collection tool, the biggest limitation of this study relates to the participants' journals as the second source of evidence. Due to a series of unanticipated events as well as restrictions in the participants' willingness to diarise their experiences, this method in data collection was generally unsuccessful. Participants were reluctant to engage in this self-reflecting activity and failed to meet the required minimum of journal entries per week. After months of non-compliance only one of the participants submitted a journal that was written as a single and undated, general reflection exercise. Therefore this source of evidence did not provide the information as was initially designed and provided significantly less information than was needed. Hence the ability to corroborate converging lines of inquiry from sufficient multiple sources of evidence were

compromised. This limitation therefore calls the trustworthiness of the information into question.

The second limitation of this study also relates to the multiple sources of evidence used. In order to enhance triangulation, participation from other members in the family would have strengthened the quality of the research design. The information provided may have been wealthier in terms of its qualitative richness if the other two children who also abuse MA were willing to participate.

These limitations may have marginally compromised the quality of the research design but have by no means undermined the integrity and richness of the findings presented. MA-abuse has been linked to significant changes in both the user and the family. Associated with violence and aggression, this drug has been found to lead to impaired family functions as well as a dysfunctional family environment. The family unit has therefore been identified as a potentially crucial site of intervention as well as the vehicle for sustainable rehabilitation.

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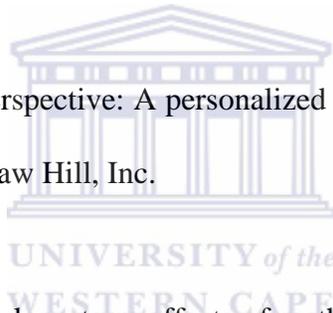
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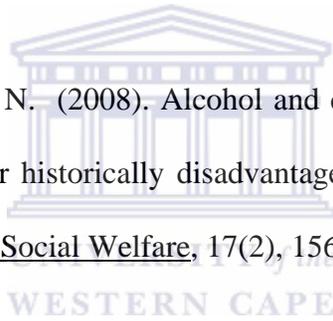
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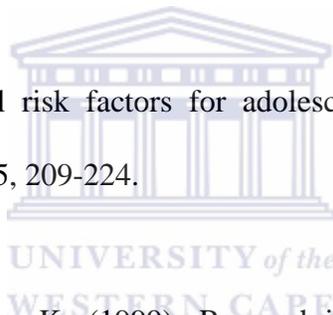
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