THE CAUSES OF RELAPSE AMONGST YOUNG AFRICAN ADULTS FOLLOWING IN-PATIENT TREATMENT FOR DRUG ABUSE IN THE GAUTENG PROVINCE

by

ILZE SWANEPOEL

A mini-dissertation submitted in partial fulfilment of the requirements for the degree

MASTER OF SOCIAL WORK (HEALTH CARE)

In the Department of Social Work and Criminology

at the

UNIVERSITY OF PRETORIA

FACULTY OF HUMANITIES

SUPERVISOR: DR LS GEYER

October 2014

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Acknowledgements

I would like to thank everyone that contributed to this study, with special thanks to:

- ❖ Firstly, I would like to express gratitude to my Heavenly Father for giving me the strength to complete this research study.

- ❖ My supervisor, Dr LS Geyer, for his professional study guidance and mentorship throughout.

- ❖ Mrs. A Britz, my editor for her professionalism in editing this research report.

- ❖ My colleague and friend, Monique Marais, who started this journey with me and who never allowed me to give up, her support is greatly appreciated.

- ❖ Mr A Masenga and Dr G Crafford for statistical consultation services provided during this project.

- ❖ My parents, Flip and Marlene Swanepoel, for their love, patience, encouragement and mostly believing in me. Especially thanking them for providing the means and support for completing this study.

- ❖ My colleague, Adele Naudé, at Dr Fabian and Florence Ribeiro Treatment Centre for sharing ideas.

- ❖ My friends for the on-going support and encouragement when it was needed the most.

- ❖ The treatment centres that allowed me to conduct my research at the centres – House of Mercy, Horizon Clinic, Wedge Gardens and Dr Fabian and Florence Ribeiro Treatment Centre.

- ❖ Lastly, I would like to thank all the respondents for their participation in the research study.

"… but those who hope in the LORD will renew their strength.
They will soar on wings like eagles;
They will run and not grow weary;
They will walk and not be faint"
Isaiah 40:31

I SWANEPOEL

Pretoria, October 2014

The causes of relapse amongst young African adults following in-patient treatment for drug abuse in the Gauteng Province

RESEARCHER:	Ms Ilze Swanepoel
SUPERVISOR:	Dr LS Geyer
DEGREE:	MSW (Health Care)
INSTITUTION:	University of Pretoria

Drug abuse is not a new concept and there is no doubt that it is a public health problem as it has reached epidemic proportions both nationally and internationally. With the increase in drug abuse, treatment demands are also proven to be increasing. Even more so, the rate of re-admissions into treatment centres following relapse after previous in-patient treatment for drug abuse, is also on the increase. "Drug addiction is a chronic, relapsing disorder in which compulsive drug-taking behaviour persists despite serious negative consequences" (Cami & Farrè, 2003:975). Relapse refers to the return of drug use, after detoxification and in-patient treatment for at least six- to twelve weeks; together with the marked return of behaviours associated with drug use. Relapse rates have been found to be high both nationally and internationally. Considering South African statistics, in 2013, 22% of admissions into treatment centres were re-admissions (SACENDU, 2014:15). The problem of relapse is undoubtedly one of the most important challenges facing the field of addictions. In line with literature, it has become apparent that young African adults are being re-admitted on a frequent basis and the need for research amongst this target group was thus confirmed. The goal of this study was to determine the causes of relapse amongst young African adults following in-patient treatment for drug abuse in the Gauteng Province.

The theoretical frameworks that guided and informed this study was the adaptation model and the eco-systems perspective. The importance of being able to adapt to the environment at all levels of functioning (micro, meso and macro level) following in-patient treatment for drug abuse was regarded as important in determining the causes of relapse amongst young African adults.

This study used a quantitative approach with a non-experimental research design. The implementation of this study fell within the applied research category and was furthermore exploratory in nature. In this study a survey was undertaken to collect quantitative data from the respondents. The replicated randomised cross-sectional survey design was applicable as the survey was conducted with different

samples randomly drawn from the population and was conducted with each sample. The study was conducted by applying stratified random sampling in combination with purposive sampling in the selection of respondents. The population was divided in terms of different strata, which included four in-patient treatment centres within the Gauteng Province that was part of this study. Within each of the strata, purposive sampling was employed to recruit prospective respondents. A total of 44 respondents took part in this study. All the respondents gave voluntary informed consent to partake in the study and completed a group-administered questionnaire. The data were analysed by making use of descriptive statistics, more specifically association statistics.

From the findings, the following causes of relapse amongst young African adults were identified: (1) Environmental risk factors, which included availability and accessibility of drugs and environmental cues; (2) interpersonal/ social risk factors including peer group influence, limited access to services in the community, lack of recreational activities, stigmatisation by community members, lack of support needed after treatment, conflict management, and difficulty finding employment; (3) intrapersonal risk factors including emotions and dealing with emotions, loneliness, lack of effective coping mechanisms and stress management, lack of assertiveness and easily influenced by others, cravings, losing motivation and commitment towards maintaining abstinence, controlled drug use, and the decision not to attend aftercare support services and (4) physical risk factors which included experiencing physical pain.

The conclusions of this study reflect that young African adults' communities (environments) are not conducive to recovery. This together with intrapersonal differences makes maintaining abstinence difficult for the young African adult. Rehabilitation of people with drug abuse problems must therefore be holistic and address both psychological developmental issues and environmental challenges as experienced by the young African adult.

Recommendations from this study can be used by in-patient treatment centres to improve their existing treatment programmes. By dividing service users in accordance to their gender and ages (developmental phase) treatment can be more specific to include specific challenges faced by them. It is recommended that a structured aftercare programme based on the causes of relapse amongst young African adults be implemented. Professionals should be educated with regard to aftercare services in an attempt to improve the utilisation and referral to such services. Future research that can contribute to relapse prevention include exploring the ignorance and barriers to effective aftercare

being rendered; the effect of including skills development in a treatment programme; and the factors hindering efficient family support.

Keywords:

Substance abuse

Illicit drug abuse

Relapse

Young African adults

In-patient treatment

Gauteng Province

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Acronyms

SACENDU	South African Community Epidemiology Network on Drug Use
DSM V	Diagnostic and Statistical Manual of Mental Disorders
SPSS	Statistical Package for the Social Sciences
WHO	World Health Organization
APA	American Psychiatric Association
AVE	Abstinence violation effect
RP	Relapse Prevention
CM	Cenaps Model
UP	University of Pretoria
NIDA	National Institute of Drug Abuse
CBT	Cognitive Behavioural Therapy

CHAPTER 1
GENERAL INTRODUCTION

1.1.   INTRODUCTION AND CONTEXTUALISATION

The purpose of this research study was to determine the causes of relapse amongst young African adults following in-patient treatment for drug abuse in the Gauteng Province. Internationally, the relapse-rates following treatment are high. According to Adinoff, Talmadge, Williams, Schreffer, Jackley and Krebaum (2010:140) "relapse to substance abuse following treatment typically reaches 75% in the 3- to 6-month period following treatment." Focusing on national data it is evident that relapse is also prevalent in South Africa following treatment for drug abuse. The South African Community Epidemiology Network on Drug Use (SACENDU)(2008) indicated that 24% of the intakes into treatment centres in Gauteng, 22% in Cape Town, 20% in the Northern Region and 32% in Port Elizabeth are not first time admissions. This remained stable in Gauteng, as indicated by SACENDU (2014:15) which still reported 22% re-admissions in the Gauteng Province. These statistics confirm that relapses in fact occur often and the researcher thus agrees with Barber (2002:130) that the problem of relapse is undoubtedly one of the most important challenges facing the field of addictions. SACENDU (2014:16) furthermore indicates that in Gauteng, Africans made up 60% of the total admissions during January to June 2013; showing an increase of 12% from SACENDU statistics in 2010. Whites accounted for 27%, Coloureds for 10% and Asians for 3% of all the admissions during this period. From these admissions, 23% constitute individuals between the ages of 20-24 years, 17% individuals aged 25-29 years, 11% individuals aged 30-34 years and 7% individuals aged 35-39 years. All of the above-mentioned statistics provide an overview of the circumstances surrounding, amongst others, young African adults.

Previous research that was conducted in South Africa in the Western Cape, focused on exploring the experiences of mostly Tik-addicted adolescents regarding relapse after treatment (cf. Van der Westhuizen, 2007). Another research done in South Africa focused on the experience of relapse in cocaine and heroin users (cf. Bain, 2004). The focus of this study was to determine the causes of relapse amongst young African adults following in-patient treatment for drug abuse in the Gauteng Province.

The researcher was specifically interested in determining what environmental, inter- and intrapersonal factors influence and cause relapses amongst young African adults. "The relapse syndrome is an

integral part of the addictive disease process. The disease is a double-edged sword with two cutting edges – drug-based symptoms that manifest themselves during active episodes of chemical use and sobriety-based symptoms that emerge during periods of abstinence" (Gorski, 2000:25). As it can be concluded from the above-mentioned statements; relapse following in-patient treatment and abstinence, is a complex issue and research in this field can benefit practice in order to maintain abstinence and to improve the outcome of in-patient treatment.

By determining the causes of relapse amongst young African adults, the information and knowledge gained could be used to offer recommendations for treatment centres and aftercare programmes, in particular.

1.2. THEORETICAL FRAMEWORK

The researcher was guided by two theories, namely the adaptational model and the eco-systems perspective.

1.2.1. Adaptation model

The adaptation model is a reliable framework from which a broad range of human phenomena and processes, the patterning of human behaviour and coping in health and illness, are studied (Dobratz, 2008:259). A person or a group of people can be seen as adaptive system(s) with internal processes for coping with change (Barone, Roy & Frederickson, 2011:353). The role of the environment is also mentioned by this model and the environment signifies all the conditions, circumstances and influences that surround and affect the development and behaviour of people as adaptive systems (Barone, et al., 2011:354). Adaptation is defined by Sigelman and Rider (2006:173) as the process of adjusting to the demands of the environments. Seeing that drug dependence is considered to be a mental illness, as defined by the American Psychiatric Association's (2013) Diagnostic and Statistical Manual of Mental Disorders (DSM V), this model provides a foundation to consider drug abuse from this angle in the sense that people's behaviour and coping with regard to this disorder can be studied by applying the premises of this model.

The researcher was interested in determining the causes of relapse amongst the respondents; be it internal or from the environment or a combination of both. The respondents were seen as adaptive systems seeing that their environments had changed from being in an in-patient treatment centre to being exposed to another environment outside the treatment centre, together with the change in the

environment, the respondents also needed to change since people must adapt to change (Dobratz, 2008:256). The researcher is of the opinion that the respondents might have relapsed because they failed to adapt effectively to the environment outside the treatment centre. Attention was paid to the internal processes of respondents and the role that their environments played in relapsing.

1.2.2. Eco-systems perspective

The adaptation model is closely related to the eco-systems perspective, which holds the premise that "the developing person, with his biological and psychological characteristics, is embedded in a series of environmental systems that interact with one another and with the individual over time to influence development" (Sigelman & Rider, 2006:22). This motion of interaction between individuals and their environments is also mentioned by other authors, such as Boehm (1958) as cited in Barber (2002:37) in terms of "social work seeks to enhance the social functioning of individuals, singularly and in groups, by activities focused on their social relationships which constitute interaction between individuals and their environments." Barber (2002:38) further quotes Bartlett (1970) who refers to social work's dual focus on person and situation in that this dual focus ties them together. It is known through experience that people are exposed to different environments and changes in their environments. Potgieter (1998:55) indicates that when any part of a system is changed, all other parts of that system are affected and change in some way.

As the individual is exposed to the environment outside the treatment centre, various changes needed to be adapted to. The researcher is of the opinion that abstinence would be maintained if the individual could effectively adapt to the changing environment. If, however, the individual cannot cope or adapt effectively to the environment as it changes, relapse might occur. The individual's return to substance use will in turn affect his/her family which is part of the system in which he or she functions. As a result of looking at the individual's environment and the interrelations between the individual and the environment, the researcher was enabled to look at the causes of relapse more holistically. When considering the dual focus of social work, as mentioned above, this was achieved by looking at the internal (the person) and external (the environment or situation) causes of relapse.

More details on the theoretical frameworks follow in Chapter 2, Paragraph 2.6.2.

1.3. RATIONALE AND PROBLEM STATEMENT

The researcher, as a social worker employed at a substance abuse treatment centre, noticed the number of young African adults admitted for treatment more than once. In other words she identified that there was a definite relapse rate, especially, amongst young African adults who previously had undergone treatment for drug abuse. The impact of the identified problem can be verified in the statistics provided by SACENDU (2011, 2014) which portrays the number of second or third admissions in various provinces. Statistics, as indicated earlier in this chapter, state that close to 90% of all clients treated for substance abuse, relapse within one year after discharge from treatment. However, what is not yet known is what the causes of relapse amongst young African adults, following the treatment for drug abuse are.

Research with regard to the causes of relapse in the South African context seems to be lacking. The researcher identified two studies related to exploring the causes of relapse. However, these studies focused on another target group and were specifically related to specific drugs. The present study was conducted within the Gauteng Province, with young African adults.

By undertaking this study the researcher was able to determine what the causes for relapse after in-patient treatment for drug abuse amongst young African adults are. In doing so, it was possible to formulate guidelines and recommendations for treatment programmes to include specific relapse prevention strategies, which are more applicable within the South African context. The findings of this research could also be used to guide aftercare services and in turn enhance the impact of such services.

Therefore, the specific research question which this study aimed to answer was: *"What are the causes of relapse amongst young African adults following in-patient treatment for drug abuse in the Gauteng Province?"*

1.4. GOAL AND OBJECTIVES OF THE RESEARCH STUDY

The **goal** of this study was to determine the causes of relapse amongst young African adults following in-patient treatment for drug abuse in the Gauteng Province.

The **research objectives** of this study were, to:

- determine which environmental risk factors have an influence on relapse amongst young African adults;
- determine which interpersonal risk factors have an influence on relapse amongst young African adults;
- determine which intrapersonal risk factors have an influence on relapse amongst young African adults;
- identify additional causes of relapse amongst young African adults;
- provide guidelines for improving professional services delivered by treatment centres, specifically during the aftercare and reintegration phase.

1.5. OVERVIEW OF RESEARCH METHODOLOGY

In this section the researcher focuses on the various research methods followed during this study.

The research approach that was utilised was the quantitative research approach. The quantitative approach to research was the most appropriate method for the implementation of this study because the study intended to determine the causes of relapse amongst individuals following in-patient treatment for drug abuse (Fouché & Delport, 2011:63). The implementation of this study fell within the applied research category. The results gathered from this study attempted to guide decision-making and solving the problem of relapse within the South African context among young African adults residing in the Gauteng Province (Bless, Higson-Smith & Kagee, 2006:45; Neuman, 2006:25). This study was also exploratory in nature as it was conducted to gain insight into the causes of relapse which relate to the South African context (Fouché & De Vos, 2011:95).

Since the study was quantitative in nature, a non-experimental research design was considered the most adequate research design for this study (Maree & Pietersen, 2010c:152). In this study a survey was undertaken to collect quantitative data from the respondents. This collected data were used to determine the causes of relapse amongst young African adults following in-patient treatment for drug abuse (Maree & Pietersen, 2010c:152). The cross-sectional survey design was applicable as the survey was conducted with different samples randomly drawn from the population and was conducted with each sample (Fouchè, Delport & De Vos, 2011:156).

The study was conducted by applying stratified random sampling in combination with purposive sampling in the selection of respondents. Stratified random sampling was used to break down the population into different groups, or strata (Holt & Walker, 2009:38). The population was divided in terms of different strata, namely the various in-patient treatment centres within the Gauteng Province. Within each stratum, purposive sampling was conducted with the specific purpose in mind to target respondents that meet the criteria to participate in the study (Botma, Greeff, Mulaudzi & Wright, 2010:178). The researcher attempted to find as many relevant cases as possible from the different strata that were representative of the study phenomenon (Brink, Van der Walt & Van Rensburg, 2005:179). The following strata, or treatment centres, formed part of this study: one within the Tshwane region and three within the Johannesburg region.

Within each of the strata, purposive sampling was employed to recruit prospective respondents who met the following criteria:

- Young African adults between the ages of 20 to 39 years, from both genders, addicted to illicit drugs;
- Young African adults who have undergone in-patient treatment for 6-12 weeks;
- Young African adults who have relapsed after having previous in-patient treatment during 2012 to 2013;
- Young African adults who were at the time of the study at one of the identified treatment centres in Gauteng;
- Young African adults who are English speaking and literate (at least a Grade 4 level of education).

In total 44 (n=44) respondents participated in the study.

As a quantitative data-collection method for the purpose of this study, the researcher made use of a group-administered questionnaire (Delport & Roestenburg, 2011:171). Each respondent in the group completed his or her own questionnaire, without discussion with the other members of the group and in the presence of the researcher, who was available to give certain instructions and to clarify uncertainties (Delport & Roestenburg, 2011:189).

After the data were collected, coding was done on the questionnaire itself and captured on a computer as numbers, in a grid format, by making use of a spreadsheet. The data were furthermore processed

with the aid of the Department of Statistics, University of Pretoria by using the Statistical Package for the Social Sciences (SPSS programme), Version 22.

The data were analysed by making use of descriptive statistics, more specifically association statistics. The descriptive method describes the distribution (or spread) of the sample with the aim being to produce a scope of the characteristics of such distributions through frequencies, measures of central tendency and measures of dispersion (Fouché & Bartley, 2011:251). Descriptive statistics were used in establishing the mean age of first drug experimentation; average income per month; the average number of people in a household; and the average length of first treatment for drug abuse.

Univariate analysis was applicable in examining the distribution of cases on only one variable at a time, making use of frequency distributions (Rubin & Babbie, 2010:290). One-way frequency analysis was used during the first phase of data analysis and the data's frequencies and percentages were determined. The frequencies and percentages were used to provide the biographic information of the respondents which included gender, age, employment status, etc.

Techniques of association were used to establish whether positions of one variable were likely to be consistently associated with positions on another variable through correlation (Fouché & Bartley, 2011:254). By implementing bivariate analysis the researcher was able to compare the variables and to assess the association of the position of one variable with the likely position of another variable. Bivariate analysis was applicable seeing that the relationships between two variables were examined as well (Rubin & Babbie, 2010:293). Two-way crosstabulation with Chi-square test was used to show the relationship between two variables and to determine whether the two variables were related (Alston & Bowles, 2003:258,264). With the Chi-square test were used to establish whether there is a relationship or association (statistical significance) between the following: (1) level of education and employment status; (2) gender and causes of relapse; (3) age groups and the causes of relapse; and (4) gender and substance abuse by family members.

All the data gathered on the causes of relapse were summarised for easy comprehension and utilisation and the summary took on various forms, such as tabular or graphic display or visual representation of the data (Fouché & Bartley, 2011:254).

The final step of the data analysis was drawing inferences from the data, which provided the researcher with the opportunity to apply the information, acquired from the samples that enabled her

to come to conclusions about the population (Fouché & Bartley, 2011:275). As this was a quantitative study, the results are presented in numerical format and reported in statistical language meaning graphs, tables and figures (Fouché & Delport, 2011:66). The p-value (Chi-square) will also be indicated in the tables presenting the data to show if there is any statistical association between the variables. It should be kept in mind that due to the small sample size the type II error might be a problem, meaning the null hypothesis is not rejected when it is fact false. The statistical significance will be set at $p < 0.1$.

The credibility of the data collection instrument was ensured through face and content validity (Pietersen & Maree, 2010:217). Face validity and content validity were established prior to data collection, by presenting a provisional version to the supervisor, the Postgraduate and Research Ethics committee of the Faculty of Humanities, for their comments before finalising the instrument. Reliability of the questionnaire meant that the researcher was able to repeat it at different times or administer it to different respondents from the same population and the questionnaire consistently yielded the same results (Delport & Roestenburg, 2011:178; Pietersen & Maree, 2010:215). The reliability coefficients for certain items in the questionnaire could be calculated by using a statistical package, but because of the small sample size, and the exploratory research purpose of the study, the tests were not conducted (Delport & Roestenburg, 2011:178). Seeing that data collection was by means of a self-developed questionnaire, based on literature, and not a standardised instrument, the calculation of a Cronbach Alpha was not considered essential.

A pilot study was firstly undertaken where the researcher pre-tested the questionnaire by selecting five respondents from one of the treatment centres and implementing the questionnaire with them (Welman, Kruger & Mitchell, 2005:148). These respondents were not included in the main study.

The feasibility of the study was ensured before undertaking the empirical study through ethical clearance from the Research Ethics Committee of the Faculty of Humanities at the University of Pretoria (see Annexure A). The researcher also obtained permission to conduct the study at the various treatment centres, granted by the Directors and Head of Institutions (see Annexure B to Annexure F). It was also ensured that each respondent gave informed consent to voluntarily participate (see Annexure G) in this study.

More detail pertaining to the research methodology is captured in Chapter 3.

1.6.   LIMITATIONS OF THE STUDY

While conducting this research study the researcher experienced certain limitations in obtaining the information that was needed for this study. The following limitations were experienced and should be kept in mind during the interpretation of this mini-dissertation:

- The study was undertaken during the beginning of the year whereas most treatment centres admissions only increase during April. The study was started too early in the year and this prevented successful data gathering on one specific occasion. The researcher had to revisit the treatment centres to increase the number of respondents.
- Respondents' that were still new in the treatment centres and who have taken detoxification medicine, experienced difficulty in concentrating on completing the questionnaire.
- There is literature available on the topic of relapse, but it is limited within the South African context, and more so with reference to the African young adult. It thus made supportive links difficult to establish.
- Due to the small sample size it was in most cases difficult to interpret statistical significance. Nevertheless, through purposive sampling the researcher attempted to include the optimal number of respondents in this study.

1.7.   DEFINITION OF KEY CONCEPTS

Within the study, the following key concepts are used and their definitions are provided below:

1.7.1. Substance abuse

Substance abuse previously defined in DSM-IV-TR of the American Psychiatric Association (APA, 2002) is replaced by the DSM V (APA, 2013) single diagnosis of substance use disorder. Substance use disorder is measured on a continuum from mild to severe, where the severity is based on the number of criteria endorsed. The DSM-5 defines a substance use disorder as the presence of at least 2 of 11 criteria, which are clustered in four groups:

1. Impaired control: (1) taking more or for longer than intended, (2) unsuccessful efforts to stop or cut down use, (3) spending a great deal of time obtaining, using, or recovering from use, (4) craving for substance.
2. Social impairment: (5) failure to fulfil major obligations due to use, (6) continued use despite problems caused or exacerbated by use, (7) important activities given up or reduced because of substance use.

3. Risky use: (8) recurrent use in hazardous situations, (9) continued use despite physical or psychological problems that are caused or exacerbated by substance use.

4. Pharmacologic dependence: (10) tolerance to effects of the substance, (11) withdrawal symptoms when not using or using less.

1.7.2. Illicit drug abuse

For the purpose of this study the researcher will only focus on the abuse of illicit drugs and will thus not include the abuse of alcohol and prescription medication. Illicit drugs have two features in common – they are psychoactive (mood altering) and they give pleasure to the consumer (Benavie, 2009:9). The following drugs are categorised by Benavie (2009:8) as illicit drugs: marijuana, heroin, LSD, ecstasy, cocaine, morphine and methamphetamine.

1.7.3. Relapse

Relapse, as defined by Marlatt and Donovan (2005:ix), is "a breakdown or setback in a person's attempt to change or to modify any target behaviour."

1.7.4. Young adults

Sigelman and Rider (2006:517) define the young adult as an individual aged 20 through 39 years. However Tanner and Arnett (2009:39) describe young adulthood as extending from ages 18 to 25 years and this stage of life is referred to as 'emerging adulthood' – the stage between adolescence and young adulthood. This study will focus on young adults aged 18 to 39 years in order to include all the developmental phases of young adulthood.

1.7.5. African

An African is defined by *Oxford Dictionary* (2012, sv 'African') as a person of black African descent. The researcher thus concludes from the above that an African is a black person, excluding Coloured and Asian people, originating from Africa and for the purpose of this study is a South African citizen.

1.7.6. In-patient treatment

In-patient treatment is referred to by the Prevention of and Treatment for Substance Abuse Act 70 of 2008, as in-patient service, meaning "residential treatment services provided at a treatment centre." The Prevention and Treatment for Substance Abuse Act 70 of 2008 further defines a treatment centre as a private or public treatment centre registered or established for the treatment and rehabilitation of service users who abuse or are dependent on substances."

1.8. CONTENTS OF THE RESEARCH REPORT

The remainder of this research report is divided into the following chapters:

Chapter 2: Causes of relapse unique to the young African adult: This chapter offers a literature review and focuses on the causes of relapse that are unique to the young African adult. It provides an overview of drug abuse and relapse in South Africa and also conceptualises the various known causes of relapse into categories – physical; intrapersonal; interpersonal/social; and environmental risk factors. This chapter also explores the characteristics of young African adults to identify contributing factors to relapse. Furthermore, it captures relapse prevention models and describes the mandate of social workers with regard to aftercare in order to prevent relapse.

Chapter 3: Research methodology, empirical findings and interpretation: In this chapter the focus is on describing the research methodology followed in this study, as well as analysing and interpreting the research data that had been gathered during the study.

Chapter 4: Conclusions and Recommendations: This chapter is dedicated to providing the key findings of the study and making conclusions and recommendations based on the empirical findings. In this chapter the researcher formulates guidelines for treatment programmes and provides a guide to inform aftercare services targeted at the young African adult that are more applicable within the South African context.

CHAPTER 2
CAUSES OF RELAPSE UNIQUE TO THE YOUNG AFRICAN ADULT

2.1. INTRODUCTION

Drug abuse is not a new concept and there is no doubt that it is a public health problem as it has reached epidemic proportions both nationally and internationally. The World Health Organization (WHO) (2012) indicates that drug use affects a significant number of individuals worldwide. Furthermore, costs associated with drug use are enormous and include not only economic costs but also health and social costs (Galea, Ahern & Vlahov, 2003:50). According to Khumalo (2008) "our country [South Africa] is a drug using society and more people are abusing drugs today than in any other time in history." Plüddemann, Parry and Bhana (2008:1) are of the opinion that drug use is increasing in South Africa. Du Preez (2010) agrees with this by stating that, "substance abuse is an ever growing problem in South Africa." With the increase in drug abuse, treatment demands are also proven to be increasing. Even more so, the rate of re-admissions into treatment centres following relapse after previous in-patient treatment for drug abuse, is also on the increase.

It is maintained by Ashenberg-Straussner (2001:23) that much research needs to be done on substance abuse among specific ethno-cultural populations. The researcher has realised this research gap with regard to relapses amongst young African adults. The causes of relapse will be examined in this chapter. This chapter will thus present the trend of drug abuse and relapse in South Africa and give a theoretical overview regarding the causes of relapse amongst young African adults following in-patient treatment. Furthermore, it will discuss relapse prevention models and the task of the social worker in relapse prevention, as well as the theoretical frameworks underpinning this study.

2.2. OVERVIEW OF DRUG ABUSE AND RELAPSE IN SOUTH AFRICA

Relapse is of importance to this study. However, in order to understand relapse it must be studied in conjunction with drug abuse and drug dependence, seeing that, as asserted by Bain (2004:17), relapse is an integral part of the process of substance dependence and it is thus necessary to discuss these two together, hence the discussion of drug abuse, drug dependence and relapse.

As previously stated drug abuse is a phenomenon that occurs internationally and affects more than 185 million people worldwide (WHO, 2012). The effects of drug abuse can be observed in all spheres

of life and the consequences can result in harm to the individual, family members and the wider community. These include cirrhosis, job loss, and criminal behaviour related to the acquisition and sale of illicit drugs (Galea et al., 2004:36; Velleman, Templeton & Capello, 2005:93). From the above it is apparent that drug abuse disrupts many dimensions of an individual's life such as physical health, in some instances mental health and financial stability. Job instability, unemployment, involvement in criminal behaviour and other antisocial behaviour can be brought about and relationships with significant others are influenced.

Recent statistics regarding drug abuse is limited and most statistics rely on the number of treatment admissions to various treatment centres in order to describe the current trends in drug abuse. The study is based in Gauteng and attention will thus be paid to admissions in Gauteng treatment centres. The South African Community Epidemiology Network on Drug Use (SACENDU) provided the following statistics with regard to treatment admissions in 2013; a total of 4026 patients were treated at Gauteng treatment centres during January to June 2013 as opposed to 2884 patients during July to December 2010 (SACENDU, 2014:19). From this the increase in drug abuse in relation to those entering treatment in the Gauteng Province is apparent.

Continuous drug use eventually leads to drug dependence. APA (2002:192) states that substance dependence is a cluster of cognitive, behavioural, and physiological symptoms indicating that a person is continuing to use a substance despite significant substance-related problems. In order for substance abuse to be diagnosed, Cami and Farrè (2003:976) are of the opinion that at least three of the following must be present: "symptoms of tolerance; symptoms of withdrawal; the use of a substance in larger amounts or for longer periods than intended; persistent desire or unsuccessful attempts to reduce or control use; the spending of considerable time in efforts to obtain the substance; a reduction in important social, occupational, or recreational activities because of drug use; and continued use of a substance despite attendant health, social or economic problems." The term substance dependence and drug addiction can be used interchangeably.

"Drug addiction is a chronic, relapsing disorder in which compulsive drug-taking behaviour persists despite serious negative consequences" (Cami & Farrè, 2003:975). This is concurred by Bain (2004:13) who states that relapse is an integral part of the cycle of addiction and it involves a number of biological and psychological factors. Relapse, in this study will refer to the return of drug use, after detoxification and in-patient treatment for at least six- to twelve weeks; together with the marked return of behaviours associated with drug use. The relapse rates can be observed as high both nationally

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and internationally. "Relapse to substance abuse following treatment typically reaches 75% in the 3- to 6-month period following treatment" (Adinoff et al., 2010:140). Considering South African statistics provided by SACENDU (2008) 24% of the intakes into treatment centres in Gauteng, 22% in Cape Town, 20% in the Northern region and 32% in Port Elizabeth were not first time admissions. It can thus be concluded that there is a definite relapse rate in South Africa. Hyman and Malenka (2001:695) state that "perhaps the most problematic aspect of addiction is the high risk of relapse to drug use…" Barber (2002:130) concurs that the problem of relapse is undoubtedly the most important single challenge currently facing the field of addictions. Another study done in South Africa by Ramlagan, Peltzer and Matseke (2010:45) agrees that there is a relapse rate and state that the relapse rate could be 50% for cannabis and 65% for harder drugs such as cocaine and heroin. SACENDU (2014:15) estimates that especially in Gauteng, 22% of the admissions into treatment centres are re-admissions, in other words, seeking treatment again after relapse.

The next part of the chapter will focus on the causes of relapse, followed by a discussion on the characteristics of young African adults which specifically predispose them to relapse.

2.3.   CONCEPTUALISING THE CAUSES OF RELAPSE

For the purpose of this study it is important to understand the causes of relapse. The causes of relapse will be discussed in terms of risk factors that increase an individual's probability of relapse. Campos (2009:773) refers to these as high-risk situations – those situations in which there is an increased desire to use, where the drug of choice may be readily available, or where social pressure to use drugs is increased. Other high-risk situations as mentioned by the author include particular environments, cognitive patterns, mood states, or social situations. As derived from Marlatt's Relapse Prevention Model (Marlatt & Witkiewitz, 2005:1), for a relapse to be prevented high-risk situations that precipitate a relapse, need to be identified.

The risk factors that can possibly precipitate a relapse that will be discussed in this section include environmental risk factors, interpersonal risk factors, intrapersonal risk factors and physical risk factors.

2.3.1. Environmental risk factors

Environmental risk factors that can increase the risk for relapse include increased availability and accessibility to drugs, and encountering people, places and paraphernalia associated with earlier drug use.

2.3.1.1.   Availability and accessibility of drugs

As expressed by Measham, Parker and Aldridge (1998), as quoted by Bain (2004:2),"the availability and prevalence of drug use by young people is escalating along with an increased range of drugs available and increased normalisation of drug-related behaviour and attitudes. The experimentation and use of illicit drugs by young people from all social backgrounds span the teenage years and extend into young adulthood." The researcher, in practice, has experienced that it is well-known that drugs can be accessed easily by users and it is available on street corners in the informal settlements, at taxi ranks, bus depots and even sold at taverns.

2.3.1.2.   Other environmental cues

In accordance to Bain (2004:29) environmental cues play an extremely important role in the process of relapse and as stated by Schubart (2001:2) in Bain (2004:29) that simply returning to the place where they took drugs can trigger relapse even months after abstinence. As stated by Cami and Farrè (2003:975) environmental stimuli (cues) associated with drug use itself can produce withdrawal and craving in the absence of the drug. For Hyman and Malenka (2001:697) environmental cues elevate the risk of a relapse when addicts encounter people, places or paraphernalia associated with earlier drug use.

2.3.2. Interpersonal/Social risk factors

'Interpersonal' is defined by the *Oxford Dictionary* (2012, sv 'interpersonal') as relating to relationships or communication between people. Interpersonal risk factors thus refer to the relations and interactions that exist or occur between persons.

2.3.2.1.   Peer group influence

In line with peer group influence, Campos (2009:773) states that individuals in recovery have substance-using peer groups that either actively discourage sobriety, model continued drug use, or do not possess the skills to help in managing high-risk situations. Depending on the influence from one's peer group, relapse is probable if one is returning to the same drug-abusing peers as before treatment. Wadhwa (2009:777) includes peer pressure as one of the most frequent high-risk situations

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for relapse. "Peer pressure can be a result of overt pressure from using friends or covert pressure within an individual to see or to be with old friends" (Wadhwa, 2009:777). This covert pressure, as referred to by Wadhwa (2009:777) can be quite persuasive seeing that individuals, as social beings, need to feel a part of a group, even if it is a group that results in negative personal consequences.

McCrady (2001:383) is of the opinion that deliberate steps need to be taken to detach oneself from a social network that is supportive of drug use and access new social networks that support new behaviour. As mentioned by Doweiko (2006:399) the individual's access to strong social support systems during times of craving seems to contribute to continued abstinence. Lack of support systems, including supportive family might then cause the individual to act on the craving experienced. Support systems can provide support when needed by the individual, especially when faced with a high-risk situation. McCrady (2001:409) concurs that the involvement of some significant social system is associated with positive treatment results.

In relation to the young African adult, the researcher has observed peer group pressure to play a significant role in drug abuse. Many young African adults are introduced to drugs by their peer group. Family support is not always there as the family is sick and tired of the dependent's behaviour and in some instances the communities become involved and act against the dependent's and stigmatise the family, in turn influencing the family's support to the dependent.

2.3.2.2. Conflict
Conflict is also listed by Wadhwa (2009:777) as one of the most frequent high-risk situations for relapse. As stated by Wadhwa (2009:777) conflict can be a result of interpersonal mishaps that set off the memory of using drugs when an individual has not developed the skills to manage interpersonal conflict appropriately. In relation to conflict O'Connell and Bevvino (2007:53) state that during drug use conflict is dealt with in dysfunctional ways – the psychological consequences of conflict may have been muted and diluted by the presence of drugs in the system. During active drug use conflict and the feelings associated with conflict is dealt with by using drugs. Alternative and healthy strategies and conflict resolution styles need to be adapted by the young African adult in order to be able to deal with conflict constructively.

2.3.2.3. Employment status
Poverty and unemployment is mentioned by Ramlagan et al. (2010:44) as a perceived reason for substance abuse. As mentioned previously employment opportunities are limited in South Africa and

lack of education is also a contributing factor when employment is sought. Finding employment after treatment, as observed by the researcher in practice, is the main goal for many individuals following in-patient treatment. Seeing that employment opportunities are limited, becoming demotivated when employment is not found is a high-risk situation. Boredom becomes another high-risk situation to consider when facing unemployment.

2.3.3. Intrapersonal risk factors

'Intrapersonal' is defined by the *Oxford Dictionary* (2012, sv 'intrapersonal') as taking place or existing within the mind. Intrapersonal risk factors then would refer to factors existing or occurring within the individual's self or mind. According to O'Connell and Bevvino (2007:32) "intrapersonal processes are internal experiences such as negative mood states (e.g., rage, anger, grief, depression, and anxiety) and negative changes in thinking, beliefs and attitudes."

2.3.3.1. Affect/Emotions

"Research suggests a strong association between negative affect states and relapse" (Doweiko, 2006:399). Campos (2009:773) declares that the most frequent cited reason for relapse among drug users is a negative mood state. Wadhwa (2009:777) concurs that some of the most frequent high-risk situations for relapse is when negative emotions are experienced. "Negative emotions include a broad range of emotions and mood states such as boredom, loneliness, sadness or depression, disappointment, anger, and resentment" (Wadhwa, 2009:777). Another negative emotional state as mentioned by Sinha (2001:343) is stress and, several models of addiction propose that stress increases the risk of drug abuse and relapse. Stress is defined by Lazarus and Folman, as quoted by Sinha (2001:343), as a process involving perception, interpretation, response and adaptation to harmful, threatening, or challenging events.

As stated by O'Connell and Bevvino (2007:67) drug users use drugs to modify and change troublesome emotions and supplant them with at least temporary feelings of pleasure and happiness. This is the way in which negative emotions and feelings were previously dealt with. O'Connell and Bevvino (2007:73) are furthermore of the opinion that feeling states need to be recognised and disclosed; allowing the self to experience the feeling state and troublesome feelings to be dealt with.

In practice, many young African adults noted to the researcher that stress, boredom, loneliness, depression and thinking too much are motivating factors for them to use drugs and to continue the use of drugs.

2.3.3.2. Coping skills

Wadhwa (2009:778) affirms that the use of drugs is the central coping mechanism for day-to-day life for addicts but it is necessary for individuals to identify specific coping mechanisms for different thoughts, feelings or moods, and situations. "Coping responses are those strategies you utilise to get yourself through high-risk situations without a return to active addiction" (O'Connell & Bevinno, 2007:49). O'Conell and Bevinno (2007:33) believe that appropriate coping responses must be learned to cope with emotions and also high-risk situations. Doweiko (2006:399) states that coping refers to the individual's ability to call on learned coping resources when confronted with drug-use cues. Young African adults have started to cope with certain situations, thoughts and feelings encountered during day-to-day life by using drugs, as the effect from the drugs relieves them from tension experienced because of the situation, thoughts and feelings.

2.3.3.3. Cravings

Doweiko (2006:399) states that a craving in itself is a poor predictor of relapse, it may be triggered by drug-use cues (smells, the sight of the drug, sounds, etc.) and trigger moods and memories that predispose the individual to substance use. Larimer, Palmer and Marlatt (1999:156) testify that ongoing cravings may erode the person's commitment to maintaining abstinence as his or her desire for immediate gratification increases. This process may lead to a relapse.

2.3.3.4. Self-efficacy

"Self-efficacy is the individual's confidence in his or her ability to cope with high-risk situations" (Doweiko, 2006:399). Bandura (1997:3) is of the opinion that self-efficacy refers to beliefs in one's capabilities to organise and execute the courses of action required to produce given attainments. Bandura (1997:289) further points out that efficacy assessments confirm that conditions such as negative emotional states which include stress, depression, loneliness, boredom and restlessness; social pressures to use drugs; and interpersonal conflict, weaken perceived efficacy to resist drugs. As this perceived self-efficacy, or the confidence in the ability to cope with high-risk situations are weakened, it can lead to a relapse.

2.3.3.5. Outcome expectancy

Outcome expectancy is related to an individual's conceptions regarding the consequences of substance use and this can influence substance use behaviour for example short-term reward contingencies can include the reduction of negative mood states, the inducement of euphoria from psychoactive substance, a shift in cognition toward a more positive sense of self, and stress reduction

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(Campos, 2009:773). Positive outcome expectancy with regard to the influence of the drug (reducing anxiety and increasing euphoria) might lead to relapse as little attention is paid to the negative consequences of the use of the drug. In other words people have higher expectations regarding the positive effects of drugs. As mentioned previously the young African adults expect the drugs to rid them of or help them cope with certain feelings, thoughts and situations.

2.3.3.6. Motivation

"Motivation is the extent to which an individual desires to refrain from problematic substance use" (Campos, 2009:773). As maintained by Marlatt and Witkiewitz (2005:11) "motivation may relate to the relapse process in two distinct ways, the motivation for positive behaviour change and the motivation to engage in the problematic behaviour." Doweiko (2006:399) is of the opinion that the individual's motivation to change his or her behaviour or to return to past behaviours has been found to play an important role in successfully coping with drug-use cues.

2.3.3.7. Personality traits

It is asserted by Doweiko (2006:399) that there are certain personality traits that predispose some people to relapse. These relapse–prone personality traits are described by Doweiko (2006:399), quoted from Chiauzzi (1991) as individuals having a tendency toward compulsive behaviours, as such individuals do not adjust well to even minor changes in routine. Another personality trait that places an individual at risk for a relapse is the passive-aggressive personality because of their tendency to blame others for their own behaviour. Antisocial personality traits according to Chiauzzi (1991), quoted by Doweiko (2006:399), underscore a tendency toward impulsiveness and a desire not to follow the road taken by others.

2.3.3.8. Seemingly irrelevant decisions

It is stated by Keller (2003), as quoted by Doweiko (2006:400), that through a series of seemingly irrelevant decisions the newly recovered individuals will place themselves in a high-risk situation, possibly without being aware of more than the last decision in a chain of choices that ultimately result in a relapse. "A central characteristic of mini-decisions is that they do not involve a decision to actively use chemicals. Rather, these irrelevant decisions will collectively set the stage for relapse" (Doweiko, 2006:400).

2.3.4. Physical risk factors

Physical risk factors that can increase the risk of relapse include physical dependence on drugs, withdrawal from drugs and being in a negative physical state.

2.3.4.1. Physical dependence

"Physical dependence indicates that the body has adapted physiologically to the chronic use of the drug, with the development of tolerance or, when the drug is stopped, of withdrawal symptoms" (Schuckit, 2006:9). As stated above tolerance to the drug also develops. "Tolerance is the toleration of higher and higher doses of the drug or the need for higher doses to achieve the same effects" (Schuckit, 2006:9).

In other words more and more of the same drug is needed to attain the same initial physical effect from taking the drug. Furthermore, it can be stated that a person's body becomes dependent on the drug which means that the drug is eventually used to feel normal and to do away with withdrawal symptoms. Relating to the young African adult, as observed in practice by having contact with service users, tolerance does develop and eventually dependency thus further resulting in negative consequences in the lives of dependents. These consequences often result in continuous use of the drugs to be able to deal or come to terms with the effects of their drug use.

2.3.4.2. Withdrawal

"Withdrawal is the appearance of physiological symptoms when drug-taking is decreased or stopped quickly" (Schuckit, 2006:9). Withdrawal symptoms, as indicated by Kring, Davison, Neale and Johnson (2007:297), are those negative physical and psychological effects that develop when a person stops taking the drug or reduces the amount of the drug taken.

Consistent with the above, physical withdrawal is a reality amongst young African adults, seeing that the most used drug amongst this group, as observed by the researcher in practice, is *nyaope* (a mix of heroin and dagga). Medication is provided to be able to deal with the physical withdrawal from drugs.

2.3.4.3. Negative physical state

According to Doweiko (2006:401), as derived from Dimeff and Marlatt (1995), a person experiencing a negative physical state such as illness, postsurgical distress, or injury might face an elevated risk of a relapse. In practice, as experienced by the researcher, a negative physical state can be a risk factor

amongst young African adults seeing that it relieves them from pain and having to deal with their health status; for example being HIV positive.

The researcher will now discuss characteristics of young African adults and how these characteristics relate to relapse amongst this group of individuals.

2.4. CHARACTERISTICS OF YOUNG AFRICAN ADULTS

In relation to various literature sources young adulthood is classified in accordance to different age groups. Sigelman and Rider (2006:517) define the young adult as an individual aged from 20 to 39 years. Tanner and Arnett (2009:39) describe young adulthood as extending from ages 18 to 25 years and this stage of life is referred to as 'emerging adulthood' – the stage between adolescence and young adulthood. In Newman and Newman (2012:428,482,526) adulthood is divided into early adulthood ranging from 24 to 34 years, middle adulthood from 34 to 60 years, and lastly late adulthood. In literature sources reviewed, it was found that during this developmental stage the young adult is faced with numerous demands, transitions and challenges and according to Urbanoski, Kelly, Hoeppner and Slaymaker (2011:1) the developmental stage of young adulthood also carries significant risk of harmful use of drugs and for the onset of substance use disorders.

The characteristics unique to the young African adult that relate to relapse will be discussed in this section of the report.

2.4.1. Characteristics related to developmental transition

Certain characteristics of the transition into young adulthood give rise to drug abuse during this developmental stage of life. This is confirmed by Furlong and Cartmel (2007) as cited in Webster (2009:69) "in the modern world young people face new risks and opportunities. The traditional link between the family, school and work seems to have weakened as young people embark on journeys into adulthood which involves a wide variety of routes, many of which appear to have uncertain outcomes." Measham, Parker and Aldridge (1998:9) state in relation to this that concepts like identity, sense of self, self-esteem, self-efficacy, social support, coping styles, isolation and meaning in life are all affected by rapidly changing political, social, cultural and moral climates, leaving today's young adults in a completely different situation than young adults thirty years ago and possibly more vulnerable to the damages of substance abuse.

The typical characteristics that are deemed as important when considering the transition into adulthood amongst Africans includes: social role changes, adolescent initiation, employment, and change in social groups.

2.4.1.1. Social role changes

The characteristics of the transition into adulthood include certain developmental roles which include social role changes as described by Newman and Newman (2012:431).The salient roles of adulthood include the role as worker, spouse, friend and parent. According to Newman and Newman (2012:431) these roles give structure to adult identity and meaning to life. In relation to this Newman and Newman (2012:431) state that social class groups tend to agree on the appropriate age for significant life events such as marriage and child-rearing, this consensus exerts social pressure pushing them to reach particular roles at expected ages. Tanner and Arnette (2009:40) refer to this change in social roles as recentering. "During this stage, individuals' relationships and roles which formerly identified them as dependent, as the recipient of guidance, support and resources, undergo a shift in dynamic toward relationships in which power is shared, mutual, and responsibility for care and support gain in reciprocity" (Tanner & Arnette, 2009:40). Konstam (2007:1) states that the transition to adulthood is a complex process in which youth who have been dependent on parents throughout childhood start taking definitive steps to achieve measures of financial, residential, and emotional independence, and to take on more adult roles. The researcher is of the opinion that coping with the responsibility of these different social role changes will vary from person to person and ineffective coping might cause drug use and/or abuse. This is supported by Velleman et al. (2005:99) who state that there is an increased risk of drug use associated with poor coping skills.

Some young adults, between the ages of 18 and 25 years, however, prolong the transition into adulthood, and, therefore, the process of serious decision-making regarding their lives in the future (Roman, Human & Hiss, 2012:1164). In South Africa, the majority of young adults live in the parental home, implying that there is still parental control and this places limitations on the individual's ability to gain autonomy and to develop decision-making skills (Roman et al., 2012:1169).

Meintjies, Hall, Double-Hugh and Boulle (2010:40) maintain that there is a widespread concern that the number of children living without adults in "child-headed households" is rapidly increasing in South Africa. These parentless children often grow up without role models, and hence will lack social skills, a moral framework and discipline (Bray, 2003:6). Bray (2003:26) is furthermore of the opinion that orphans are found to exhibit internalised behaviour changes such as increased stress, trauma,

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anxiety, depression and low self-esteem. All the above mentioned might make them more vulnerable to drug abuse. The researcher observed in practice that many of the young African adults being admitted for treatment have one or both parents absent in their lives.

Part of social role change or for certain social role change to occur, adolescent initiation is still practices in certain African cultures and therefore the researcher will provide attention to this practice.

2.4.1.2. Adolescent initiation

Some African cultures require certain initiation practices to take place in order to enter the stage of adulthood. A well-known cultural initiation practice is circumcision of boys at initiation school. Male circumcision is normally associated with adolescent initiation schools, which, in turn, commonly defines age-grades (Marck, 1997:346). Marck (1997:357) defines circumcision as a clear break between childlike status and the general toughening or hardening of boys to men. According to Marck (1997:357) there is a difference in risk behaviour between circumcised and uncircumcised persons – some leave their traditional environments for wage labour in cities or at mines before they have reached an age to be circumcised, and some specifically leave for such employment to avoid circumcision. These boys are faced with a whole different experience from their traditional environment and might be introduced to drugs without having appropriate knowledge regarding addictive chemicals.

As mentioned above even circumcision plays a role in employment, but employment plays an even more significant role in the transition into adulthood.

2.4.1.3. Employment

Central to acquiring this independence is finding employment and being employed. Konstam (2007:8) states that "the primary goal for young adults is to establish the ability to support themselves independent of their parents." Newman and Newman (2012:457) maintain that work provides a major structural factor in the establishment of an individual's lifestyle and, furthermore, determines the activities, social relationships, challenges, satisfactions, and hassles or frustrations of daily life. Opportunities for employment are limited in South Africa especially for those less educated. In relation to unemployment among young African adults Du Toit (2003:9) states that in 2002 the majority of the unemployed youth (89, 7%: 4.9 million out of 5.5 million) were young Africans. Along with this he confirms that the most vulnerable group seems to be Africans between the ages of 25 and 34. The National Treasury (2011:12) report that young adults are particularly affected by unemployment in

South Africa. The report furthermore highlights that 42% of young people under the age of 30 years are unemployed (National Treasury, 2011:5).

It should, however, be noted that "working lives tend to begin later with educational participation occupying young people for longer periods of time" (Furlong, 2009a:145). Heinz (2009:4) furthermore comments on education and employment by stating that the core transition to adulthood concerns the matching of education and employment which is the backbone for implementing aspirations and to coordinate participation in the spheres of family life, consumption and citizenship. Du Toit (2003:9) concurs with this in that nearly two thirds (65, 5%: 3.6 million) of the unemployed youth do not hold a Grade 12 certificate and the majority (90%: 3.2 million) of this group is African. Webster (2009:67) notes that school failure is a strong predictor of 'failed' transitions, delinquency, crime and anti-social behaviour. The National Treasury (2011:12) also highlights the relationship between youth unemployment and low education levels. According to the National Treasury (2011:5) unemployed young people tend to be less skilled and experienced with almost 86% not having formal further or tertiary education. Overton-de Klerk and Oelofse (2010:399) maintain that unemployment is one of the reasons for the high incidence of drug abuse in communities and in turn, drug abuse aggravates high crime levels.

It can be concluded that opportunities for employment are limited in South Africa and even more so for those less educated. The trend noticed by the researcher in practice at Dr Fabian and Florence Ribeiro Treatment Centre, is that most young African adults admitted to the Centre did not matriculate and is unemployed. According to Galea et al. (2004:46) higher education is associated with the cessation of marijuana use. Employment is usually sought after treatment. With the lack of employment opportunities in South Africa, most young African adults are faced with the high-risk situation of being unemployed. North (2002:24) identifies the urgent need for young people to be educated and trained in the field of entrepreneurship in order for them to become job-creators rather than job-seekers. North (2002:24) further indicates that entrepreneurship education will therefore contribute to the ideal of empowering as many people as possible in order to unleash the previously stifled human potential of all South Africans.

Another characteristic of the transition into adulthood is the change of social groups.

2.4.1.4.   Change in social groups

As maintained by Bassani (2009:76) "for youths, the family acts as the primary (influencing) group…
"as youths pass from childhood into adolescence and young adulthood, the primary group changes.
During this transformation the peer group becomes more prominent." This can also be supported by
the notion previously mentioned that transition into adulthood involves becoming independent, thus
moving away from family in order to explore and form other significant relationships. Mulder
(2009:203) describes this developmental task of leaving home as an important marker in the transition
into adulthood. Furlong (2009b:201) with regard to independent living states that young adults
experience different forms of independent living that may involve periods of living alone, with peers
and cohabiting as partners. According to Nation and Heflinger (2006:418) of all the risk factors for drug
use and/or misuse, the usage by friends was the only factor found to be significant across all age
groups, gender, and substances.

As mentioned above the peer group and functioning within the groups becomes more prominent and
thus might dominate decision-making with regard to drug initiation or use. The researcher observed in
practice that most young African adults receiving in-patient treatment mentioned that their peer group
introduced them to drug use and this eventually lead to the misuse of drugs. As stated by Gelea et al.
(2004:47) social supports and social network norms not supportive of illicit drug use have been
associated with both cessation and sustained abstinence. It can thus be stated that by returning to the
drug abusing social group the young African adult is placing him/herself in a high-risk situation.

As mentioned earlier (see paragraph 2.4.1.1.) the transition into adulthood is a complex process and
there is vulnerability to drug use and/or abuse during this life stage, and according to Velleman et al.
(2005:93), the use and misuse of alcohol and drugs is widespread amongst young people.

2.4.2. Position of the young African adult within society and socio-economic status

Heinz (2009:5) states that the transitional arrangements for moving towards adulthood differ between
societies according to their respective cultural traditions, education, employment, and welfare system.
For this study the focus is on young African adults. The researcher will thus explore the characteristics
of young Africans that can possibly influence drug abuse amongst this group. The position of Africans
within the class structure however differs and not all young African adults are faced with issues such
as poverty, violence, low socio-economic status, racism and discrimination. In relation to those young
African adults faced with some of the above-mentioned, Bennett and Olugbala (2010:179) state that
"poverty, residential mobility, and population density are important contributors to the social

breakdown of many neighbourhoods and communities. In turn this social disorganisation is thought to be a major factor in the proliferation of a host of social ills including drug trafficking, gang activity, exposure to violence, high rates of crime, frequent police harassment, residential density and high ambient noise." This phenomenon is described by Brook, Brook and Pahl (2006:32) who state that individuals that have little access to resources and opportunities can experience indifference or even opposition to dominant social norms. "This detachment from social norms may ultimately be expressed in high levels of substance use and abuse" (Brook et al., 2006:32).

In South Africa, Africans with lower socio-economic status inhabit rural areas in all parts of the country. Unique problems faced by this subgroup of Africans include the same problems faced by African American communities in the United States as mentioned by Wright (2001:36) – there is an overabundance of available alcohol and other drugs in which liquor stores, taverns and drug dealers are readily accessible and the economic frustration over not being able to get a job to fulfil their financial responsibilities is a factor in the use and abuse of drugs. This high population density makes the distribution of drugs even easier and the access and availability to young African adults faced with these conditions are increasing. A further challenge is the lack of infrastructure; Overton-de Klerk and Oelofse (2010:401) describe the lack of infrastructure as including the lack of constructive entertainment such as sport facilities, cinemas, libraries, and community halls. They conclude that poor infrastructure and lack of constructive entertainment result in drug abuse, promiscuity and crime. Without constructive entertainment opportunities young African adults might become bored and boredom can be seen as another high-risk situation for relapse. Other issues related to poor infrastructure as mentioned by Overton-de Klerk and Oelofse (2010:402) is the lack of schools and tertiary institutions, over-crowded classes and school buildings not being up to standard. All these issues contribute to the lack of education and skills development amongst these communities. Furthermore, Brook et al. (2006:31) agree by quoting Ryan et al., 1999, Sampson, Raudenbush and Earls, 1997, that "environmental factors such as drug availability, adverse economic conditions, a high crime rate, and neighbourhood disorganisation have all been found to be related to drug use."

It can be summarised that unique challenges faced by young African adults from low socio-economic minority groups predispose them to initiate and even continue the use of drugs. This argument is supported by Doweiko (2006:16) who states that if something increases the individual's sense of pleasure or decreases discomfort, then the person is most likely to repeat that behaviour.

In conclusion, high-risk situations that might cause relapse amongst young African adults include not being employed and thus not being able to fulfil certain social role changes, returning to the drug-using social group, access and the availability of drugs, especially in high density areas, and the lack of infrastructure especially constructive entertainment in communities.

Relapse prevention models will be discussed in order to gain an understanding of the models used in practice for aftercare; focusing on relapse prevention and continued treatment even after discharge from in-patient treatment centres.

2.5.   RELAPSE PREVETION MODELS

As indicated by Campos (2009:773), the goal of relapse prevention is to provide individuals with specific skills to cope with high-risk situations and can include cognitive operations like choosing to avoid focusing on cravings and urges, thinking about the long-term consequences of a return to drug use, or behavioural strategies such as leaving the area where drugs are available and seeking social support, to mention only a few. Concurring with this, Marlatt and Donovan (2005:1) state that the major goal of relapse prevention is to address the problem of relapse and to generate techniques for preventing or managing its occurrence.

The relapse prevention models that will be discussed in this section include the Cognitive-Behavioural Model (Relapse Prevention Model) proposed by Marlatt and Gordon, and the Cenaps Model developed by Terence Gorski.

2.5.1. Cognitive-Behavioural Model (The Relapse Prevention Model)

The Relapse Prevention Model (RP model) was developed by Marlatt and Gordon (1985:46) to be used in the provision of aftercare services to addicted persons. In accordance with Marlatt and Witkiewitz (2005:1) this model seeks to identify high-risk situations in which an individual is vulnerable to relapse and to use both cognitive and behavioural coping strategies to prevent future relapses in similar situations. As stated by Marlatt and Witkiewitz (2005:2) this model centres on an individual's response to a high-risk situation and the components include the interaction between the person (affect, coping, self-efficacy, and outcome expectancies) and environmental risk factors (social influences, access to substance, cue exposure). The premise of this RP model is that if the individual lacks an effective coping response and/or confidence to deal with the situation; in other words has low self-efficacy, the tendency is to give in to temptation. In relation to this Marlatt, Parks and Witkiewitz

(2002:3) maintain that this model of relapse prevention focuses on the identification and redress of risk factors and the identification and development of protective factors. Risk factors refer to events, situations and perceptions that could lead to drug use (Fisher & Harrison, 2005:307), whereas, protective factors are characteristics associated with the ability to survive and thrive in adverse circumstances (Compton, Galaway & Cournoyer, 2005:45).

The decision to use or not to use is then mediated by the individual's outcome expectancies for the initial effects of using the substance (Marlatt & Witkiewitz, 2005:3). According to Curry, Marlatt and Gordon (1987) as cited in Marlatt and Witkiewitz, (2005:3) individuals who choose to indulge may be vulnerable to the "abstinence violation effect" (AVE), which is the self-blame, guilt, and loss of perceived control that individuals often experience after the violation of self-imposed rules. The AVE contains both affective and cognitive components and depending on how the relapse is categorised – internal, global and uncontrollable or external, unstable and uncontrollable, the likelihood of a relapse is heightened or decreased, respectively (Marlatt & Witkiewitz, 2005:3). A lapse does not have to lead to the AVE, and eventually relapse, but can also be viewed as a learning experience (Marlatt et al., (2002:5). In relation to AVE, King and Polaschek (2003:68) concur that AVE is a welling up of negative cognitions and emotions that precipitate further lapse behaviour and relapse, and possibly the return to a dysfunctional pattern of drug abuse.

The RP Model is based on the cognitive-behavioural approach and relapse prevention thus combines behavioural skills training with cognitive interventions designed to prevent or limit the occurrence of relapse episodes (Marlatt & Witkiewitz, 2005:4). Larimer et al. (1999:152) add that a central aspect of the model is a detailed classification – taxonomy – of factors or situations that can precipitate or contribute to relapse episodes.

In summary as derived from Marlatt and Witkiewitz (2005:4) once the potential high-risk situations are identified strategies are developed to intervene and include teaching effective coping strategies, enhancing self-efficacy, and encouraging mastery over successful outcomes. According to Marlatt and Witkiewitz (2005:4) relapse prevention also focuses on the implementation of global self-management strategies in that it incorporates the assessment of lifestyle factors that may relate to an increased probability of relapse. These lifestyle changes include reducing stressors or increasing pleasurable activities (stress management) so that a balance between daily negatives and positives can be achieved, time management, relaxation and meditation training (Marlatt & Witkiewitz, 2005:5). Furthermore, Marlatt and Witkiewitz (2005:5) assert that a 'relapse road map' can be developed

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which is an analysis of possible outcomes that may be associated with different choices in high-risk situations; this is effective in enhancing an individual's self-efficacy and preventing the incidence of a lapse seeing that appropriate coping responses to certain high-risk situations have been planned and rehearsed. Marlatt et al. (2002:20) indicate that the other aspects that should receive attention during the practical implementation of the model include, teaching clients coping strategies and guidance in evaluation of honesty and cognitive decisions.

Some advantages of this model that presented itself to the researcher is the fact that by implementing the concepts of this model, various life skills which are needed for daily functioning are taught and this improves overall life skills of an individual. Together with life skills, coping skills are also integrated in the RP model and as maintained by Marlatt and Witkiewitz (2005:6), changes in coping skills lead to a decreased probability of relapse. The model furthermore considers a lapse to be a learning opportunity. Another advantage as mentioned by Marlatt and Witkiewitz (2005:6) and proven by several studies, is that there are sustained main effects for RP, suggesting that RP may provide continued improvement over a longer period of time (indicating a "delayed emergence effect"), whereas other treatments may only be effective over a shorter duration. All children are raised differently and within different environments – the prevalence of single-parent households and child-headed households are high in South Africa. Meintjies and Hall (2012b) state, in accordance with the 2010 General Household Survey, that there are just under 90 000 children living in a total of 50 000 child-only households across South Africa. With regard to single-parent households Meintjies and Hall (2012a) conclude that less than one third (28%) of African children live with both their parents. The acquisition of appropriate and necessary life skills and coping skills might not have been acquired as it should have, due to the above-mentioned circumstances and will thus benefit the young African adult in such a way. In other words, young African adults lacking necessary life skills and coping skills will benefit from this RP model not only to prevent relapse but also to employ in daily living and thus improving functioning within society.

A disadvantage as mentioned by Marlattt and Witkiewitz (2005:21) is that the determinants described in the model are multidimensional and dynamic; in other words the use of an effective coping response may not guarantee an increase in self-efficacy and continued abstinence. This specifically can be related to the young African adult, in that they might be faced with more high-risk situations especially in impoverished communities. In black communities, as stated previously, drugs are readily available and easy to access. Another disadvantage as stated by Barber (2002:133) is that the development of excessive self-efficacy (over-confidence) about the capacity to recover from a lapse is

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actually associated with higher relapse rates. Another disadvantage as explained by King and Polaschek (2003:68) is that the model does not differentiate the variable affective states that might follow a lapse, and their implications for relapse-related behaviour. In other words the various emotional states and attributions are not measured specifically (King & Polaschek, 2003:69).
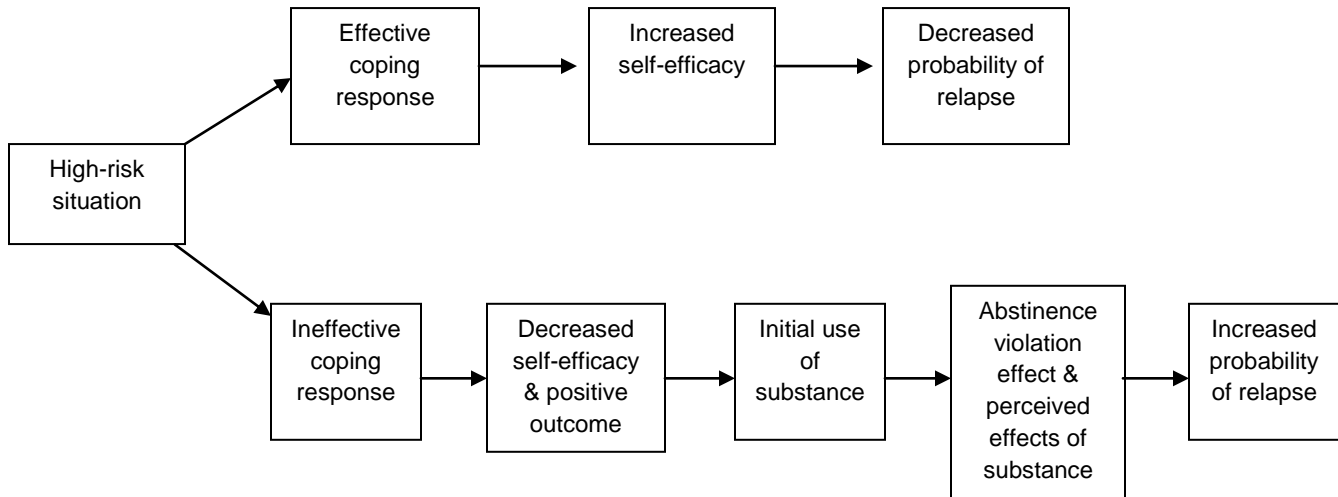
Figure 1: Marlatt and Gordon's model of relapse
Source: Marlatt and Gordon (2005)

The researcher will make use of a practical example in order to explain this model:

As explained previously this RP model is effective in identifying high-risk situations in which an individual is vulnerable to relapse (Marlatt & Witkiewitz, 2005:1). A high-risk situation for a young African adult residing in a rural area where there is a high population density might be the increased accessibility and availability of drugs in such an area. Going back to such an environment in itself can be a high-risk situation for the young African adult. The scenario above furthermore presents the interaction between the person and environmental risk factors to which Marlatt and Witkiewitz (2005:2) refer to. Depending on the young African adult's response – effective or ineffective; the individual's self-efficacy is determined. If the young African adult, mentioned above, is able to cope with his environment and drugs being readily available and accessible, his or her self-efficacy will increase and this will decrease the probability of relapse. As soon as the young African adult is not able to effectively cope with the situation, in other words, has decreased or low self-efficacy the tendency is to give in to temptation. The decision to use drugs is based on the young African adult's outcome expectancies for the initial effects of using the drug (Marlatt & Witkiewitz, 2005:3). The young African adult who chooses to indulge becomes vulnerable to the ″abstinence violation effect″ (AVE) which

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refers to self-blame, guilt and loss of perceived control that individuals experience after the violation of self-imposed rules (Curry, Marlatt & Gordon, 1987 in Marlatt & Witkiewitz, 2005:3). It is furthermore stated by Marlatt and Witkiewitz (2005:4) that ″depending on how the relapse is categorised – internal, global and uncontrollable or external, unstable and uncontrollable, the likelihood of a relapse is heightened or decreased, irrespectively.″ In the instance that the young African adult attributes his relapse to the availability and accessibility of drugs in his or her environment (external), the likelihood of relapse is decreased seeing that the self-blame, guilt and loss of perceived control will not be based on internal violation of self-imposed rules (Curry, Marlatt & Gordon, 1987 in Marlatt & Witkiewitz, 2005:3) but rather on external factors out of his or her control.

2.5.2. Cenaps Model

As stated by Wadhwa (2009:776) the Cenaps Model (CM) integrates the disease concept of addiction with bio-psychosocial strategies to help maintain abstinence and positive change in recovery. Fisher and Harrison (2012:167) concur with the disease concept as a guiding philosophy affirming that chemical dependency is viewed as a bio-psychosocial disease. "This means that the disease affects biological or physical, psychological, and social functioning" (Fisher & Harrison, 2012:167). The physical consequence of chemical dependence is brain dysfunction, occurring during intoxication, short-term withdrawal, and long-term withdrawal (Fisher & Harrison, 2012:167; Gorski, 2000:25). According to Gorski (2000:25) the symptoms of brain dysfunction cause difficulty in thinking clearly, managing feelings and emotions, remembering things, sleeping restfully, recognising and managing stress, and psychomotor coordination during the first 6 to 18 months of sobriety. The other areas affected are personality, social, and occupational problems due to the above-mentioned effects on the brain (Fisher & Harrison, 2012:167; Gorski, 2000:25). It is mentioned by Fisher and Harrison (2005:167) since the disease is chronic and affects the brain, causing other psychological and social problems, total abstinence is necessary.

The CM conceptualises recovery as a developmental process that goes through six stages – transition, stabilisation, early recovery, middle recovery, late recovery and maintenance. These are discussed according to Gorski (2000:25).

1. Transition – This is the stage where clients recognise that they are experiencing drug-related problems and need to pursue abstinence as a lifestyle goal so as to resolve these problems.
2. Stabilisation – During this stage clients recover from acute and post-acute withdrawal and stabilise their psychosocial life crisis.

3. Early Recovery – In this stage clients identify and learn how to replace addictive thoughts, feelings, and behaviours with sobriety-centred thoughts, feelings and behaviours.

4. Middle Recovery – In middle recovery clients repair lifestyle damage caused by addiction and develop a balanced and healthy lifestyle.

5. Late Recovery – Here clients resolve family-of-origin issues that impair the quality of recovery and act as long-term relapse triggers.

6. Maintenance – Clients continue a programme of growth and development and maintain an active recovery programme to ensure that they do not slip back into old addictive patterns.

For the researcher an advantage of the CM is that when drug dependence is viewed as a disease it means that it can be treated and this in itself sounds optimistic and can be a motivating factor for many people. By integrating bio-psychosocial strategies into the CM, attention is focused on all related problems to drug use; for example - physical, psychological and social functioning. All aspects of the young African adult's life are incorporated and the treatment provided is thus more holistic. The CM for Relapse Prevention is premised on the cognitive approach and McLeod (2003:80), as quoted by Van der Westhuizen (2010:247), explains that the client may not be consciously aware of the true motive or impulses behind his or her actions. This approach assists the client to modify beliefs, faulty patterns or perceptions and destructive behaviour (Van der Westhuizen, 2010:247).

A disadvantage of the CM of relapse prevention as stated by Gorski (1990) and quoted by Fisher and Harrison (2012:168) is that it will only be effective for clients who believe that they have the disease, require abstinence, and need to use recovery tools, but are unable to maintain abstinence. The number of people that can be reached by the CM is limited seeing that not all clients believe they have a disease. Another disadvantage as presented by Fisher and Harrison (2012:166) is that this disease model of addiction and its depiction of addiction as a progressive, chronic disease that can be managed only through abstinence, may create a sense that a slip means complete deterioration to pre-treatment levels of functioning and the emotions attached to this might lead to further, heavier use. An assumption by the researcher based on experience is that not all young African adults perceive their addiction as a disease. The CM can thus not effectively be used for that particular young African adult. As experienced by the researcher in practice, some young African adults rather attribute their addiction to aspects like peer pressure, negative emotional states and conflict with family members.

The researcher will make use of a practical example in order to explain this model.

According to the CM, drug abuse that results in chemical dependency is a bio-psychosocial disease meaning that drug abuse affects all aspects of the young African adults' functioning. There are certain physical, psychological and social consequences of drug abuse for the young African adult. Some of the physical consequences of drug abuse for the young African adult include brain dysfunction during intoxication, darkening in complexion, damage to intestines, and short-term withdrawal symptoms such as stomach cramps, vomiting, sweating, headaches, etc. Psychological consequences for the young African adult can include difficulty in thinking clearly, and managing feelings and emotions. The young African adult is also affected by various social consequences such as occupational problems, educational problems, family and other relationship problems as a result of drug abuse. With regard to the treatment and recovery of the young African adult, the CM ensures that all the aspects of functioning that were affected by drug abuse/ dependency can be addressed in accordance to six stages.

It can be summarised that chemical addiction is a disease resulting in the abuse of mood-altering chemicals (drugs) which in the course of long-term use causes brain dysfunction that eventually disorganises personality and causes occupational and social problems.

The social worker performs important tasks in relapse prevention and this will thus be discussed by the researcher.

2.6. TASKS OF SOCIAL WORKER(S) IN RELAPSE PREVENTION

By exploring the high relapse potential amongst young African adults, it becomes apparent that social work intervention is needed during recovery and in order to maintain sobriety after treatment through relapse prevention.

"Relapse prevention can be described as a tertiary prevention strategy with two specific aims namely; preventing an initial lapse and maintaining abstinence or harm reduction treatment goals, and providing lapse management if a lapse occurs, to prevent further relapse" (Marlatt & Witkiewitz, 2005:1). Developing relapse roadmaps can assist clients in maintaining sobriety after treatment as it is a cognitive-behavioural analysis of high-risk situations that emphasises the different choices available to clients for avoiding or coping with these situations as well as their consequences (Larimer et al., 1999:161).

The social worker should also provide access to aftercare services or refer a client for aftercare services following in-patient treatment. According to Section 5 of the Prevention of and Treatment for Substance Abuse Act 70 of 2008, chemically addicted persons should have access to professional aftercare services to ensure that treatment is not terminated prematurely, ensuring that the persons be equipped with additional skills to maintain their treatment gains, sobriety and avoid relapse. Section 1 of the Prevention of and Treatment for Substance Abuse Act 70 of 2008 defines 'aftercare' as "[an] ongoing professional support to a service user after a formal treatment episode has ended in order to enable him or her to maintain sobriety or abstinence, personal growth and to enhance self-reliance and proper social functioning." Aftercare is furthermore simplified by McNeece and DiNito (1998), quoted by Van der Westuizen (2010:8), as the maintenance of the changes made in treatment.

The Prevention of and Treatment for Substance Abuse Act 70 of 2008, as well as the National Drug Master Plan 2006-2011 inform and guide the delivery of aftercare services. The researcher will discuss the provisions and mandate by each of the above-mentioned. There are also theoretical models that the social worker can implement and apply in relapse prevention and aftercare services.

2.6.1. Provisions and mandate with regard to aftercare

The Prevention of and Treatment for Substance Abuse Act 70 of 2008 makes certain provisions and stipulations with regard to the provision of aftercare services. From the National Drug Master Plan (DSD, 2007) certain tasks of social work in the provision of tertiary strategies can be identified.

2.6.1.1.   The Prevention of and Treatment for Substance Abuse Act 70 of 2008

Section 30 of the aforementioned Act makes provision for the establishment of aftercare and reintegration services. Section 30 of the Act furthermore specifies that ″integrated aftercare and reintegration services must include elements that –

- (a) allow service users to interact with other service users, their families and communities;
- (b) allow service users to share long term sobriety experiences;
- (c) promote group cohesion among service users;
- (d) enable service users to abstain from substance abuse;
- (e) are based on structured programmes;
- (f) must focus on successful reintegration of a service user into society, and family, and community life;
- (g) prevent the recurrence of problems in the family environment of the service user that may contribute to substance abuse.″

The Prevention of and Treatment for Substance Abuse Act 70 of 2008 defines a service user as a person who is abusing or is dependent on substances and who, following, assessment, receives services in a treatment centre, halfway house or community-based service.

Furthermore, Section 31 of the Prevention of and Treatment for Substance Abuse Act 70 of 2008 makes provision for the establishment of support groups, in that service users and persons affected by substance abuse may, as prescribed, establish support groups that focus on integrated on-going support to service users in their recovery. The Act proposes the purpose of the establishment of support groups as follows:

(a) ″provide a safe and substance free group experience where service users can practice re-socialisation skills;

(b) facilitate access by service users to persons in recovery or have recovered from substance abuse who can serve as role models to service users who are in the beginning or middle stages of the recovery process;

(c) encourage service users to broaden their support system from persons contemplated in (b).″

2.6.1.2.   The National Drug Master Plan 2006-2011[1]

As mentioned previously RP is a tertiary strategy aimed at maintaining sobriety. In accordance to the National Drug Master Plan (DSD, 2007:23) tertiary prevention strives to end compulsive use of alcohol and other drugs and to ameliorate their negative effects through treatment and rehabilitation. This type of programme is most often referred to as ″treatment″ but also includes rehabilitation and relapse prevention. Treatment is furthermore defined in the National Drug Master Plan (DSD, 2007:47) as ″a process aimed at promoting the quality of life of the drug dependent and his/her system (husband/wife, family members and significant persons in his/her life) with the help of a multi-professional team″

Mentioned previously is the importance of successful reintegration into society after treatment. In relation to this, one of the goals of the National Drug Master Plan (DSD, 2007:13) it is ″to promote family and community-based intervention approaches in order to facilitate the social reintegration of abusers.″

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[1] This study was conceptualised and the empirical study conducted, while the NDMP 2006-2011 was still in operation. Therefore, the researcher does not refer to the current NDMP 2013-2017.

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From the stipulations made by the Prevention of and Treatment for Substance Abuse Act 70 of 2008 and the mandate according to the National Drug Master Plan (2007), as discussed above, the task and responsibilities of a social worker can be comprehended as:

- Providing effective treatment to service users within designated treatment centres;
- Providing integrated aftercare and reintegration services through the establishment of support groups;
- Promoting family and community-based intervention approaches to facilitate the social integration of abusers; and
- Promoting the quality of life of the drug dependent and his or her system (family members, husband/wife and significant persons in his/her life).

The researcher will continue by explaining the application of the theoretical models within the context of social work practice to assist in relapse prevention.

2.6.2. Application of theoretical models

According to Barber (2002:37) social work seeks to enhance the social functioning of individuals, singularly and in groups, by activities focused on their social relationships which constitute interaction between individuals and their environments. As discussed previously various high-risk situations for relapse exist in the individual's environment. The theoretical models that social workers can implement in the process of relapse prevention and involvement in aftercare services, includes the adaptation model and the eco-systems perspective.

2.6.2.1.   Adaptation model

From the adaptation model the following can be derived - a person or a group of people can be seen as adaptive system(s) with internal processes for coping with change, furthermore, environmental conditions, circumstances, and influences affect people as adaptive systems (Barone et al., 2011:353). Adaptation is defined by Sigelman and Rider (2006:173) as the process of adjusting to the demands of the environments. The service users will be seen as adaptive systems as their environment has changed from being in an in-patient treatment centre to being exposed to another environment outside the treatment centre, together with the change in the environment, the service user has also needed to change as people must adapt to change (Dobratz, 2008:256).

Tasks of a social worker, as mentioned above, are to facilitate social reintegration of abusers and providing reintegration services through the establishment of support groups. By providing such

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service successful adaptation, in other words, reintegration can occur, thus preventing relapse and maintaining sobriety.

An advantage of this model is that individuals are seen as adaptive systems with internal processes for coping with change; if taught the appropriate skills and ways of coping they will be able to adapt effectively and reintegration will be successful. A further advantage of this model, as identified by the researcher, is that this model is effective in identifying high-risk situations in environments. A disadvantage of this model, for the researcher, is that the focus on internal, individual characteristics is neglected as this model focuses on adapting to the environment.

This model can especially be useful during relapse prevention planning in developing relapse roadmaps, as discussed previously (see paragraph 2.5.1.), which can assist clients in maintaining sobriety after treatment as it is a cognitive-behavioural analysis of high-risk situations that emphasise the different choices available to clients for avoiding or coping with these situations as well as their consequences.

2.6.2.2.   Eco-systems perspective

In accordance with the eco-systems perspective the ecological environment is conceived of as existing from a set of nested structures extending far beyond the immediate situation experienced by the person to the connection between other persons not present in the setting and their indirect influence on that person (Barber, 2002:39). People are constantly involved in dynamic and reciprocal interaction with their environments and many problems experienced by people are the consequence of inadequacies in the environment (Compton et al., 2005:4; Zastrow, 1992:18). Potgieter (1998:264) describes the different levels of environments as follows:

➢   The micro-level of the environment is that part of a system's social and physical reality with which it interacts directly on a daily basis and could include the family, experiences in class at school, or being a member of the soccer team, employee at work, a patient in a hospital ward or a member of a particular congregation.

➢   The meso-level of the environment refers to the part which influences and determines the functioning of the micro-environment and could include relationships between major groups, organisations and institutions that affect the individual's life, such as the church, school, workplace and other resources.

> ➤ The macro-level of the environment refers to the wider structures in which meso-groups are functioning and could include health, economic, social, cultural, political, religious and educational systems.

As mentioned above these different levels of environments are in constant interaction with each other. In relation to the interaction between environments and systems, Potgieter (1998:265), asserts that when difficulty arises between a system and a depriving environment, efforts must be made to change the particular part of the social system so that it can support rather than impede the system's efforts toward more effective social functioning. Potgieter (1998:55) also indicates that when any part of a system is changed, all other parts of that system are affected and change in some way.

An advantage of using this perspective is that it enables individuals to identify which part or parts of a system is experiencing problems or difficulty and thus be able to deal with that problem or difficulty experienced at its level of occurrence. Another advantage is that high-risk situations at all levels can be identified and prepared for. The researcher further identified a possible disadvantage of this perspective. An individual can misuse environmental causes at various levels to justify a relapse.

By implementing the premises of the eco-systems perspective a more comprehensive focus on possible high-risk situations/factors can be anticipated during relapse prevention seeing that attention is given to the various environments which an individual is exposed to (micro-level, meso-level and macro-level environments). The eco-systems perspective can furthermore be useful in promoting the quality of life of the drug dependent and his or her system.

The researcher will make use of a diagram in order to explain the implementation of the eco-systems perspective. As seen below, the person (called here, Brian Mabena), with his biological and psychological characteristics, is embedded in a series of environmental systems - the micro-level, meso-level and macro-level - that interact with one another and with the individual over time to influence development (Sigelman & Rider, 2006:22). There is reciprocity of person and environment exchanges in which each shapes and influences the other over time (Gitterman & Germain, 2008:1). The possible causes of relapse that can be derived from the figure below include: at micro-level family conflict, failure of or difficulties experienced at school, peer pressure and stress; at meso-level limited recreational activities, and difficulty making friends; and at macro-level stigmatisation from the community for being a drug addict, living in poverty, excessive exposure to drugs, only to mention a few.
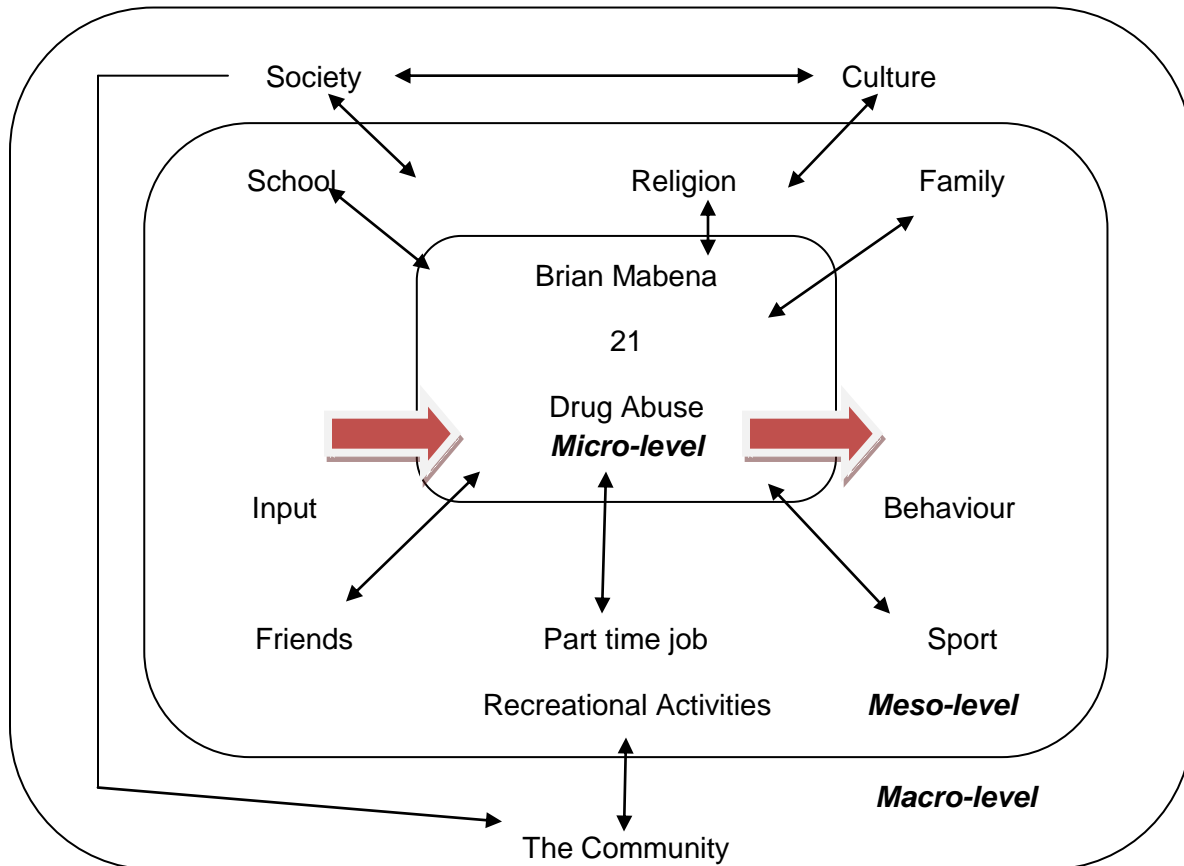
Figure 2: Diagram to illustrate the eco-systems perspective

In providing the services, as stipulated above, the adaptation model and eco-systems perspective can be implemented in that the focus will be on identifying and adapting to environmental stressors that might cause a relapse. The implementation of these models can be identified as important when considering that aftercare needs are diverse and multi-levelled and services should therefore be aimed at intrapersonal and interpersonal functioning, as well as functioning in the environment (Van der Westhuizen, 2010:iv). These models can thus be implemented in the provision of aftercare services such as support groups.

2.7.   SUMMARY

Drug abuse is an epidemic and the demand for treatment is increasing. Not only is the rate of treatment admissions increasing but also the rate of re-admissions. The researcher established a link between young African adults and relapse by paying attention to certain characteristics which make them more vulnerable to relapse. These characteristics include social role changes, becoming

independent, finding employment or being unemployed, social group changes, the position of the young African adult within society and the socio-economic status of the young African adult. The causes of relapse as conceptualised from various literature sources include physical risk factors, intrapersonal risk factors, interpersonal/social risk factors and environmental risk factors. There are several models to conceptualise the maintenance of sobriety or the relapse process. The most prominent models in relapse prevention were discussed – the RP model (Cognitive-Behavioural Model) by Marlatt and Gordon, and the Cenaps Model by Terence Gorski. Attention was furthermore paid to the task of social work in relapse prevention. Relapse prevention is a tertiary prevention strategy with two aims, namely: preventing an initial lapse and maintaining abstinence. Another important task of a social worker is facilitating the successful reintegration of a service user into society by providing aftercare services through support groups and promoting the quality of life of the drug dependent and his/her system.

In the next chapter the research methodology, empirical results and the main findings will be discussed and interpreted.

CHAPTER 3

RESEARCH METHODOLOGY, EMPIRICAL FINDINGS & INTERPRETATION

3.1. INTRODUCTION

As indicated in the first chapter the relapse rate, especially amongst young African adults, is increasing in South Africa. Research with regard to the causes of relapse is lacking especially within the Gauteng Province. Through this study the researcher aims to determine the causes for relapse amongst young African adults, specifically after initial treatment, as this might be used to formulate guidelines for relapse prevention programmes, which will be more applicable within the South African context. The findings of this research can also be used to guide aftercare services and in turn enhance the impact of such services.

The focus of this chapter is to analyse and interpret the quantitative data gathered from the respondents through a questionnaire. This chapter attends to the following research objectives of this study, namely to determine which environmental risk factors have an influence on relapse amongst young African adults; to determine which interpersonal risk factors have an influence on relapse amongst young African adults; to determine which intrapersonal risk factors have an influence on relapse amongst young African adults; and to identify additional causes of relapse which are unique to young African adults.

The researcher will firstly outline the research methods that informed the study. This will be followed by an analysis and interpretation of the research findings.

SECTION A: RESEARCH METHODOLOGY

The researcher utilised the following research methods:

3.2. RESEARCH APPROACH

For the purpose of this study the quantitative research approach was followed as the researcher was interested in measuring objectively the variable of interest, namely the causes of relapse amongst young African adults following in-patient treatment for drug abuse (Fouché & Delport, 2011:63). The researcher furthermore relied on deductive reasoning, which implied that she moved from the general

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to the specific (Fouché & Delport, 2011:63). Previously, many studies have been done on causes of relapse (general), but lacking were studies within the South African context that focused on young African adults (specific). In other words the phenomena of the causes of relapse, were conceptually and theoretically well-developed. The researcher also attempted to understand the facts of the research investigation from an outsider's perspective and viewed the facts of the research investigation objectively (Welman et al., 2005:9). This study was furthermore exploratory in nature as it was conducted to gain insight into the causes of relapse which are unique to the South African context (Fouché & De Vos, 2011:95). The primary purpose was to examine the little understood phenomenon of relapse within the South African context and to move toward refined research questions by focusing on the "what" question (Neuman, 2006:33): "What are the causes of relapse amongst young African adults following in-patient treatment for drug abuse in the Gauteng Province?"

3.3.   TYPE OF RESEARCH

Applied research was appropriate for this study due to the fact that the results that were gathered guided decision-making and assisted in solving the problem of relapse within the South African context among young African adults residing in the Gauteng Province (Bless et al., 2006:45; Neuman, 2006:25).

3.4.   RESEARCH DESIGN

Through a non-experimental research design the respondents were selected to take part in the research (Maree & Pietersen, 2010c:152). In the study a survey was undertaken to collect quantitative data from the respondents. This collected data were used to determine the causes of relapse amongst young African adults following in-patient treatment for drug abuse (Maree & Pietersen, 2010c:152). The replicated randomised cross-sectional survey design was applicable as the survey was conducted with different samples that were purposively drawn from the different strata that approved the study to be conducted at their treatment centres. It was furthermore conducted with each sample over selected time periods (Fouchè, Delport & De Vos, 2011:156).

3.5.   DATA COLLECTION INSTRUMENT

As a quantitative data-collection method for the purpose of this study, the researcher made use of a group-administered questionnaire (see Annexure H) (Delport & Roestenburg, 2011:171). Each

respondent in the group completed his or her own questionnaire, without discussion with the other members of the group and in the presence of the researcher, who availed herself for giving certain instructions and to clarify the uncertainties of the respondents (Delport & Roestenburg, 2011:189). The advantages of implementing a group-administered questionnaire in this study, was that many respondents completed the questionnaire in a short space of time and the researcher was able to immediately assist with aspects of the questionnaire which were unclear to the respondents (Maree & Pietersen, 2010b:156). One limitation of the group-administered questionnaire is that some respondents might experience difficulties in understanding certain questions and instructions, but are too embarrassed to ask for clarification in the group and thus answered the questions arbitrarily (Delport & Roestenburg, 2011:189). The researcher mentioned to the group, prior to the completion of the questionnaire, that they can summon her in private to assist them.

To enable the researcher to construct the questionnaire the researcher had to gain clarity on precisely what information was needed to be obtained by such questionnaire. This was determined by doing a literature study (Delport & Roestenburg, 2011:190). The researcher made use of conceptual operationalisation, where three columns were used to assist her in the formulation of the questionnaire. In the first column the key concept was defined, in the second column a list of elements regarding the key concept were listed and in the third column indicators (statements of how a concept may be observed in reality), for the definitional elements to be placed (Delport & Roestenburg, 2011:191). The questionnaire was furthermore constructed to include various types of questions and categories. The questionnaire consists of completion questions, which collected data about issues where too many responses could be given; multiple choice questions or closed questions where three or more response options were offered and respondents had to choose the most appropriate one; dichotomous questions where only two response possibilities were provided and the respondent had to choose the best suited, and Likert-scales were also employed (Delport & Roestenburg, 2011:198). The questionnaire was compiled with the assistance and support of the Department of Statistics (UP). The statisticians involved, compiled the questionnaire on the UP template based on the guidelines provided by the researcher, they furthermore refined the questionnaire and assisted in the pilot study and implementation thereof. The questionnaire was completed in English, by each respondent, as the inclusion criteria for the respondents were clearly for English literate respondents. For a mini-dissertation it was considered appropriate to rely on respondents who are literate in English, because translating and validating the questionnaire for different African languages spoken in the Gauteng Province, was beyond the scope of this study.

Considering data analysis and the use of a computer in the analysis of data, the questionnaire was coded and questions were numbered and divided into different categories in order to assist with the final processing of quantitative data (Delport & Roestenburg, 2011:196). The researcher consulted with the Department of Statistics (UP), which assisted in adding coding blocks to the questionnaire.

In order to obtain valid and reliable data, the researcher ensured, before implementing the study that the measurement procedure and the measurement instrument used, had acceptable levels of reliability and validity (Delport & Roestenburg, 2011:172).

3.6. RELIABILITY AND VALIDITY IN QUANTITATIVE RESEARCH

3.6.1. Reliability

Reliability of the questionnaire meant that the researcher was able to repeat it at different times or administer it to different respondents from the same population and the questionnaire consistently yielded the same results (Delport & Roestenburg, 2011:178; Pietersen & Maree, 2010:215). The reliability of the questionnaire was based on the internal consistency of the questionnaire, seeing that a number of items were formulated to measure a certain construct (Pietersen & Maree, 2010:216). The reliability was also based on the high degree of similarity among the items, since they were supposed to measure one common construct (Pietersen & Maree, 2010:216). The reliability coefficients for certain elements in the questionnaire could be calculated by the statistical packages, but because of the small sample size and the exploratory research purpose of the study, the tests were not conducted (Delport & Roestenburg, 2011:178). Seeing that data collection was by means of a self-developed questionnaire, based on literature, and not a standardised instrument, the calculation of a Cronbach Alpha was not considered essential.

3.6.2. Validity

Validity of the questionnaire involves whether it measured what it claims to measure (the causes of relapse) and that these causes were measured accurately (Delport & Roestenburg, 2011:173). Face validity refers to the extent to which the instrument "looked" valid and content validity of the questionnaire, refers to the extent to which it covered all the different aspects of the causes of relapse (Pietersen & Maree, 2010:217). Face validity and content validity were established prior to data collection, by presenting a provisional version to experts in the field for their comments before finalising the instrument (Delport & Roestenburg, 2011:173; Pietersen & Maree, 2010:217). Face validity and content validity were established prior to data collection, by presenting a provisional

version to the supervisor, the Postgraduate and Research Ethics committee of the Faculty of Humanities, for their comments before finalising the instrument.

3.7.   DATA ANALYSIS

After the data were collected, the researcher had to make sense of it and bring order, structure and meaning to the data (Welman et al., 2005:227). The data were captured on a computer as numbers, in a grid format, by making use of a spread sheet (Fouché & Bartley, 2011:253). The quantitative data were furthermore processed with the aid of the Department of Statistics, University of Pretoria by using the Statistical Package for the Social Sciences (SPSS programme), Version 22. In order to calculate the Chi-square test the 'strongly disagree' and 'disagree' categories were clustered as 'disagree'; while the 'strongly agree' and 'agree' were combined as 'agree'. It should be noted that this study only reports on the association statistics for the category 'agree' as the researcher only determined the statistical significance for respondents where the respondents of different age groups or gender agreed.

The data were analysed by making use of descriptive statistics, specifically association statistics. The descriptive method described the distribution (or spread) of the sample where the aim was to produce a scope of the characteristics of such distributions through frequencies, measures of central tendency, and measures of dispersion (Fouché & Bartley, 2011:251). Descriptive statistics were used in establishing the mean age of first drug experimentation; average income per month; the average number of people in a household; and the average length of first treatment for drug abuse.

Univariate analysis was applicable in examining the distribution of cases on only one variable at a time, making use of frequency distributions (Rubin & Babbie, 2010:290). One-way frequency analysis was used during the first phase of data analysis and the data's frequencies and percentages were determined. The frequencies and percentages were used to provide the biographic information of the respondents which included gender, age, employment status, etc. In terms of the age, the respondents were clustered as emerging adulthood (18 – 24 years) and young adulthood (25 – 38 years).

Techniques of association were used to establish whether positions of one variable were likely to be consistently associated with positions on another variable through correlation (Fouché & Bartley, 2011:254). By implementing bivariate analysis the researcher was able to compare the variables and

to assess the association of the position of one variable with the likely position of another variable. Bivariate analysis was applicable seeing that the relationships between two variables were examined as well (Rubin & Babbie, 2010:293). Two-way crosstabulation with Chi-square test was used to determine the relationship between two variables and to identify whether the two variables were related (Alston & Bowles, 2003:258,264). Crosstabulation with Chi-square test were used to establish the association or relationship (statistical significance) between the following: (1) level of education and employment status; (2) gender and causes of relapse; (3) age groups and the causes of relapse; and (4) gender and substance abuse by family members.

All the data gathered on the causes of relapse were summarised for easy comprehension and utilisation and the summary took on various forms, such as visual representation of the data (Fouché & Bartley, 2011:254).

The final step of the data analysis was drawing inferences from the data, which provided the researcher with the opportunity to apply the information acquired from the samples that enabled her to reach conclusions about the population (Fouché & Bartley, 2011:275). As this was a quantitative study, the results were presented in numerical format and reported in statistical language meaning tables and figures (Fouché & Delport, 2011:66). The p-value (Chi-square) will also be indicated in the tables presenting the data to show if there is any statistical association between the variables. It should be kept in mind that due to the small sample size the type II error might be a problem, meaning the null hypothesis is not rejected when it is fact false. The statistical significance will be set at $p < 0.1$.

3.8.   RESEARCH POPULATION AND SAMPLING

Certain boundaries were set for the study. The target population for this study was all the young adults that have relapsed after in-patient treatment in the Gauteng Province (Holt & Walker, 2009:25; Strydom, 2011a:223). As it is impossible to include the entire population in the study a representative sample, which consisted of a subset of the population, was drawn from the population (Holt & Walker, 2009:27; Maree & Pietersen, 2010a:172).

The study was conducted by applying stratified random sampling in combination with purposive sampling in the selection of respondents. Stratified random sampling was selected by the researcher to be able to break down the population into different groups, or strata (Holt & Walker, 2009:38). The population was divided in terms of different strata namely the various in-patient treatment centres

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within the Gauteng Province. Within each stratum, purposive sampling was conducted where inclusion criteria of respondents were formulated and respondents who fitted the criteria were selected to participate in the study (Botma et al., 2010:178).

According to the different sets of data collected, there are several in-patient treatment centres in the Gauteng Province. The researcher has thus decided to draw a sample from the centres based on the percentage of admissions of young African adults during a six month period. The centres that had the highest percentage of admissions for the given period were selected to be included in the study. A total of four in-patient treatment centres were selected to participate in the study. The population of the treatment centres (the number of patients admitted to each centre) was different and ranged from 18 to 125 adults per treatment centre.

Within the different treatment centres, the researcher managed to reach 44 respondents to partake in this study, who were purposively identified according to the following criteria:

- Young African adults between the ages of 20 to 39 years, from both genders, addicted to illicit drugs;
- Young African adults who have undergone in-patient treatment for 6-12 weeks;
- Young African adults who have relapsed after having previous in-patient treatment during 2012 to 2013;
- Young African adults who were at the time of the study at one of the identified treatment centres in Gauteng;
- Young African adults who are English speaking and literate (at least a Grade 4 level of education).

3.9. PILOT STUDY

Before the questionnaire was administered to the actual sample the researcher first had to "test it out" by means of a pilot study. This was done to confirm the validity and reliability of the measuring instrument. The pilot study entailed that the researcher administered the questionnaire to a limited number of respondents from the same population as that for which the research was intended (Welman et al., 2005:148). After the questionnaire was compiled, it was tested on a section of the population to determine whether it was effective and to improve the questionnaire based on the respondents' feedback (Strydom, 2011b:241). The pilot study was thus conducted to detect possible flaws in the measurement procedure, to identify unclear or ambiguously formulated items and it gave

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the researcher the opportunity to notice the non-verbal behaviour of the respondents (Welman et al., 2005:148).

The respondents that were used for the pilot study did not take part or form part of the main study. Part of the developmental process was to involve the researcher's supervisor and experts in the field of drug abuse, to go through the questionnaire as well, where its face and content validity was evaluated and recommendations made accordingly.

Five respondents participated in the pilot study and consisted of three male and two female young African adults. The respondents did not have any suggestions regarding the questionnaire and felt that it would provide a true reflection of relapse amongst young African adults. There were some uncertainties that were modified before the study was conducted. There were uncertainties regarding the meaning of certain words - "cohabiting", "occupant" and "glamorised". These words were explained in brackets or stated differently on the questionnaire in order for the questions to be easily understandable for the respondents. The other uncertainties were related to their source of income per month and referral source to their first treatment. These were explained in brackets and added to the questionnaire to avoid the problem in the main study.

3.10. ETHICAL CONSIDERATIONS

Ethics are seen as a set of moral principles, put forward by an individual or group, which is widely accepted and offers rules and behavioural expectations about the most correct conduct towards those involved in the research project (Strydom, 2011c:114). This study received ethical clearance from the University of Pretoria's Faculty of Humanities, Research Ethics Committee (see Annexure A). Within this study the following ethical issues were applicable:

3.10.1. Avoidance of harm
The research project did not cause any harm which involved discomfort, anxiety, harassment, invasion of privacy, or demeaning or dehumanising procedures (Kumar, 2005:214). Respondents could have been harmed in several ways, harm of an emotional nature might have been more obvious within this study although the researcher did not foresee that respondents would have been harmed in any way (Strydom, 2011c:115). To avoid harm to the respondents the researcher provided them with thorough information about the study before the study commenced.

3.10.2. Voluntary participation

The ethical principle followed by social researchers is that of voluntary consent, which implies that no individual will be forced to participate in this research (Neuman, 2006:135). It is important to avoid instances where respondents will feel obliged to participate in the research, for example that thinking that they must participate, seeing that they are receiving treatment for drug abuse (Strydom, 2011c:117). The respondents were informed beforehand that they were not obliged to participate just because of the fact that they were receiving treatment for drug abuse at the treatment centre that was involved.

3.10.3. Informed consent

Respondents were made adequately aware of the type of information the researcher wanted to obtain from them, why the information was being sought, what purpose it would be put to, how they were expected to participate in the study and how it will directly or indirectly affect them (Kumar, 2005:212). Informed consent, in the form of a written agreement, in English, was given to the respondents to sign in order to participate in the study after they were given the relevant information regarding the research study (see Annexure G) (Neuman, 2006:135). To avoid respondents' right to self-determination being impaired, their consent was required to participate in the study (Strydom, 2011c:117). The researcher ensured that the respondents were competent people and were capable of signing the consent letter (Neuman, 2006:137). The respondents were furthermore informed that the data collected from them would be archived for 15 years as in accordance with the University of Pretoria's policy.

3.10.4. Deception of respondents

Deception of respondents was avoided by not misleading the respondents and by not deliberately misrepresenting facts or withholding information from them (Struwig and Stead (2001) in Strydom, 2011c:119). The purpose of the study was clarified from the inception and there was no hidden agenda. Respondents were not misled by being offered incorrect information to ensure their participation.

3.10.5. Violation of privacy/confidentiality

The researcher could protect the privacy of a respondent by not disclosing the individual's identity after the information was gathered and this took on two forms namely anonymity and confidentiality (Neuman, 2006:139). Respondents remained nameless, information was kept in confidence and the information was not released in a way that does not permit linking specific individuals to specific

responses (Neuman, 2006:139). The researcher handled information obtained from respondents in a confidential manner and in this way protected their right to privacy. No identifying particulars were used and a numbering system was implemented.

3.10.6. Debriefing of the respondents

Debriefing after the study gave the respondents the opportunity to work through their experience and its aftermath (Strydom, 2005:67). No debriefing was required after the research in order to explain the study to the respondents and in order to get the respondents back into the state they would have been in, had they not taken part in the study (Holt & Walker, 2009:236).

3.10.7. Publications of findings

The findings of the research could be made public by means of a written research report that conveyed the truth of the research findings (Strydom, 2011c:126). By making use of language editors and statisticians, the accuracy of the findings was sufficient for publications. The findings were scientific, objective and accurate for submissions to professional journals or papers presented at conferences. The researcher's supervisor was given co-authorship of potential journal publications and/or conference papers.

While Section A focuses on the Research Methods, the next section, Section B, focuses on the research findings and an interpretation thereof.

SECTION B: RESEARCH FINDINGS AND INTERPRETATION

The primary aim of this chapter is to present, analyse and interpret the quantitative data that were collected by means of a group-administered questionnaire with respondents that previously relapsed after in-patient treatment. This section will focus on the biographic profile of the respondents, as well as the actual analysis and interpretation of the quantitative research findings. Where applicable, literature is integrated with the findings and interpreted by the researcher. By integrating literature with the findings it places the researcher's efforts into perspective, situating the topic in a larger knowledge pool (Fouchè & Delport, 2011b:134). O'Leary (2004:75) states that research requires engagement with literature at each and every stage of the process.

3.11. BIOGRAPHIC PROFILE OF RESPONDENTS

A total of 44 respondents (n=44) from the various treatment centres voluntarily participated in this study. The biographic information of respondents include gender; age; drug of choice and frequency of use; level of education; employment status; income per month; source of income; marital status; and number of occupants in the household.

Leggett (2001:16) is of the opinion that social fragmentation, poverty and youthful populations are factors that contribute to South Africa's crime problem in general and to its drug problem in particular. It was thus useful to describe the age, income, source of income, and number of occupants to form an idea of the profile of the respondents and how it associates with literature. It should be recalled that for the purpose of the study only young African adults in the Gauteng Province were requested to participate in the study. The research gap with regard to relapse related to this target group was identified in the previous chapters.

3.11.1. Gender
Figure 3 below represents the distribution of gender amongst the respondents. Out of the total number of 44 respondents (n=44) who participated in the study, 35 (80%) of the respondents were males and nine (20%) females. Out of the four treatment centres that committed themselves to partake in the study, all the female respondents that qualified to participate in the study came from one treatment centre.
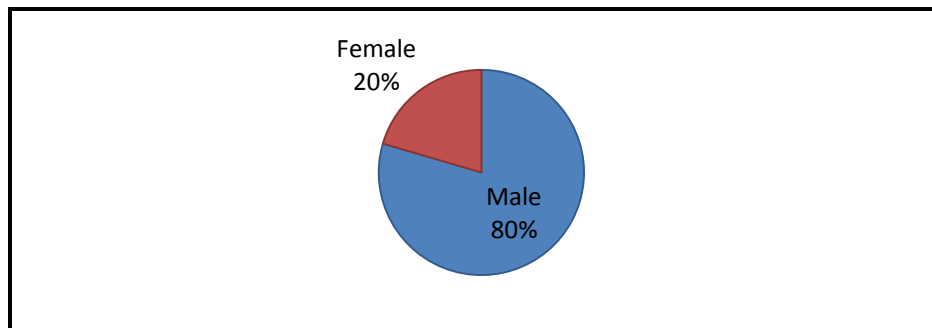
Figure 3: Gender of respondents

Where treatment centres cater for female service users the rate of admissions of females is much lower than those of men. As per SACENDU (2014:16) in January to June 2013, 87% of admissions to treatment centres in Gauteng were male and only 13% female. SACENDU (2014:3) data from specialised treatment centres suggest that the use of certain substances is still mainly a male

phenomenon and male patients continue to dominate admissions for treatment. Several studies have reported on higher drug prevalence rates amongst males than females; this however does not necessarily reflect lower levels of use among women but may allude to women experiencing more barriers in accessing treatment (McCann, Burnhams, Albertyn & Bhoola, 2011:47).

3.11.2. Age

The mean age of the respondents was 26 years at the time of study. The youngest respondents were 19 years old and the oldest respondent that took part in this research study was 38 years old. The respondents can thus all be placed within the early adulthood phase. Sigelman and Rider (2006:517) define the young adult as an individual aged from 20 to 39 years. Tanner and Arnett (2009:39) describe young adulthood as extending from ages 18 to 25 years and this stage of life is referred to as 'emerging adulthood' – the stage between adolescence and young adulthood. During young adulthood people are faced with various developmental tasks including demands, transitions and challenges. Most important of these tasks include: social role changes, development of adult identity, adolescent initiation (in African cultures), preparation for career, employment (including development towards independence), changes in social group and development of socially acceptable behaviour and establishing positions in society and socio-economic status. Consistent with the developmental stage of young adulthood, Urbanoski et al. (2011:1) state that this stage of development also carries significant risk of harmful use of drugs and for the onset of substance use disorders.

The phase of adulthood in which the respondents are, is significant seeing that different phases of life are characterised by continuing changes in basically all areas of functioning (Louw & Louw, 2009:8). In this research the researcher also attempted to relate causes of relapse to phases of adulthood – emerging adulthood (thus, respondents aged 18 to 24 years) and young adulthood (thus, respondents aged 25 to 38 years). In doing so, treatment programmes, relapse prevention and aftercare services can be formulated to address challenges, demands and changes faced that can cause relapse in a certain phase of adulthood.

3.11.3. Level of education

It was important to estimate the level of education of the respondents in relation to drug abuse. Below in Figure 4 it is indicated that the majority of the respondents (*f*=18; 41%) did not complete their education up to Grade 12 (matriculated), compared to 11 (25%) that matriculated and 8 (18%) that continued to tertiary level of education. It should be noted that a limitation of this study is, that it did not

estimate whether the tertiary studies were completed or whether the respondents dropped out because of drug abuse.
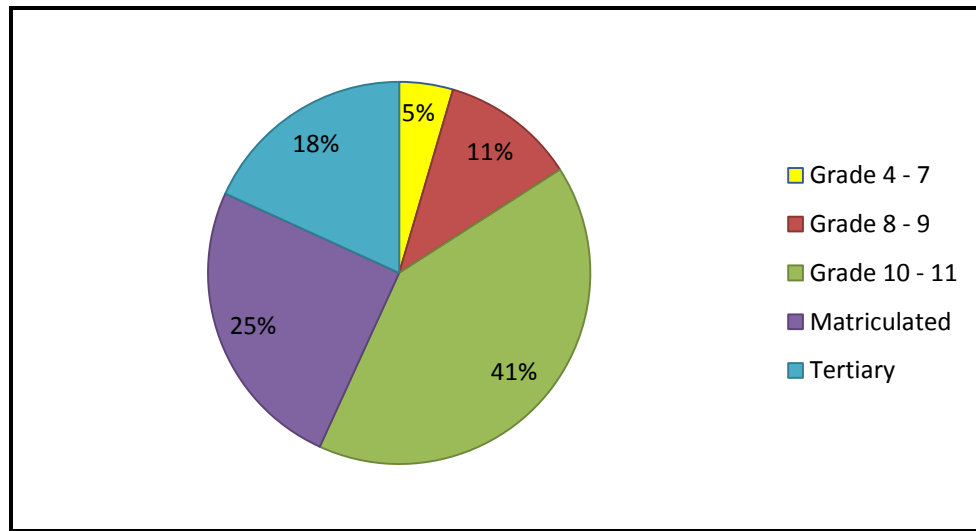
Figure 4: Level of education of respondents

Webster (2009:67) notes that school failure is a strong predictor of 'failed' transitions, delinquency, crime and anti-social behaviour. The level of education that the respondents hold can be correlated with the employment status that they have, in that most respondents (as seen in Figure 5) are also unemployed. Du Toit (2003:9) concurs with this in that nearly two thirds (65.5%; 3.6 million) of the unemployed youth do not hold a Grade 12 certificate and the majority (90%; 3.2 million) of this group is African.

3.11.4. Employment status

From Figure 5 below it can be seen that 31 (70.4%) of the 44 respondents are unemployed, only five (11.4%) have employment and are part time employed (11.4%). Two (4.5%) are part-time students and one (2.3%) respondent was suspended from his employment.
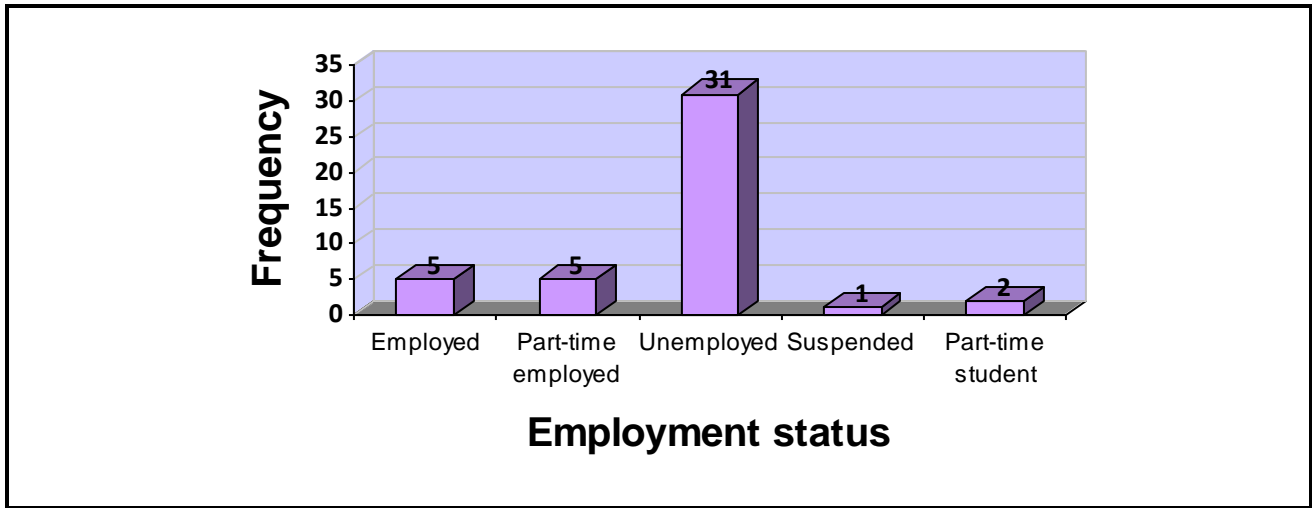
Figure 5: Employment status of respondents

Overton-de Klerk and Oelofse (2010:399) maintain that unemployment is one of the reasons for the high incidence of drug abuse in communities and in turn, drug abuse aggravates high crime levels. Parrillo (2005:403) agrees with this by stating that addiction correlates strongly with nonviolent crime, as addicts often steal, burglarise, sell drugs, or prostitute themselves to support their habits.

The level of education of each respondent was also correlated to their employment status. From Figure 6 it can be concluded that most respondents who only completed Grade 10 to 11 remain unemployed and those most likely to be employed, matriculated.
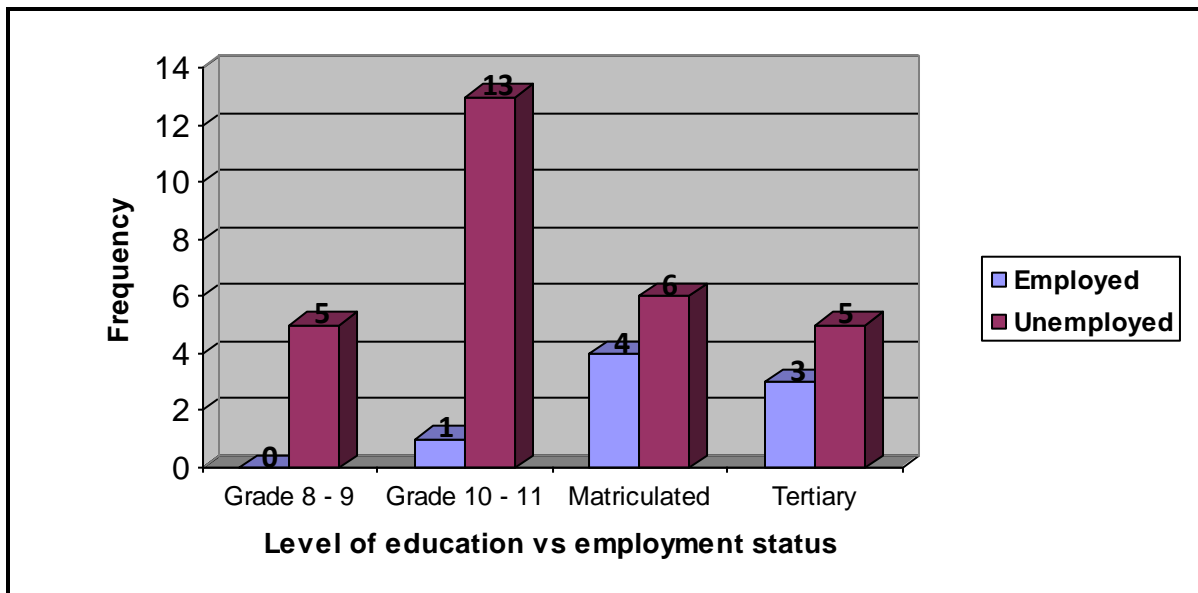
Figure 6: Level of education correlated with employment status

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3.11.5. Income per month

The average income per month was measured to establish how much money respondents receive per month. The average income of respondents amounted to R2237 with the minimum income being R100 for some and a maximum income of one employed respondent R15 046. It should be noted that the sources of income for respondents differ, and those being employed subsequently receive more income. It is commonly known that most money received by drug dependent persons are meant to feed their addictions. The sources of income will be discussed accordingly.

3.11.6. Source of income

It should be noted that not all respondents answered this question on the questionnaire seeing that not all respondents are receiving any income.
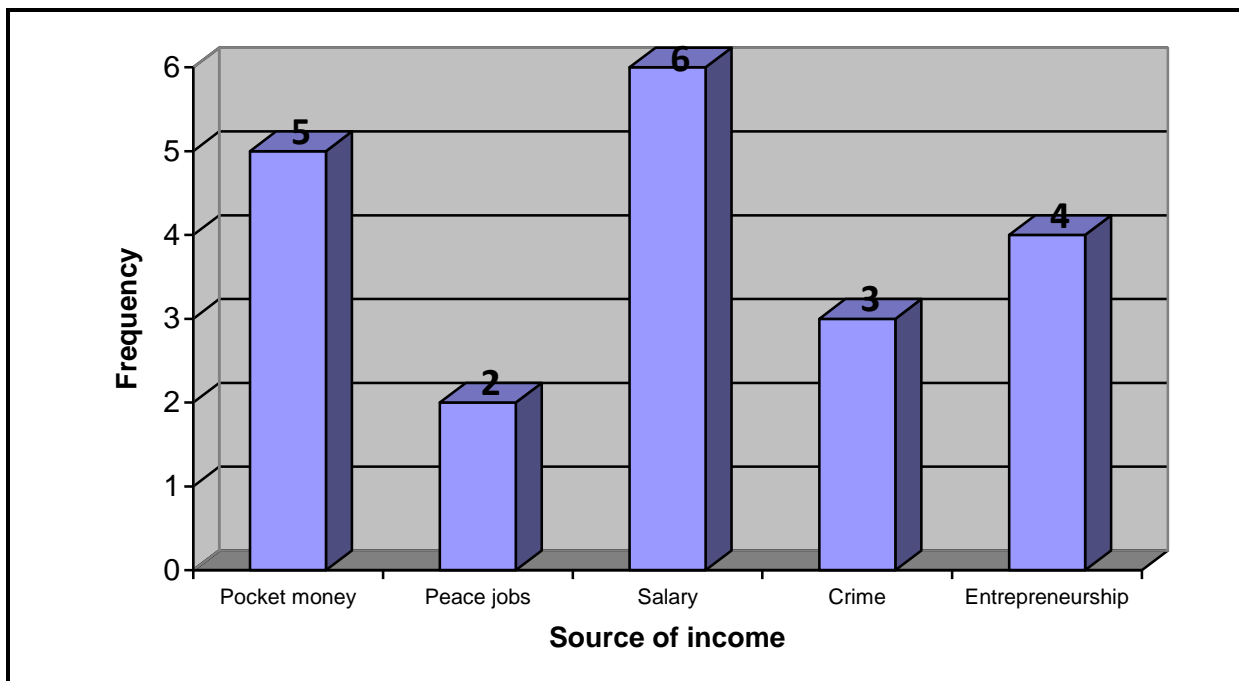
Figure 7: Source of income

Twenty-four respondents did not answer the question. Most respondents (f=6; 30%) indicated that they were receiving a salary. It is, however, uncertain whether it is from stable employment or part-time jobs. Only three (15%) respondents reported crime as being a source of income whilst it is recognised that crime (like prostitution, drug dealing, house breaking, theft, hijacking, shoplifting and armed robbery) is often used to feed drug addiction. In relation to this, Leggett (2001) states that South Africa's population is extra-ordinary youthful, and crime is often associated with numbers of unemployed youth. It was discussed above that the number of unemployed young adults that

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participated in the study was 31 (70.4%) out of 44 respondents. The researcher is of the opinion that not all respondents considered the crime that they were doing as being a source of income seeing that the money is spent on another illegal trade (drug abuse). It is also a possibility that only a few respondents reported on crime because it is not in accordance with the norms of society.

3.11.7. Marital status

Most respondents in this study were single (*f*=36; 83.72%) which also correlates with the phase of adulthood in which the respondents develop adult identity and establish relationships.

Table 1: Marital status of respondents

Marital status	Number and % of respondents (*f*;%)
Single	36 (83.72%)
Separated	1 (2.33%)
Living together/ Co-habiting	6 (13.95%)

As stated before (paragraph 2.4.1.1.) social class groups tend to agree on the appropriate age for significant life events such as marriage and child-rearing, this consensus exerts social pressure pushing them to reach particular roles at expected ages (Newman & Newman, 2012:431). "Although marriage is still a popular institution for many, marriage rates in South Africa have declined" (Louw & Louw, 2009:153). In line with this, Statistic South Africa (2011:9) confirm that during the 2011 census 36.7% people in South Africa were married at the time of the Census and 43.7% had never been married before. The researcher considers that the choice to get married might be affected by drug addiction. Interest in stability (like in the case of marriage) is reduced seeing that the life of the addicted young adult revolves around drug abuse during the chronic phase of addiction. Furlong (2009b:201) states, with regard to independent living, that young adults experience different forms of independent living that may involve periods of living alone, with peers and cohabiting as partners – this explaining the number of respondents living with a partner.

3.11.8. Number of occupants in household

The average number people reported to be living in the households of respondents are four. Only one respondent reported on severe overcrowded living conditions with 11 occupants in the household.

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Many of the respondents are still under the care of their parents or extended family members due to being unemployed.

The researcher will now follow the discussion by presenting the respondent's drug of choice, thereafter followed by discussing the perceptions, views and experiences of respondents related to drug abuse, drug abuse treatment, and relapse.

3.12. DRUG OF CHOICE

The respondents were asked to indicate their drug of choice together with their frequency of use. Most respondents indicated the use of *nyaope* (heroin and dagga mix), followed by crack abuse.
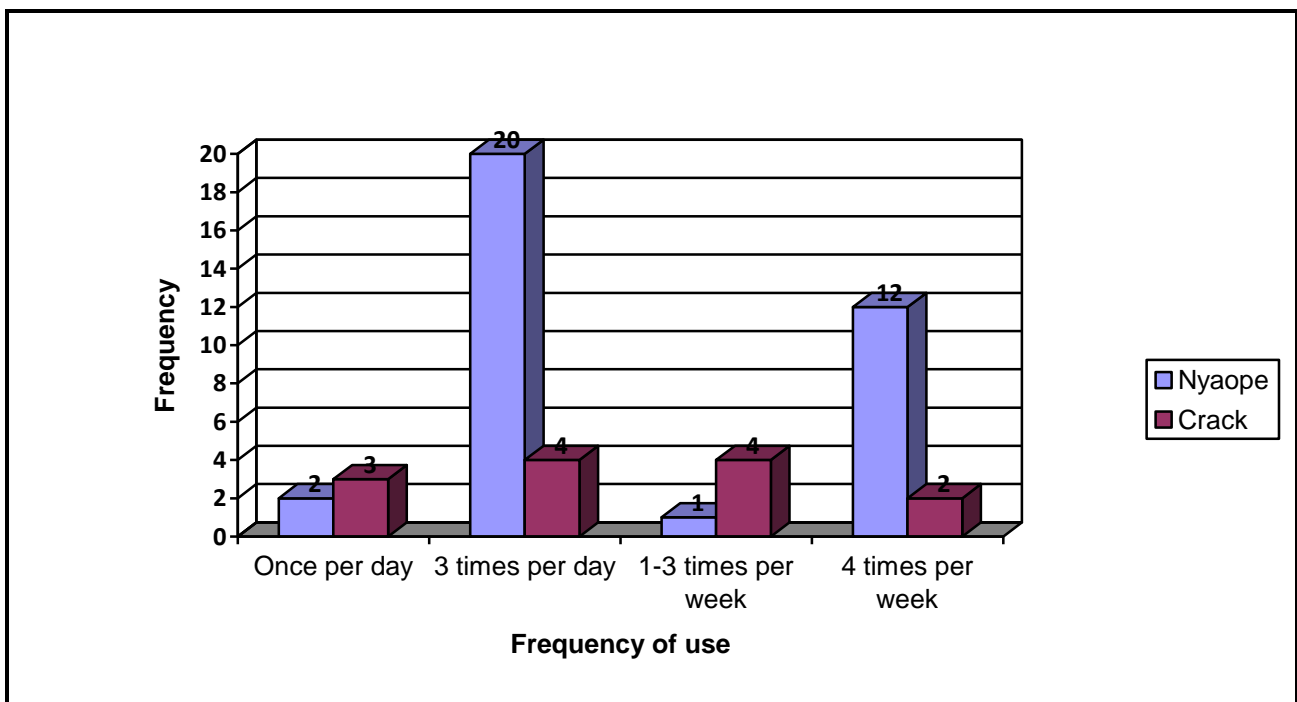
Figure 8: Drug of choice and frequency of use

From Figure 8 above it can be seen that most respondents indicated the abuse of *nyaope.* Most respondents indicated that they used *nyaope* three times per day, followed by others that indicated they are using it four times per week. Crack was also indicated by most respondents to be used three times per day, followed by other respondents that indicated crack use one to three times per week.

Ghosh (2013) states that in a nation already beleaguered by high rates of unemployment, poverty, HIV infection, violent crime and rape, the poor black underclass of South Africa is dealing with yet another crisis that is ravaging their communities – an epidemic of *nyaope* addiction. Ghosh (2013) is furthermore of the opinion that South African youths who become entangled in drug addiction find themselves trapped in a nightmarish existence compounded by extremely high joblessness (as much as 60% in some townships), low education attainment and hopelessness leading to criminal activity. The above-mentioned is shortly confirmed by the findings of this study.

Many respondents indicated multi-drug use (also known as poly-drug abuse); where one drug is used in conjunction with other drug/s.
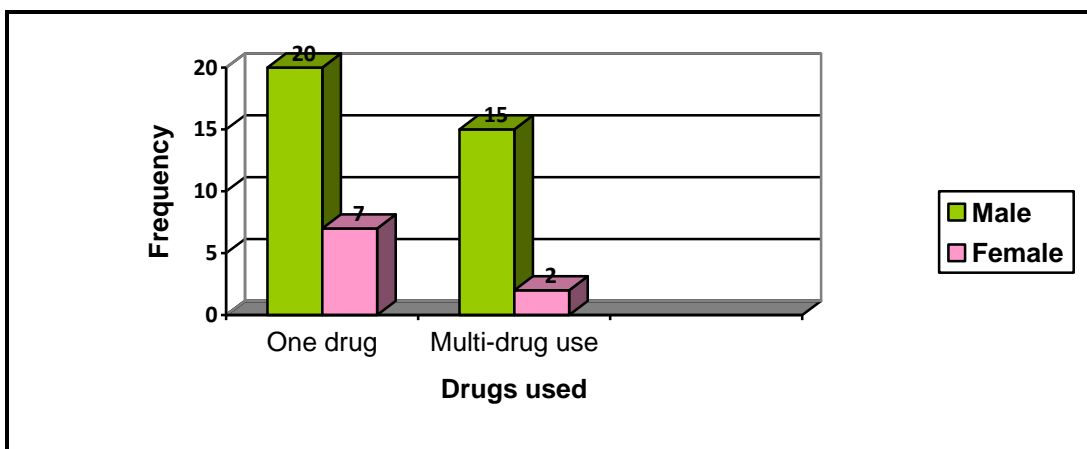
Figure 9: Multi-drug abuse by male and female respondents

From Figure 9 above most respondents from both genders indicated the abuse of only one drug, there were however some that indicated the abuse of more than one drug at a time. Fifteen (43%) males out of the 35 that participated indicated poly-drug abuse and only two (22.2%) out of the nine female respondents reported poly-drug abuse.

Schuckit (2006:305) explains the phenomenon of dependence on multiple drugs – it is likely to occur and/or frowned upon by society, e.g. most people begin substance abuse with nicotine and alcohol and progress to dagga (known as the "gateway" drug) and later progress to other drugs such as heroin and crack. This might be because the body develops tolerance to one drug and the drug user seeks the 'high' which cannot be felt by using only his or her drug of choice and then progresses to another drug. Another cause might be the phenomenon known as 'upping and downing' – a drug user

would use a stimulant, such as cocaine or amphetamines, followed by the use of depressants, opioids or dagga to decrease the effect of the stimulant.

The researcher will now present and discuss the findings with regard to the respondents' perceptions, views and experiences related to their drug abuse.

3.13. PERCEPTIONS, VIEWS AND EXPERIENCES RELATED TO DRUG ABUSE

Respondents were asked to indicate the age at which they started to experiment with drugs and the reasons why they started experimentation with drugs. They were also asked to indicate after they initially started experimenting with drugs, how long it took for their drug abuse to become problematic and after what period of time did they seek for help for their drug abuse. The respondents were also asked about the substance abuse of their family members and social groups.

3.13.1. Age of experimentation with drugs

The average age that the respondents indicated as the time they started experimenting with drugs was 17 - 18 years. The youngest age of experimentation was 11 years and the oldest was 30 years of age. The age of experimentation thus ranges between the middle childhood and adolescence phase of human development.

Table 2: Descriptive statistics with regard to age of drug experimentation

Variable	Mean	Median	Minimum	Maximum
Age of drug experimentation	17.61	17.00	11	30

The middle childhood phase is referred to as the 'school years' (Ntshangase, 2004:64). The *United Nations Environment Programme*, 2002, as cited in Ntshangase (2004:64) indicates that during this stage, children's environment expands beyond their homes and care centres, providing them with frequent opportunities to interact with a wider range of people in more places than when they were younger. It is known that drugs are now also being sold to children at schools or children are being used by drug dealers to sell drugs to their peers. Ntshangase (2004:67) mentions that currently school-going children are confronted with a variety of social factors, which are more demanding and more likely to put them at risk.

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Adolescence is the development stage where there is transition between childhood and adulthood. This is an emotional turbulent and 'difficult' stage of development (Shefer, 2004:73). Adolescence presents the person with a wide range of changes – physical, cognitive and emotional changes. It is a time when the developing child strives for autonomy from the family and parents, 'pulling away' from parents and investing more in the peer group (Shefer, 2004:80).

3.13.2. Reasons for drug experimentation

Most respondents indicated that they started experimenting with drugs because their peer group or a friend introduced them to drugs. The respondents also reported that they observed the effects of drug(s) on their friends and this influenced them to also experiment with drugs. Many of the respondents started to experiment with drugs because they were looking for excitement and because they heard that it would help them to cope better with stress and emotions. Developmental issues for substance abusers often occur at adolescence where three patterns of risk emerge: normal experimentation with drugs escalates to severe abuse or dependency; drugs are selected as maladaptive coping strategy to deal with stress and peer pressure; and there is concurrent emphasis on drug lifestyles (Benshoff & Janikowski, 2000:74).
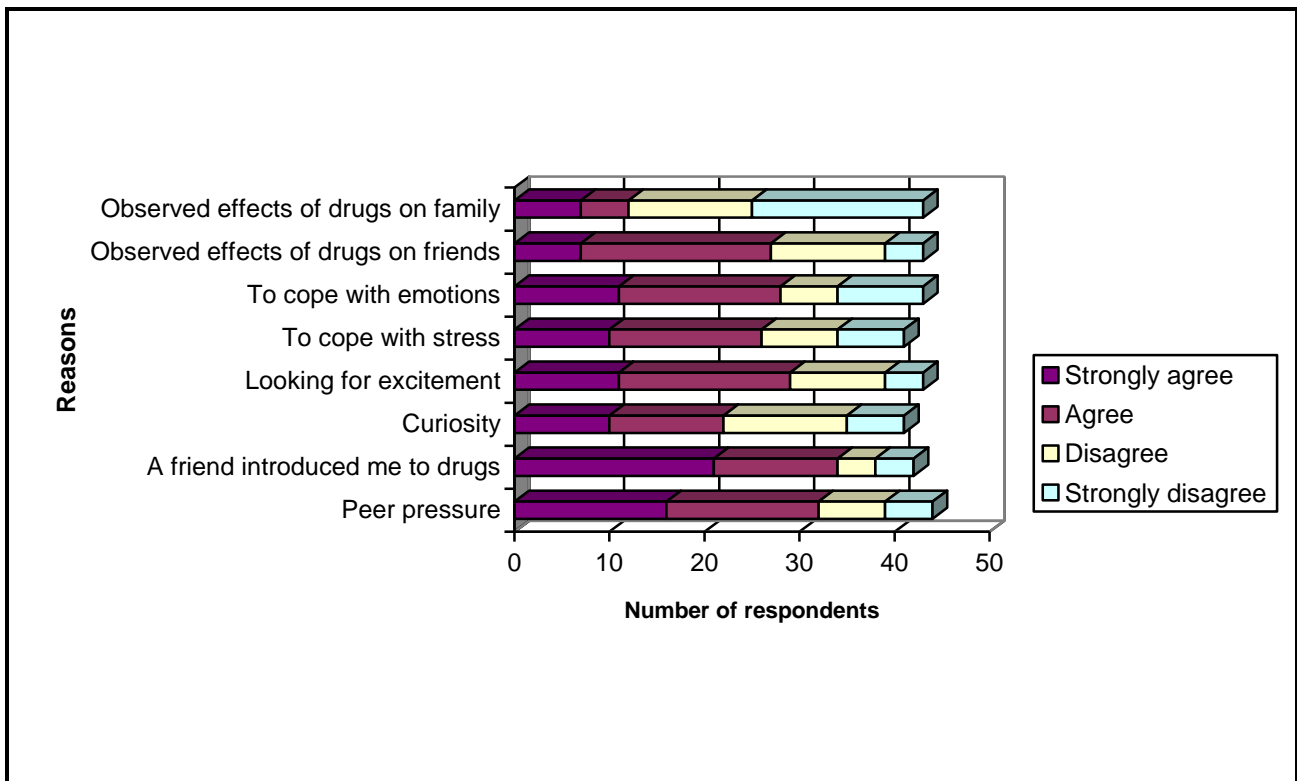
Figure 10: Reasons for experimenting with drugs

The respondents also mentioned other causes of experimentation (in sequence of mostly indicated to least indicated):

- To deal with insecurities about themselves
- Relationship problems with family
- Loss of significant relationships
- The body developed tolerance
- Boredom
- Lack of support in life
- Had money available to use according to own will
- Absent parents
- Part of adolescence and wanted to rebel.

3.13.3. Period between drug experimentation and dependency

Most respondents indicated that their experimentation with *nyaope* became problematic (dependency) after eight months to a year of using the drug. Others also indicated that their use of *nyaope* became problematic after three weeks to two months of drug use. Most respondents that abused *nyaope* also indicated that they sought treatment for drug abuse after two to three years of drug abuse. The second most noteworthy drug of choice is 'crack' abuse – most respondents that indicated crack abuse also indicated that their abuse became problematic after eight months to a year. Most of the respondents that indicated crack abuse indicated that they sought treatment for drug abuse after three to four years of abusing crack.

3.13.4. Substance abuse in the family

Upon indicating the possible abuse of substances among family members it was mostly the male respondents that indicated alcohol abuse amongst their fathers, uncles/ aunts, siblings, nephew/ nieces and grandparents. From the research findings it is indicated that alcohol abuse by fathers mostly correlates with male drug abuse. There was a statistical association found where the causes of relapse and gender were correlated (p=.057). This was done by making use of the Pearson Chi-Square test to identify whether there is an association between two categorical variables. It was found that mostly males are inclined to relapse because one or more family members are abusing alcohol and/or drugs.

In relation to this Van Wormer and Davis (2013:17) state that mental health professionals can expect that approximately 50% of their clients to have problems stemming from their own or a family

member's alcoholism. Not only do these individuals experience problems related to family's alcoholism but hereditary factors are involved in addiction as well (Van Wormer & Davis, 2013:20). As indicated by Chassin, Pitts, DeLucia and Todd (1999:106), quoted from Gotham and Sher (1996), adult children of adults who abuses alcohol are at risk for drug abuse or dependence. Chassin et al. (1999:107) explain that parental alcoholism effects on young adult substance abuse and dependence may also be worsened through earlier externalising problems, furthermore they are thought to be at risk for poor emotional regulation and negative affectivity. The above-mentioned might contribute to the likelihood of substance abuse amongst young adults.

The researcher will continue by providing feedback on the findings that are related to the respondents' perceptions, views and experiences regarding previous treatment for their drug abuse.

3.14. PERCEPTIONS, VIEWS AND EXPERIENCES REGARDING DRUG ABUSE TREATMENT

The respondents were asked how many previous admissions to drug abuse treatment centres they had had; where they had received their first treatment; who funded their first treatment; and who referred them to treatment. Furthermore, they were asked whether they completed the previous treatment for drug abuse; the length of the treatment programme and how they experienced aftercare services after discharge from a treatment centre.

3.14.1. Previous drug abuse treatment

The average number of previous admissions was two, with a minimum of one and a maximum of four admissions to treatment centres. Most respondents indicated that they had been admitted to a treatment centre for drug abuse treatment only once before their current treatment. Below is Figure 11 that demonstrates previous admissions of the respondents.
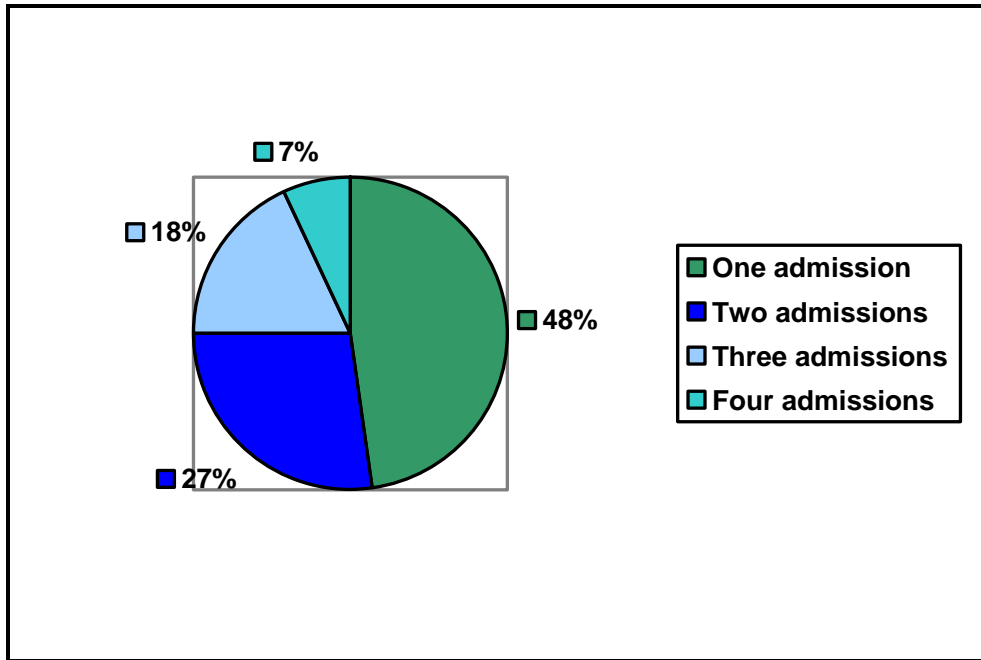
Figure 11: Previous admissions of respondents

The following figures represent where respondents received their first treatment, followed by who referred them to the treatment centre for their first admission.
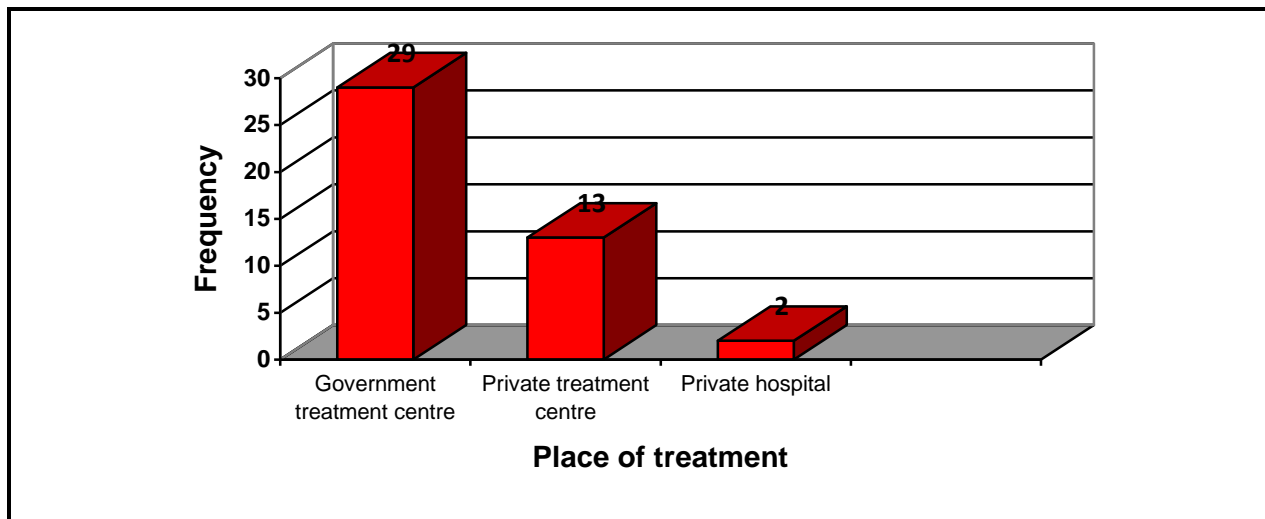
Figure 12: Place where first treatment was received

Most respondents received their first treatment for drug abuse at a governmental (public) treatment centre. Governmental treatment centres are funded by government and considering the biographic profile of the respondents it can be considered that they do not have funds (or medical aid) to pay for drug abuse treatment at a private rehabilitation centre.

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According to the Prevention of and Treatment for Substance Abuse Act 70 of 2008, a public treatment centre means an "in-patient or out-patient treatment centre that is owned and financed by the government or an organ of state and established for the treatment and rehabilitation of service users who abuse or are dependent on substances." The Act also defines a private treatment centre as "a treatment centre that is privately owned and registered for the treatment and rehabilitation of service users who abuse or are dependent on substances."

The respondents also indicated who referred them for treatment when they first sought treatment for drug abuse.
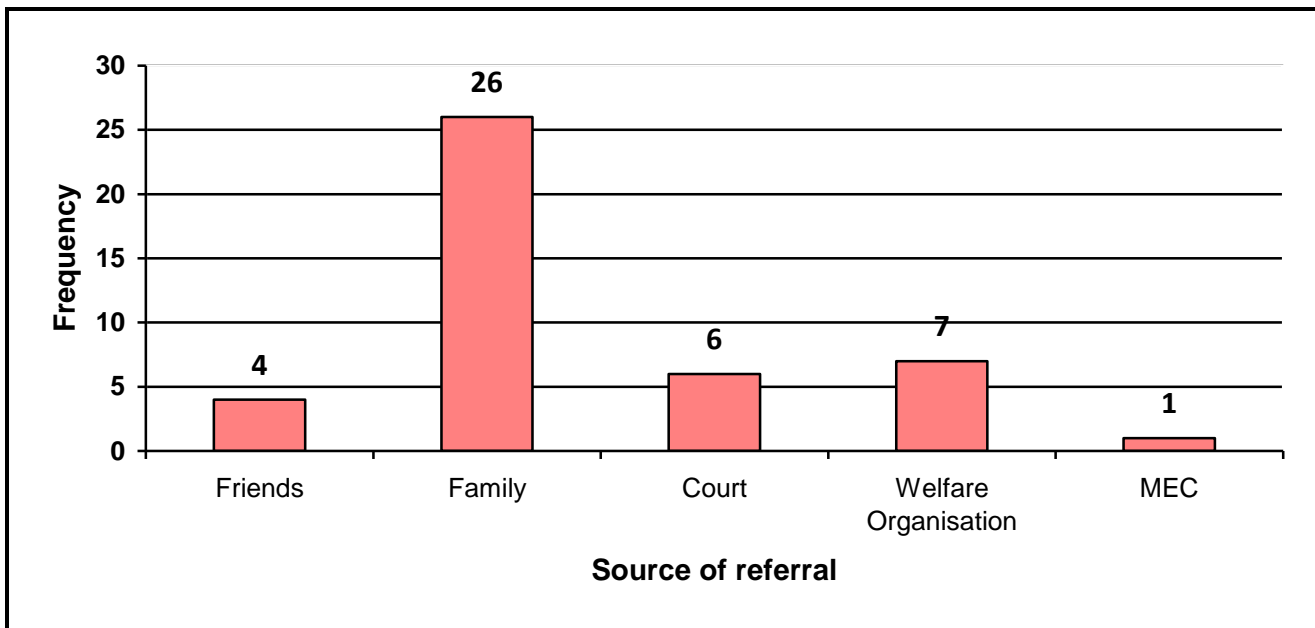
Figure 13: Source of referral to first treatment centre for drug abuse

Most respondents were referred to their first treatment centre by family members, followed by being referred by a welfare organisation and court.

3.14.2. Completion of previous treatment for drug abuse

Related to treatment for drug abuse, respondents were asked whether they completed their previous treatment for drug abuse. Twenty-nine respondents (65.91%) indicated that they completed their previous treatment; whereas 15 (34.09%) indicated that they did not complete their previous treatment for drug abuse.

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Reasons mentioned by respondents for not completing previous treatment included (in sequence of mostly indicated to least indicated):

- Self-discharge because of personal reasons
- Not ready to receive treatment for drug abuse and was forced to go to treatment
- Was discharged from the treatment centre for bad conduct
- Insecurities about own ability to complete treatment and maintain abstinence
- Thinking about friends outside of the centre that are still using drugs
- Ineffective treatment: no detoxification and using strange practices
- Withdrawals.

3.14.3. Length of previous treatment for drug abuse

Respondents were asked to indicate the length of their previous treatment for drug abuse. The average length of treatment was indicated as 6 weeks. Benshoff and Janikowski (2000:184) refer to in-patient treatment for drug abuse as 28-day programmes. It should be considered that individuals progress through drug addiction treatment at various rates, so there is no predetermined length of treatment. However, research has shown unequivocally that good outcomes are contingent on adequate treatment length. Generally, for residential or outpatient treatment, participation for less than 90 days is of limited effectiveness, and treatment lasting significantly longer is recommended for maintaining positive outcomes (National Institute of Drug Abuse [NIDA], 2012:15). The treatment centres that participated in the study provide treatment programmes of 28 days (6 weeks) with the exclusion of one treatment centre that also provides a three-month treatment programme.

3.14.4. Aftercare support services

Following the treatment for drug abuse is aftercare support services. The Department of Social Development's Substance Abuse Aftercare Programme manual (2013:4) indicates that the initial period following substance abuse rehabilitation offers the greatest potential for relapse and aftercare is offered, following in-patient treatment, for continued support as the service user eases back into society. This Substance Abuse Aftercare Programme manual stipulates that aftercare programming can vary greatly depending on the needs of the service user. By exploring the causes of relapse amongst young African adults, aftercare programmes can be formulated to specifically incorporate and focus on the causes of relapse in an attempt to prevent relapse amongst this target group.

The respondents were asked to indicate how they experienced aftercare services. The results are presented in the Figure 14. Most respondents (f=27; 61.4%) indicated that they did not attend

aftercare following treatment for drug abuse. In equal levels respondents indicated that they did not have money to attend and they lacked motivation to attend aftercare (*f*=7; 15.9%). Lack of family support (*f*=6; 13.6%) and not having transport (*f*=5; 11.4%) to attend aftercare was also indicated by respondents. It should be noted that with this question there was no limitation for only selecting one answer and respondents could therefore indicate more than one experience related to aftercare services.
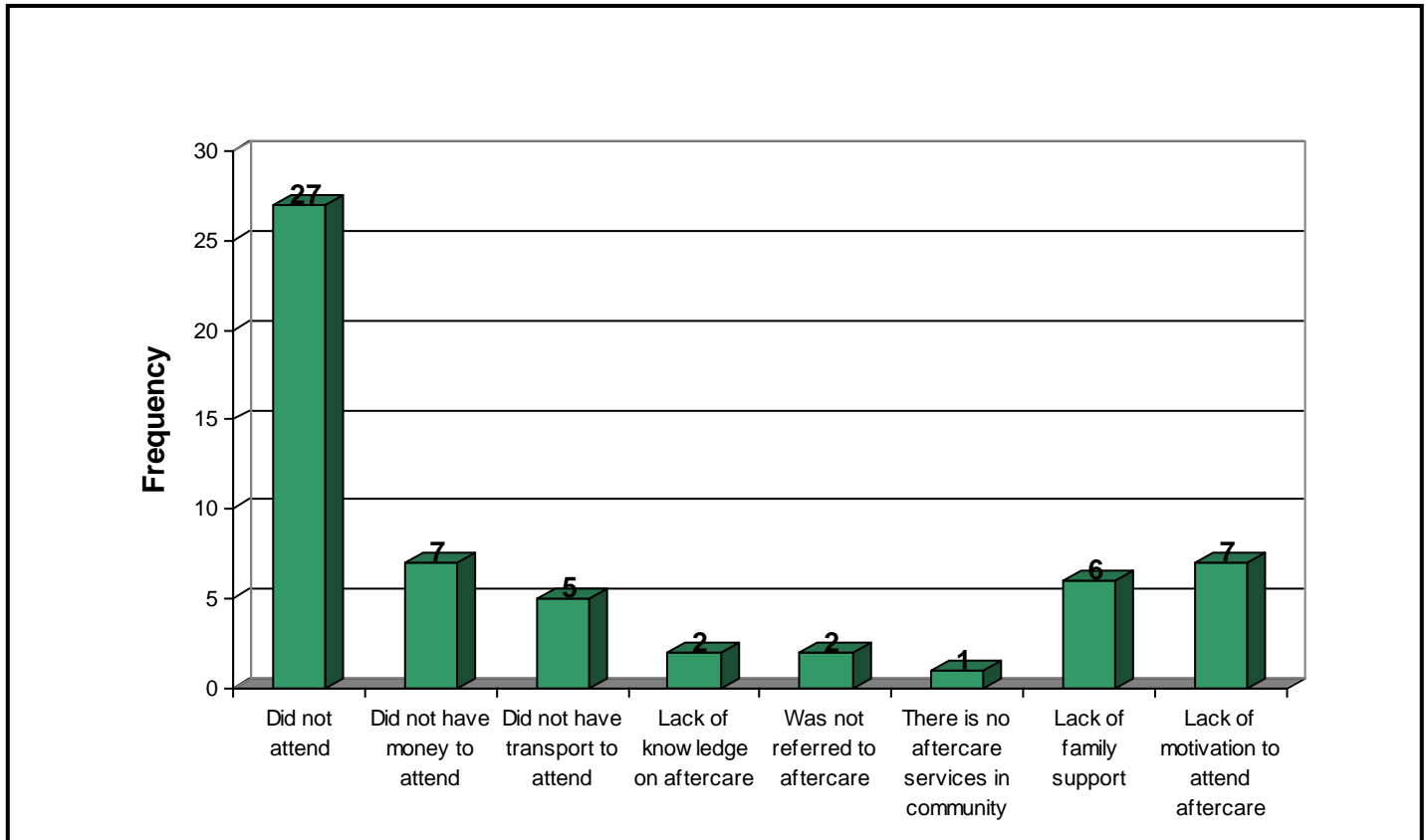
Figure 14: Experience of aftercare services

With regard to aftercare, the Prevention of and Treatment for Substance Abuse Act 70 of 2008 defines aftercare as on-going professional support to a service user after a formal treatment episode has ended in order to enable him or her to maintain sobriety or abstinence, personal growth and to enhance self-reliance and proper social functioning. According to NIDA (2012:35) it is important for individuals, following stays in residential treatment programmes, to remain engaged in outpatient treatment programmes and/or aftercare programmes. These programmes help to reduce the risk of relapse once a patient leaves the residential setting. However, as described by Van der Westhuizen, Alpaslan and De Jager (2013:1) aftercare appears to be a neglected area in service delivery, contributing to the high relapse potential following treatment.

The Department of Social Development (2013:11) proposes an aftercare and reintegration process. The stages presented in the following process can be linked to the stages as indicated by Van der Westhuizen (2010:277): Assessment of aftercare needs and planning of aftercare services; Aftercare intervention; Evaluation and termination of aftercare services.
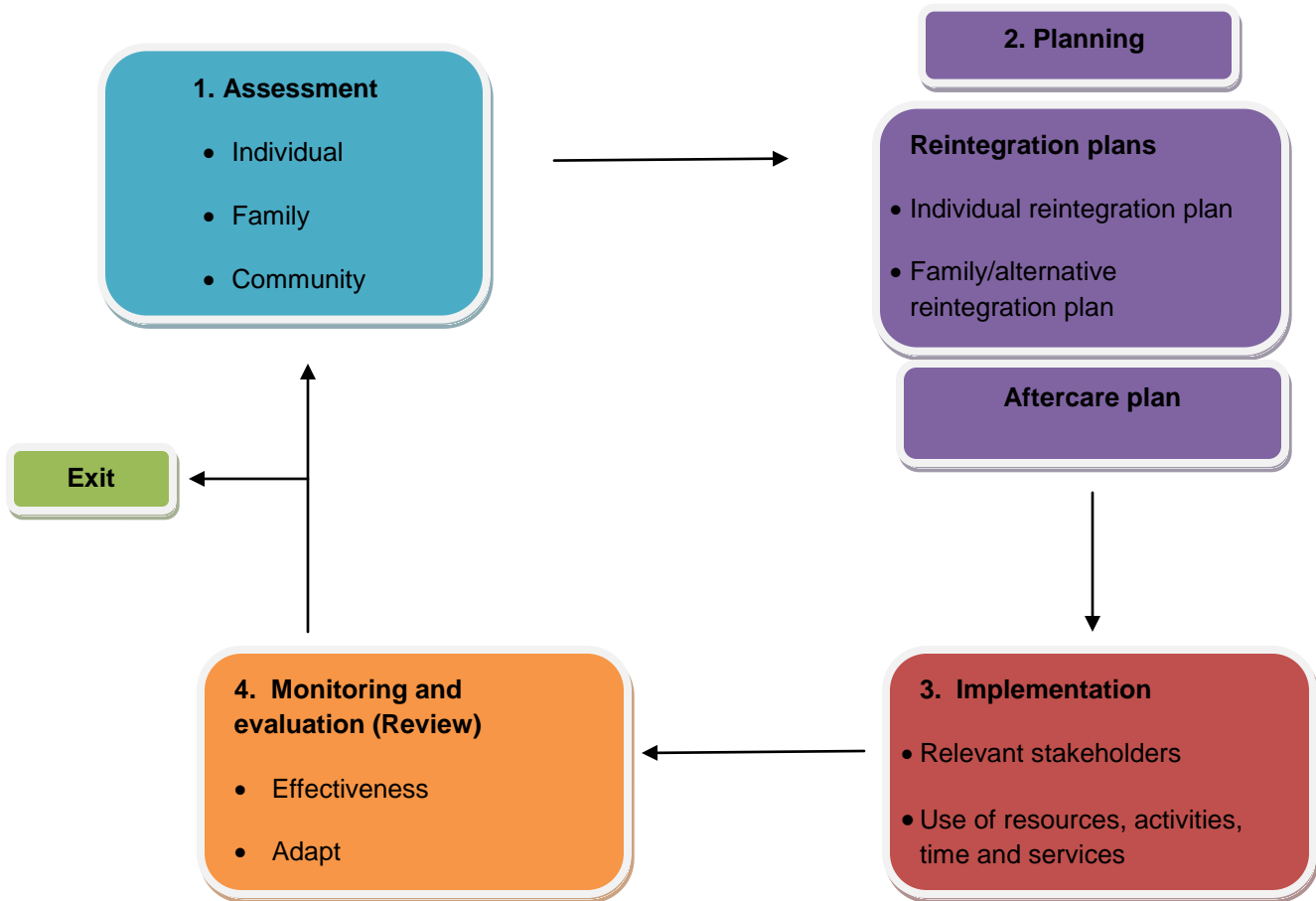
Figure 15: Aftercare and reintegration process (Department of Social Development, 2013:11)

Considering the theoretical perspectives that informed this study, people are considered to be adaptational, with internal processes for coping with change (Barone, et al., 2011:353) and as functioning in dynamic interaction with different environments (Compton et al., 2005:4; Zastrow, 1992:18). Linking these two theoretical perspectives, Janse van Rensburg (1998:53), states that the continuing functioning of any system depends on its ability to adapt to change. If an individual experiences difficulty in adapting to his/ her environment after treatment it will influence his/ her involvement in aftercare support services. Considering an individual's functioning as a system, if the

person perceives problems or inadequacies in one or more of his/ her environments, he/ she will be less intended on maintaining abstinence and attending aftercare services.

The researcher will now give attention to the findings that relates to the respondent's perceptions, views and experiences with regard to their relapse.

3.15. PERCEPTIONS, VIEWS AND EXPERIENCES RELATED TO RELAPSE

The goal of this research study was to determine the causes of relapse amongst young African adults following in-patient treatment for drug abuse. Previously in this chapter, the profile of the respondents in this study received attention. The researcher reasoned that it would be beneficial to also distinguish between the causes of relapse amongst males and females and in accordance to different age groups (emerging adulthood and young adulthood). Both gender and age (phase of development) can influence treatment, relapse prevention programmes and aftercare services. Services should reflect on gender, age and race considering that it might result in more effective drug abuse treatment. This could provide service users with more beneficial services during and after treatment for drug addiction.

3.15.1. Causes of relapse amongst genders

The causes of relapse amongst gender will be demonstrated in table format. This table will display the different causes of relapse and how it was rated by each gender in accordance to whether the specific cause predisposed their relapse. The researcher reported on the column percentages for each gender group.

It should be kept in mind that only nine females participated in this study compared to 35 males. The percentages were calculated in accordance to the number of males and females that participated, separately, and thus provides a reflection of gender-specific causes of relapse.

Table 3: Association between gender and the causes of relapse

Causes of relapse	Male	Female	Chi-Square (p-value)
Easy access to drugs	77.1%	37.5%	.028*
Living in poverty stricken area	25.7%	33.3%	.647
Limited access to services in community	54.3%	66.7%	.504
Opportunities to be successful in South Africa is limited	42.9%	22.2%	.257

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Lack of recreational activities to keep busy	60.0%	44.4%	.401
Drug dealers at places frequently passed	77.1%	88.9%	.436
Overcrowded living conditions	25.7%	33.3%	.647
Difficult to avoid social gathering places (taverns, bars and clubs)	61.8%	62.5%	.969
Stigmatisation by community	77.1%	77.8%	.968
Peer pressure	71.4%	66.7%	.780
Pressure from one significant friend	62.9%	66.7%	.832
Easily influenced by others	65.7%	44.4%	.242
Lacked support needed after treatment	88.6%	77.8%	.400
Dealing with conflict	74.3%	75.0%	.967
Experimented with a new drug	40.0%	22.2%	.323
Difficulty finding employment	76.5%	37.5%	.032*
Change in marital status	33.3%	11.1%	.194
Significant relationship ended	48.5%	44.4%	.830
One/ more family members abuse alcohol or drugs	45.7%	11.1%	.057*
Social group still abuses drugs or alcohol	66.7%	44.4%	.224
Glamorised drug abuse in peer group	77.1%	62.5%	.392
Difficult to avoid social gatherings	54.5%	66.7%	.515
Approached by dealer after treatment	42.9%	33.3%	.604
Experienced stressful life event	57.6%	66.7%	.622
Lack effective coping mechanisms	62.9%	87.5%	.180
Felt less committed to maintain sobriety	70.6%	66.7%	.820
Lost motivation to maintain sobriety	77.1%	77.8%	.968
Craving drugs and or alcohol	77.1%	66.7%	.517
Challenged by too many triggers	85.7%	88.9%	.805
Lacked ability to cope with triggers	79.4%	100%	.160
Don't believe in self (lack self-efficacy)	48.6%	0.0%	.011*
Experienced negative emotional states	74.3%	77.8%	.829
Experienced euphoric states	60.0%	62.5%	.896
Dealing with emotions by using drugs	71.4%	100%	.068*
Change in employment status	36.4%	33.3%	.866
Controlled use	85.7%	88.9%	.805

Not attending aftercare support groups	57.1%	25.0%	.101
Experienced physical pain	57.1%	11.1%	.014*
Feeling oppressed by other races	25.7%	0.0%	.088*
Financial problems	45.7%	44.4%	.946
Lack of financial support	47.1%	22.2%	.179
Availability of money to spend	70.6%	66.7%	.820
Loneliness	76.5%	66.7%	.549
Boredom	88.2%	62.5%	.079*

☐ Indication of statistical significance based on p<0.1

* Some of the expected frequencies in the table less than 5.

Table 3 above presents the findings on the causes of relapse as indicated by both genders. It allows the reader to see if gender influences the causes of relapse. It also provides the Chi-Square (p-value) that is used to see whether there is any statistical association between the causes of relapse indicated by males and females.

The statistical associations that were found to more likely increase the likelihood of relapse amongst different genders include:

- more males than females have easier access to drugs than females;
- more males than females find it more difficult to find employment;
- more males than females have one or more family member(s) abusing alcohol or drugs;
- more males than females don't believe in themselves;
- more females than males deal with their emotions by using drugs;
- more males than female experience physical pain;
- more males than females feel oppressed by other races;
- more males than females experience boredom.

3.15.2. Personal accounts of relapse

The respondents also indicated alternative causes of relapse based on their personal experiences. With regard to indicating personal reasons for relapse, it was not compulsory to answer, only if the respondents had other causes for relapse not listed above. Not all respondents thus answered this question in the questionnaire.
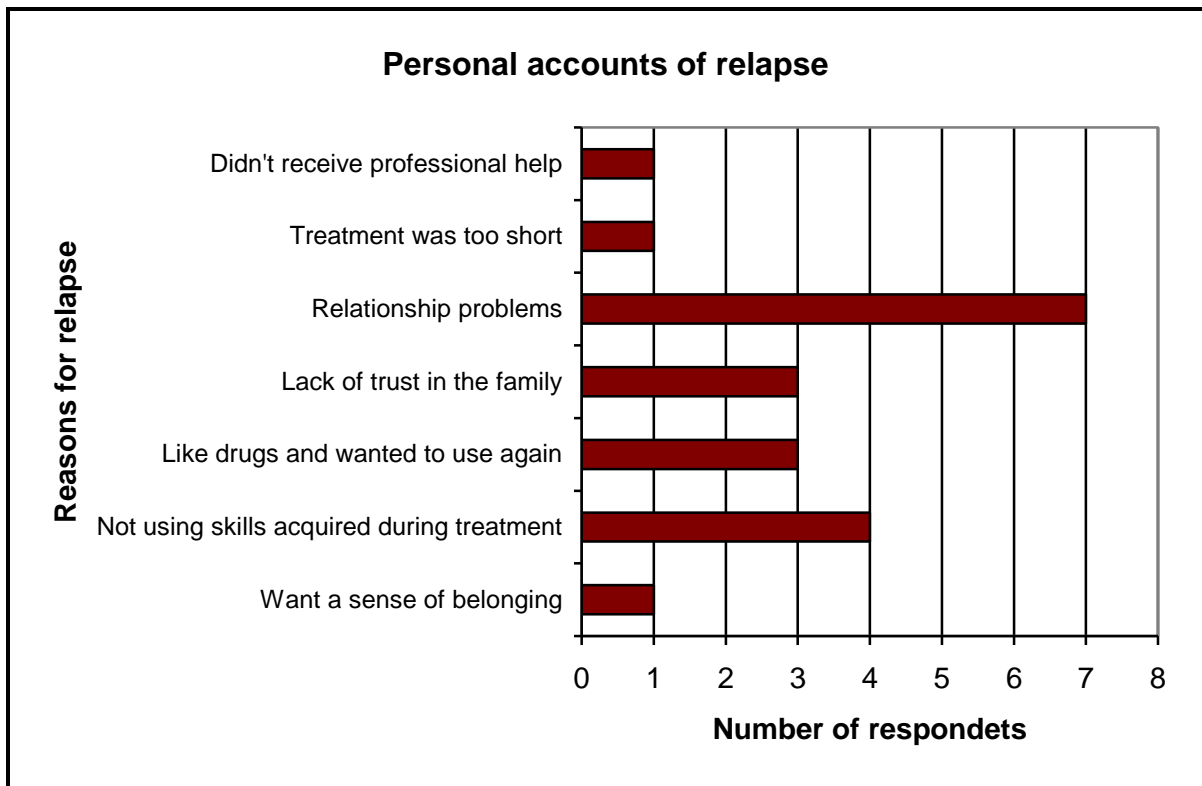
Figure 16: Personal accounts of relapse

The most important causes of relapse amongst the respondents that answered; include: relationship problems, not using the skills that were acquired during treatment, wanting to use again because drugs are enjoyed, and lack of trust in the family. These causes of relapse can be categorised into inter- and intrapersonal risk factors for relapse.

3.15.3. Significant causes of relapse

The researcher identified the most significant causes of relapse amongst the respondents and categorised the causes in accordance to environmental, interpersonal- and intrapersonal and physical risk factors that predispose relapse amongst young African adults. The researcher focused on the causes where more than 50% of respondents indicated agreement, making it the most prominent causes. Again it should be noted that the percentages provided are a reflection of the nine female and 35 male respondents that participated in the study.

3.15.3.1. Environmental risk factors

Certain environmental factors predispose relapse amongst young African adults. These risk factors are presented in Table 4 below. Following the tabular representation will be a discussion of the findings.

Table 4: Environmental risk factors that cause relapse amongst young African adults

Environmental causes	Male (n=35) f(%)	Female (n=9) f(%)	Chi-Square (p-value)
Easy access to drugs	27(77.1%)	3(37.5%)	.028*
Drug dealers at places frequently passed	27(77.1%)	8(88.9%)	.436
Challenged by too many triggers	30(85.7%)	8(88.9%)	.805
Lacked the ability to cope with triggers	27(79.4%)	8(100%)	.160

☐ Indication of statistical significance based on p<0.1

* Some of the expected frequencies in the table less than 5.

- Availability and accessibility of drugs

Male respondents have easy access to drugs and both genders are influenced by dealers being at places that they frequently have to pass. A statistical association (p=.028) was found with regard to easy access to drugs whereby this seems to be mostly a predisposing factors for relapse amongst young African males. From the male respondents (f=27; 77.1%) and (f=8; 88.9%) of the female respondents reported that they were faced with drug dealers on a frequent basis.

Leggett (2001:20) specifies that various factors contributed to the increase of drug abuse and distribution in South Africa. "The opening of borders has allowed new immigrants with substantial experience in the international drug trade, particularly Nigerian nationals, to import and market drugs aggressively to all segments of the population" (Leggett, 2001:20). Leggett (2001:21) is furthermore of the opinion that local Africans are working for Nigerian dealers and are becoming suppliers themselves. It seems to be a vicious cycle of buying and selling (trade with financial gain) which improves the attractiveness of the drug market.

South Africa is believed to be one of the largest producers of dagga in the world, and international demand is very high. This drug trade is however not one-sided; while dagga is being exported to international countries other drugs are being imported, increasing the availability of drugs in South Africa (Leggett, 2001:35) The drugs are 'cut' by various cheap and affordable products (such as household cleaning products) in an attempt to make profit from dealing with drugs. The drugs can then be sold in its greater quantity for cheaper causing drugs to become more accessible to many South Africans, including the poor and as stated before, becoming an epidemic.

- Environmental cues

There was a considerable high report rate of users being challenged by too many triggers (such as people, places, things, and times) and not being able to cope effectively with triggers, amongst both genders. All of the female respondents who answered the question reported that they lacked the ability to cope effectively with triggers, compared to (f=27; 79.4%) of the male respondents.

Hyman and Malenka (2001:697) are of the opinion that environmental cues elevate the risk of a relapse when addicts encounter people, places or paraphernalia associated with earlier drug use. Young African adults are faced with various environmental cues following treatment, many of which are unavoidable. During treatment service users are provided with the necessary information, knowledge and skills to enable them effectively cope with environmental cues. Some respondents indicated that one of the causes for their relapse was not using the skills gained during treatment.

Environmental cues, including the availability and access to drugs, are part of the recovering drug abuser's environment after he/she is discharged from a treatment centre. Entailing that the recovering drug abuser should cope with environmental conditions or be affected by the influences thereof (Barone et al., 2011:353). If the recovering drug abuser cannot cope with environmental cues it might result in relapse.

3.15.3.2. Interpersonal/ social risk factors

Interpersonal or social factors that seem to predispose the target group to relapse are captured in Table 5, followed by a discussion of each cause of relapse.

Table 5: Interpersonal/ social risk factors that cause relapse amongst young African adults

Interpersonal/ social causes	Male (n=35) f(%)	Female (n=9) f(%)	Chi-Square (p-value)
Difficult to avoid social gathering places (taverns, bars and clubs)	21(61.8%)	5(62.5%)	.969
Peer pressure	25(71.4%)	6(66.7%)	.780
Pressure from one significant friend	22(62.9%)	6(66.7%)	.832
Social group still abuses drugs or alcohol	24(66.7%)	4(44.4%)	.224
Glamorised drug abuse in peer group	27(77.1%)	5(62.5%)	.392
Difficult to avoid social gatherings	18(54.5%)	6(66.7%)	.515
Limited access to services in community	19(54.3%)	6(66.7%)	.504
Lack of recreational activities to keep busy	21(60.0%)	4(44.4%)	.401
Boredom	30(88.2%)	5(62.5%)	.079*
Stigmatisation by community	27(77.1%)	7(77.8%)	.968
Dealing with conflict	26(74.3%)	6(75.0%)	.967
Lacked support needed after treatment	31(88.6%)	7(77.8%)	.400
Difficulty finding employment	26(76.5%)	3(37.5%)	.032*

▭ Indication of statistical significance based on p<0.1

* Some of the expected frequencies in the table less than 5.

- Peer group influence

Wadhwa (2009:777) presents peer pressure as one of the most frequent high-risk situations for relapse. In the category of peer group influence the findings on whether the social group still abuses drugs and/or alcohol, drug abuse is glamorised in the peer group and finding it difficult to avoid social gathering places such as pubs, bars, clubs and taverns is also included as it relates to social groups. With regard to peer pressure (f=25; 71.4%) males and (f=6; 66.7%) females indicated this as predisposing their relapse. Both genders indicated that the above factors influenced them to relapse after treatment, especially glamorising drug abuse in their peer groups. Only few female respondents,

however, reported that the fact that their social group still abused drugs and/or alcohol predisposed their relapse. Both genders in almost equal percentages indicated that they found it difficult to avoid social gathering places, where they are challenged with peers using alcohol and or drugs.

In line with peer group influence, Campos (2009:773) states that individuals in recovery have substance-using peer groups that either actively discourage sobriety, model continued drug use, or do not possess the skills to help in managing high-risk situations. Depending on the influence from one's peer group, relapse is probable if one is returning to the same drug-abusing peers as before treatment. Deliberate steps need to be taken to detach oneself from a social network that is supportive of drug use and access new social networks that support new behaviour (McCrady, 2001:383). The researcher perceives this as a major challenge for young African adults, especially those from townships, finding it more difficult to avoid drug-using peers.

- Limited access to services in the community

Respondents indicated whether their relapse was predisposed by having limited access to services in their communities. It was found that more females (f=6; 66.7%) than males (f=19; 54.3%) are effected by limited access to services or in other terms poor service delivery such as housing, water, sanitation and electricity. It can be argued that hygiene is more of a priority to females because of female bodily functions which requires access to sanitation.

Limited access to services and poor service delivery are the reality faced by many communities in the Gauteng Province. In the past few years there has been a growing wave of protests to demand better government services. Grant (2014) reports that the reasons for community protests are diverse. The top five grievances were about service delivery in general, housing, water and sanitation, political representation and electricity. Corruption, municipal administration, roads, unemployment, demarcation, land, health and crime also featured.

- Lack of recreational activities

It was remarkable to find that much more male respondents (f=21; 60%) than female respondents (f=4; 44.4%) reported a lack of recreational activities in their communities. The lack of recreational activities can be linked to boredom seeing that a lack of recreational activities to keep busy can lead to boredom. In relation to boredom, the statistical association (p=.079) indicated that mostly male respondents feel that being faced with boredom is a predisposing factor for relapse. The lack of

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recreational activities might not be affecting females as much as males because they are more likely to be kept busy at home with tasks such as cleaning, cooking, taking care of younger siblings, etc.

The lack of recreational activities in communities contributes to the amount of leisure time that young African adults have per day. The United Nations (2003:215) are of the opinion that depending on how young people spend their leisure time it is also linked to pressing threats to their well-being, including HIV/AIDS, delinquency, conflict and drug abuse, and to issues of globalisation and interdependence. Linked to another cause of relapse namely peer group influence; the United Nations (2003:216) state that in developing societies, young people tend to spend most of their time at home, with boys generally venturing outside the family with peers, somewhat more than girls. This might explain why more males than females reported the lack of recreational activities available to them.

- Stigmatisation by community members

Drug abuse in itself is socially unacceptable and is frowned upon even more by society because of associated behaviours such as crime and gangsterism causing anxiety amongst community members. Room (2005:144) defines stigmatisation according to Wisconsin law as "disqualification from social acceptance, derogation, marginalization and ostracism encountered by persons who abuse alcohol or other drugs as the result of societal negative attitudes, feelings, perceptions, representations and acts of discrimination." According to Luoma, Twohig, Waltz, Hayes, Roget, Padilla and Fisher (2007:1331) there is little doubt that a person who abuses a substance faces stigma in its various forms, including enacted, perceived, and self-stigma, especially during recovery. For this study the focus is more on enacted stigma which Luoma et al. (2007:1332) refer to as directly experienced social discrimination such as difficulty in obtaining employment, reduced access to housing, poor support for treatment, or interpersonal rejection.

A considerable number of male (f=27; 77.1%) and female (f=7; 77.8%) respondents indicated that they felt stigmatised by community members and that even after treatment community members still looked down on them. This feeling of being looked-down upon while trying to change affects confidence in ability to maintain abstinence and can also influence motivation and commitment to maintain abstinence.

- Lack of support after treatment

Lack of support after treatment was also one of the most highly indicated predisposing factors for relapse amongst young African adults from both genders. (f=31; 88.6%) male and (f=7; 77.8%) female

respondents indicated that they had relapsed after previous treatment because they did not have sufficient support following treatment. Support does not only imply support from family members and should be regarded as a responsibility of the recovering drug abuser to seek support after treatment. As stated by Van der Westhuizen et al. (2013:2) aftercare is an essential component of treatment, even though practice indicates a lack of focus on aftercare. Meyer (2005), as cited in Van der Westhuizen et al. (2013:2), refers to aftercare as continued support and guidance to develop a sober lifestyle and to reintegrate into society to prevent relapses.

- Conflict

Both male and female respondents indicated that they had relapsed because they thought that they would be more able to deal with conflict while under the influence of drugs. There was not a noteworthy difference in the report of this amongst the genders, (f=26; 74.5%) male and (f=6; 75%) female respondents indicated conflict as a predisposing factor for relapse.

Conflict is also listed by Wadhwa (2009:777) as one of the most frequent high-risk situations for relapse. As stated by Wadhwa (2009:777), conflict can be a result of interpersonal mishaps that set off the memory of using drugs when an individual has not developed the skills to manage interpersonal conflict appropriately. In relation to conflict, O'Connell and Bevvino (2007:53) state that during drug use conflict is dealt with in dysfunctional ways – the psychological consequences of conflict may have been muted and diluted by the presence of drugs in the system. During active drug use conflict and the feelings associated with conflict is dealt with by using drugs.

- Employment status – difficulty finding employment

It was interesting to find the remarkably low indication of female respondents with regard to difficulty finding employment predisposing them to relapse, in relation to the indication of male respondents being influenced by this to relapse. There was a statistical association (p=.032) found whereby it was indicated that mostly males are affected by difficulty in finding employment predisposing them to relapse. Only (f=3; 37.5%) female respondents indicated that they are affected by the challenge of finding employment as opposed to (f=26; 76.5%) of the male respondents. This might be because males have the perception that they need to be employed as opposed to females based, on gender roles.

The number of unemployed people increased by 237 000 (or 4.9%) between October to December 2013 and January to March 2014 in South Africa. This is largely attributable to an increase of 153 000

among unemployed men. The number of unemployed women increased by 134 000 (or 5.8%) while the number of unemployed men increased by 71 000 (or 2.8%) (Statistics South Africa, 2014:xv). It is a known reality that opportunities for employment is limited in South Africa and especially for those less educated. In relation to this Du Toit (2003:9) states that nearly two thirds (65.5%; 3.6 million) of the unemployed youth do not hold a Grade 12 certificate and the majority (90%; 3.2 million) of this group is African.

Finding employment after treatment, as observed by the researcher in practice, is the main goal for many individuals following in-patient treatment. Seeing that employment opportunities are limited, becoming demotivated when employment is not found is a predisposing factor for relapse. As mentioned before, boredom becomes another predisposing factor for relapse to consider when facing unemployment. There was a statistical association (p=.079) found where it indicated that mostly males were faced with boredom compared to females.

The same point of view as with environmental risk factors can be made when considering the adaptation model and eco-systems perspective that underlie this study. As described by Potgieter (1998:264) all individuals function within different levels of environments, including the meso-level under which the above-mentioned interpersonal risk factors can be categorised. The meso-level of the environment refers to the part which influences and determines the functioning of the micro-environment including peer group involvement; limited access to services in the community; lack of recreational activities; stigmatisation by community members; lack of support; conflict; and difficulty finding employment. It can be anticipated that if the recovering drug abuser experiences difficulty in adapting to the above-mentioned, then it is most likely to affect his/ her micro-environment and consequently cause intrapersonal risk factors (such as emotional effects, loneliness, stress, etc) which might influence relapse.

3.15.3.3.   Intrapersonal risk factors
It was found that various respondents' relapse was predisposed by certain intrapersonal risk factors. Intrapersonal factors that seem to be pertinent in predisposing relapse amongst young African adults are included in Table 6 below.

Table 6: Intrapersonal risk factors that cause relapse amongst young African adults

Intrapersonal causes	Male (n=35) f(%)	Female (n=9) f(%)	Chi-Square (p-value)
Experienced negative emotional states	26(74.3%)	7(77.8%)	.829
Experienced euphoric states	21(60.0%)	5(62.5%)	.896
Dealing with emotions by using drugs	25(71.4%)	9(100%)	.068*
Loneliness	26(76.5%)	6(66.7%)	.549
Experienced stressful life event	19(57.6%)	6(66.7%)	.622
Lack effective coping mechanisms	22(62.9%)	7(87.5%)	.180
Easily influenced by others	23(65.7%)	4(44.4%)	.242
Craving drugs and or alcohol	27(77.1%)	6(66.7%)	.517
Felt less committed to maintain sobriety	24(70.6%)	6(66.7%)	.820
Lost motivation to maintain sobriety	27(77.1%)	7(77.8%)	.968
Controlled use	30(85.7%)	8(88.9%)	.805
Not attending aftercare support groups	20(57.1%)	2(25.0%)	.101

☐ Indication of statistical significance based on p<0.1

* Some of the expected frequencies in the table less than 5.

- Emotions

Both male and female respondents reported experiencing negative or euphoric emotional states which caused them to relapse. (*f*=26; 74.3%) of the male, compared to (*f*=7; 77.8%) of the female respondents relapsed because they experienced negative emotional states. (*f*=21; 60%) males compared to (*f*=5; 62.5%) females relapsed, because they experienced euphoric states. All the female respondents (*f*=9; 100%) reported that they dealt with their emotions by using drugs compared to (*f*=25; 71.4%) of the males. There is a statistical association (p=.068) which indicates that dealing with emotions by using drugs is mainly a female phenomenon.

Bain (2004:153) also established that the primary problem with addicts is dealing with their emotions. "They seem to be sensitive to negative emotions because they experience them as overwhelmingly

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painful and 'out of control', so much so they are forced to self-medicate with substances" (Bain, 2014:153). Empirical research supports the idea that some of the most frequent high-risk situations for relapse is when negative emotions are experienced (Wadhwa, 2009:777). There is a strong association between negative affect states and relapse (Doweiko, 2006:399). Campos (2009:773) declares that the most frequent cited reason for relapse among drug users is a negative state of mood.

Illicit drugs are psychoactive (mood altering) and they give pleasure to the consumer (Benavie, 2009:9). By using these drugs their moods are altered and pleasure is received meaning that these people never really learn how to cope with emotions on their own seeing that they are used to depending on drugs in order to cope better with their emotions. O'Connell and Bevvino (2007:67) confirm that drug users use drugs to modify and change troublesome emotions and supplant them with at least temporary feelings of pleasure and happiness. This is the way in which negative emotions and feelings were previously dealt with. O'Connell and Bevvino (2007:73) are furthermore of the opinion that emotions and feelings need to be recognised and disclosed which allows the person to experience the emotion and in this way troublesome feelings can be dealt with.

- Loneliness

Loneliness was found to be a predisposing factor that influenced relapse amongst the respondents. Most male respondents (*f*=26; 76.5%) in relation to female respondents (*f*=6; 66.7%) indicated that loneliness was a cause of relapse for them. This might be explained by females feeling more attached to family and friends especially when one considers sharing thoughts and feelings.

Definitions of loneliness include "sadness because one has no friends or company", "solitariness" and "isolation" (*Oxford Dictionary*, 2014, sv 'loneliness'). Halsey (1979), as quoted by Bain (2004:130), defines loneliness as being "without friendship or companionship" and the feeling of being "depressed from lack of friendship or companionship", "lacking people", "unfrequented" or "deserted". All of the above definitions imply that a person will have negative emotional consequences (sadness or depressed) when there is a lack of meaningful or close relationships.

In the study by Bain (2004:130) it was also found that loneliness was one of the main contributing factors in relapse. Stickley, Koyanagi, Koposov, Schwab-Stone and Ruchkin (2014:368) state that loneliness can be an extremely painful and distressing phenomenon. Shevlin, Murphy, Mallett, Stringer and Murphy (2013:230) agree that loneliness is an emotionally unpleasant state resulting

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from inadequate or poor quality social relationships. Stickley et al. (2014:368) state that in order to cope with, or minimise, the painful feelings that can emanate from loneliness people pursue 'alternative gratifications' which might include risky health behaviours. One of these risky health behaviours includes drug abuse.

Other findings in this study can also be related to loneliness seeing that it can contribute to the feeling of loneliness. Many respondents reported a lack of support and stigmatisation by community members – these increasing the feeling of loneliness since both resemble rejection. Within the family context lack of trust was also reported to be a predisposing factor to relapse, again causing the young African adult to feel rejected and a lack of belonging. Respondents reported highly on peer pressure being a predisposing factor to relapse, this might be because they seek and eventually find a sense of belonging within their peer groups, compensating for the lack of belonging that they feel in their families and communities.

- Lack of effective coping mechanisms and stress management

It was notable to find that more female respondents (f=7; 87.5%) than male respondents (f=22; 62.9%) reported that they lacked effective coping mechanisms that lead to relapse. Experiencing a stressful life event was also indicated more amongst females (f=6; 66.7%) as opposed to males (f=19; 57.6%). Zhao, Shi, Zhang, Epstein, Zhang, Lui, Kosten and Lu (2009:720) agree that stress is associated with relapse to drugs after abstinence. Contradicting this finding is the statistical association (p=.011) that was found with regard to believing in oneself. It was found that more males do not believe in themselves than females, which is strange when considering this perceived lack of coping mechanisms amongst female respondents which also indicated that they believe in themselves. According to the researcher if a person believes in oneself, that person would also feel capable of coping effectively in stressful situations.

There are a number of definitions for stress and, based on this, the researcher defines stress as any event that places a demand on the system, both physically and psychologically. Hunter and Gillen (2006:115) define a stressor as an event or status that occurs in one's environment that is likely to pose a threat and when experiencing a stressor it generally requires a response so that the individual avoids negative stress-reaction symptoms. Hunter and Gillen (2006:117) state that coping is any behavioural, social, or psychological action taken in response to a perceived stressor. Hunter and Gillen (2006:117) further state that the goal of the individual when adopting a coping mechanism is to reduce the present of probable negative symptoms associated with the stress that is being

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experienced. "Coping responses are those strategies you utilise to get yourself through high-risk situations without a return to active addiction" (O'Connell & Bevinno, 2007:49).

As indicated above, most respondents expressed that they lack effective coping mechanisms in relation to stressful life events. Explanations for return to drug abuse was found in literature - Zhao et al. (2009:720) are of the opinion that stress enhances abstinent addicts to recall memories of drugs as stress relievers. In relation to stress and abstinent addicts, Harrington Cleveland and Harris (2010:60) suggest that recovering addicts who avoid coping with stress succumb easily to cravings for addictive substances, making them more likely to relapse during recovery seeing that cravings are a strong predictor of relapse. Wadhwa (2009:778) asserts that the use of drugs is the central coping mechanism for day-to-day life for addicts but it is necessary for individuals to identify specific coping mechanisms for different thoughts, feelings or moods, and situations.

- Lack of assertiveness and easily influenced by others

Lack of assertiveness and being easily influenced by others did not seem to be an important predictor of relapse amongst females (f=4; 44.4%) as opposed to males (f=23; 65.7%). In correlation with this, their indication of peer pressure being a predisposing factor to their relapse (as discussed under paragraph 3.15.3.2) - females indicated that peer pressure least influenced them to relapse (f=6; 66.7%) as compared to males (f=25; 71.4%). It seems as though males are more likely to conform to peer pressure after treatment which predisposes them to relapse.

The researcher could not identify recent scientific literature sources on gender differences in conformity. However, studies over the years (Becker, 1986) and (Eagly, 1983) showed a higher rate of conformity among females than males. This is in contrast with the finding in this study, where more male respondents than female respondents indicated that they were easily influenced. Bear in mind the recent social role changes of females becoming more dominant in various settings. Van Avermaet (2001), as cited by Swart (2004:254), refers to conformity as change in an individual's judgements, opinions and attitudes that occurs because of exposure to judgements, opinions and attitudes of other individuals. In relation to this Swart (2004:254) states that conformity is one kind of social influence that involves modifying individual behaviour in response to real or imagined pressure from others.

It is the opinion of the researcher that more male respondents, especially in black townships, conform to the lifestyle associated with drug abuse (including gangsterism) to fit in with the growing tendency of

these trends occurring in their communities. Being part of a gang provides the young African adult with perceived status amongst others.

- Cravings

As mentioned previously, cravings are a strong predictor of relapse (Harrington Cleveland & Harris, 2010:60). (f=27; 77.1%) of the male respondents and (f=6; 66.7%) of the female respondents reported that they craved alcohol and/or drugs and this caused them to relapse.

Bain (2004:7) views a drug craving as a powerful motivational state or intense desire that drives the user to seek the substance. Doweiko (2006:399) states that a craving in itself is a poor predictor of relapse, it may be triggered by drug-use cues (smells, the sight of the drug, sounds etc.) and trigger moods and memories that predispose the individual to substance use. Larimer et al. (1999:156) give evidence that on-going cravings may erode the person's commitment to maintaining abstinence as his or her desire for immediate gratification increases. Cravings are thus triggered by certain environmental cues influencing the underlying process of a craving – an individual will be confronted by a trigger (high-risk situation) which will be followed by thoughts of using drugs, eventually progressing to a craving for drug use. The researcher considers that males might be faced with more drug-use cues than females which then predispose them more to crave.

- Losing motivation to maintain abstinence and feeling less committed to staying abstinent

"Motivation is the extent to which an individual desires to refrain from problematic substance use" (Campos, 2009:773). As maintained by Marlatt and Witkiewitz (2005:11) "motivation may relate to the relapse process in two distinct ways, the motivation for positive behaviour change and the motivation to engage in the problematic behaviour." Doweiko (2006:399) is of the opinion that the individual's motivation to change his or her behaviour or to return to past behaviours have been found to play an important role in successfully coping with drug-use cues.

Respondents reported that they started to lose motivation and felt less committed to staying abstinent. Almost in equal amounts both genders, males (f=27; 77.1%) and females (f=7; 77.8%) indicated that they lost motivation to maintain abstinence. More male (f=24; 77.1%) than female (f=6; 66.74%) respondents indicated the loss of commitment towards maintaining abstinence.

Young African adults might lose interest in maintaining a sober lifestyle for various reasons influencing their motivation and commitment to maintaining abstinence. Some of the reasons might include the

above-mentioned predisposing factors to relapse – dealing with emotions, loneliness (by using drugs they become part of a peer group which is more beneficial to them than being lonely), stigmatisation by community members (they are perceived as drug abusers even after treatment thus influencing their perception of themselves), stress and lack of effective coping mechanisms. By using drugs young African adults cope with day-to-day challenges, being under the influence of drugs makes these challenges seem less threatening, in turn making the drug-abuse lifestyle seem more comfortable. Depending on the phase of adult development seeking excitement might also affect motivation and commitment to maintaining abstinence.

- Perception of controlled drug use

The indication of respondents that thought they could control their use of drugs after treatment was very substantial and only a small difference was noticed amongst the genders. Controlled use of drugs was indicated by (f=30; 85.7%) males and (f=8; 88.9%) females.

The researcher relates this phenomenon of controlled use to outcome expectancy seeing that while controlled use was contemplated, the short-term reward contingencies such as the reduction of negative mood states, the inducement of euphoria, a shift in cognition toward a more positive sense of self, and stress reduction (Campos, 2009:773) were also considered. For example, the young African adult feels stressed because of difficulty in finding employment, bearing in mind the recall of memories that drugs are stress relievers, the young African adult contemplates the he/she would only use once to relieve the stress. Considering the process and phases of addiction it is highly unlikely that the young African adult would cease use. Positive outcome expectancy with regard to the influence of the drug (reducing anxiety and increasing euphoria) might lead to relapse as little attention is paid to the negative consequences of the use of the drug. In other words people have higher expectations regarding the positive effects of drugs. As mentioned previously the young African adults expect the drugs to rid them of or help them cope with certain feelings, thoughts and situations.

- Decision not to attend aftercare

The decision not to attend aftercare services is a decision often made lightly by service users after treatment. Mostly the male respondents (f=20; 57.1%) indicated that deciding not to attend aftercare services following treatment predisposed them to relapse.

It is stated by Keller (2003), as quoted by Doweiko (2006:400), that through a series of seemingly irrelevant decisions the newly recovered individuals will place themselves in a high-risk situation,

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possibly without being aware of more than the last decision in a chain of choices that ultimately results in a relapse. "A central characteristic of mini-decisions is that they do not involve a decision to actively use chemicals. Rather, these irrelevant decisions will collectively set the stage for relapse" (Doweiko, 2006:400). Deciding not to attend aftercare services following treatment can cause a downward spiral for the young African adult seeing that it might give way to a chain of wrong, not well-thought through decisions. Aftercare is an essential part of the recovery process and will receive attention in the concluding chapters of this research report.

Considering the eco-systems perspective, it can be considered that the meso-level (interpersonal) influences micro-level (intrapersonal) functioning, seeing that inadequacies in the meso-level environment cause instability in the micro–environment. In the case of the research findings, they include: negative and euphoric emotional states; loneliness; lack of effective coping mechanisms; ineffective stress management; lack of assertiveness and easily influenced by others; cravings; losing motivation and feeling less committed to maintain abstinence; controlled drug use; and decision-making. It can thus be concluded that if a recovery drug abuser is experiencing difficulty in adapting to the meso-environment following treatment it might affect the individual's micro-level functioning and cause to the above-mentioned becoming risk for relapse amongst the young African adult.

Another cause of relapse, as indicated by respondents, is categorised as the physical causes of relapse and will be discussed subsequently.

3.15.3.4.   Physical risk factors

The only physical cause of relapse that was identified by the respondents during the study was experiencing physical pain. The findings are presented in Table 7 below.

Table 7: Physical risk factors that cause relapse amongst young African adults

Physical causes	Male (n=35) f(%)	Female (n=9) f(%)	Chi-Square (p-value)
Experienced physical pain	20(57.1%)	1(11.1%)	.014*

☐   Indication of statistical significance based on p<0.1

* Some of the expected frequencies in the table less than 5.

Through the findings of the study it became apparent that physical risk factors do not commonly predispose relapse amongst young African adults. From the 35 male respondents that participated in the study, (f=20; 57.1%) indicated that they relapsed because they experienced some form of physical pain. Only one female (f=1; 11.1%) indicated that this influenced her to relapse. The statistical association (p=.014) confirms that mainly males are predisposed by physical pain to relapse. Along with Doweiko (2006:401), as derived from Dimeff and Marlatt (1995), a person experiencing a negative physical state such as illness, postsurgical distress, or injury might face an elevated risk of a relapse. In this study however the cause of physical pain was not identified.

A number of studies have demonstrated a higher prevalence of chronic pain and greater pain sensitivity among females compared to males, by sex hormones influencing pain sensitivity; pain threshold and pain tolerance in women, vary (Wiesenfeld-Hallin, 2005:137). Several studies have shown that estrogen in women can help dampen the activity of pain receptors, helping them to tolerate higher levels of pain (Park, 2012). The above-mentioned arguments confirm the finding in the study – which implies that females are less likely to relapse because of physical pain in comparison to males.

Considering that most respondents used *nyaope* it can be deemed that the drug was used to relieve physical pain. Heroin is classified as an opiate and is naturally derived from the opium poppy which is known to have sedative effects (Kaplan & Sadock, 1998). This is confirmed by Benshoff and Janikowski (2000:112) who state that one of the principle effects of opium is pain reduction. Even though heroin is semi-synthetic drugs it is still considered to be opiates (Benshoff & Janikowski, 2000:112).

The causes of relapse were also looked at within the different age groups of emerging adulthood (18 to 24 years) and young adulthood (25 to 38 years). This will be presented and discussed next.

3.16. CAUSES OF RELAPSE AMONGST DIFFERENT AGE GROUPS

The causes of relapse amongst different age groups will be demonstrated in table format. This table, Table 8, will display whether specific causes of relapse influenced relapse in relation to the different age groups of respondents. The researcher indicated the number of respondents that agreed to the cause of relapse followed by the percentage divided into the age groups. The percentages reported on are the column percentages. The p-value (Chi-square) will also be indicated in the table to show if there is any statistical significance (association between the age groups). It should be kept in mind

that due to the small sample size it was difficult to interpret the statistical significance. The age distribution of the respondents should also be considered as affecting the findings.

Table 8: Association between age groups and causes of relapse

Causes of relapse	Number of respondents that agreed	18 – 24 Years	25 – 38 Years	Chi-Square (p-value)
Easy access to drugs	30	82.4%	61.5%	.146
Living in poverty stricken area	12	33.3%	23.1%	.453
Limited access to services in community	25	72.2%	46.2%	.086*
Opportunities to be successful in South Africa is limited	17	50.0%	30.8%	.198
Lack of recreational activities to keep busy	25	55.6%	57.7%	.888
Drug dealers at places frequently passed	35	94.4%	69.2%	.041*
Overcrowded living conditions	12	38.9%	19.2%	.150
Difficult to avoid social gathering places (taverns, bars and clubs)	26	72.2%	54.2%	.233
Stigmatisation by community	34	83.3%	73.1%	.425
Peer pressure	31	88.9%	57.7%	.026*
Pressure from one significant friend	28	77.8%	53.8%	.105
Easily influenced by others	27	72.2%	53.8%	.218
Lacked support needed after treatment	38	83.3%	88.5%	.626
Dealing with conflict	32	94.4%	60.0%	.011*
Experimented with a new drug	16	33.3%	38.5%	.728
Difficulty finding employment	29	77.8%	62.5%	.289
Change in marital status	11	31.3%	26.1%	.725
Significant relationship ended	20	50.0%	45.8%	.789
One/ more family members abuse alcohol or drugs	17	38.9%	38.5%	.977
Social group still abuses drugs or alcohol	26	70.6%	56.0%	.339
Glamorised drug abuse in peer group	32	88.2%	65.4%	.093*
Difficult to avoid social gatherings	24	68.8%	50.0%	.233
Approached by dealer after treatment	18	66.7%	53.8%	.395

Experienced stressful life event	25	47.1%	68.0%	.175
Lack effective coping mechanisms	29	70.6%	65.4%	.722
Felt less committed to maintain sobriety	30	66.7%	72.0%	.707
Lost motivation to maintain sobriety	34	83.3%	73.1%	.425
Craving drugs and or alcohol	33	66.7%	80.8%	.288
Challenged by too many triggers	38	100%	76.9%	.028*
Lacked ability to cope with triggers	35	100%	70.8%	.012*
Don't believe in self (lack self-efficacy)	17	23.5%	50.0%	.083*
Experienced negative emotional states	33	72.2%	76.9%	.723
Experienced euphoric states	26	58.8%	61.5%	.859
Dealing with emotions by using drugs	34	83.3%	73.1%	.425
Change in employment status	15	25.0%	42.3%	.256
Controlled use	38	94.4%	80.8%	.194
Not attending aftercare support groups	22	50.0%	50.2%	.897
Experienced physical pain	21	38.9%	53.8%	.329
Feeling oppressed by other races	9	22.2%	19.2%	.809
Financial problems	20	38.9%	50.0%	.467
Lack of financial support	18	33.3%	48.0%	.336
Availability of money to spend	30	77.8%	64.0%	.332
Loneliness	32	77.8%	72.0%	.668
Boredom	35	100%	72.0%	.017*

☐ Indication of statistical significance based on p<0.1

* Some of the expected frequencies in the table less than 5.

The focus was on two different age groups which represent the different phases of adulthood. For the purpose of the study 18 – 24 years represent the emerging adulthood phase (the stage between adolescence and young adulthood) and 25 – 38 years represent young adulthood. In literature sources that were reviewed for this study, it was found that during these developmental stages the young adult is faced with numerous demands, transitions and challenges. The developmental stage of young adulthood also carries significant risk of harmful use of drugs and for the onset of substance use disorders (Urbanoski et al., 2011:1). The researcher wanted to identify specific causes of relapse related to a specific age group.

It seems as though emerging young adults (18 to 24 years old) are more likely to relapse as opposed to young adults (25 to 38 years old), even though the average age of respondents were indicated to be 26 years.

Statistical associations were indicated amongst some of these causes of relapse being mostly related to a specific age group. Amongst the emerging adulthood age group (18 – 24 years) compared to the young adulthood age group (25 to 38 years) significant associations were found with: having limited access to services in the community, drug dealer at places they frequently have to pass, peer pressure and glamorising drug abuse in their peer group, dealing with conflict, being challenged with too many triggers and lacking the ability to cope effectively with triggers, and boredom. Considering the statistical association pertaining to the belief in oneself, young adults (25 to 38 years old) were found to be lacking this trait and it can be considered as one of the factors that predisposed them to relapse. Amongst the young adulthood age group (25 – 38 years) it was reported that they are more affected by the lack of recreational activities, lack of support needed after treatment, stressful life events, cravings, experiencing negative and/ or euphoric emotional states, not attending aftercare support services, and physical pain.

The researcher will list the most significantly indicated causes of relapse as indicated by the respondents in different age groups, starting with emerging adulthood.

3.16.1. Emerging adulthood (18 – 24 years)
Most respondents in this age group indicated the following as predisposing them to relapse:
- Boredom (100%)
- Challenged by too many triggers (100%) and lacking the ability to cope with triggers (100%)
- Drug dealers at places they frequently have to pass (94.4%)
- Dealing with conflict (94.4%)
- Controlled drug use (94.4%)
- Peer pressure (88.9%)
- Glamorising drug abuse in peer group (88.2%)
- Stigmatisation by the community (83.3%)
- Lack of support (83.3%)
- Dealing with emotions by using drugs (83.3%)
- Losing commitment to maintain abstinence (83.3%)
- Easy access to drugs (82.4%)

- Loneliness (77.8%)

- Difficulty in finding employment (77.8%)

- Limited access to services in the community (72.2%)

- Social gathering places (72.2%)

- Being easily influenced by others (72.2%)

- Experiencing negative emotional states (72.2%)

- Lacking effective coping mechanisms (70.6%)

- Social group that still abuses alcohol and/or drugs (70.6%)

- Difficulty in avoiding social gatherings (68.8%)

- Being approached by dealers after treatment (66.7%)

- Cravings (66.7%)

- Not attending aftercare support services (50%)

Related to development and peer pressure, Bassani (2009:76) states that "for youths, the family acts as the primary (influencing) group … as youths pass from childhood into adolescence and young adulthood, the primary group changes. During this transformation the peer group becomes more prominent." This can be seen where emerging adults indicated that they were influenced by the various factors related to their peer group. Socialising seems to be important to emerging adults which can be linked to the statement that during transformation the peer group becomes more prominent. Emerging young adults also reported easier access to drugs and being faced with dealers more often than young adults, this might be linked to the fact that they have difficulty in avoiding social gatherings and social gathering places, seeing that drugs nowadays are readily available at social gatherings and social gathering places, such as pubs, clubs, and taverns. Boredom was reported by all of the emerging young adults that took part in this study as predisposing them to relapse. The boredom experienced by this age group might cause them to find relief from boredom by spending idle time with their peer groups. It should be considered that the more time these emerging young adults spend with their peer groups, roaming the streets, the more they are faced with triggers (environmental cues) predisposing them to relapse.

Considering limited access to services in the community the following is explained by Brook et al. (2006:32) who state that individuals that have little access to resources and opportunities can experience indifference or even opposition to dominant social norms. "This detachment from social norms may ultimately be expressed in high levels of substance use and abuse" (Brook et al., 2006:32). With regard to conflict management and lack of effective coping mechanisms, the following

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can be considered, "coping styles of youths nowadays are affected by the rapidly changing political, social, cultural and moral climates causing adults of today to be more vulnerable" (Measham et al., 1998:9). Velleman et al. (2005:99) also associate an increased risk of drug use associated with poor coping skills. Bearing in mind that emerging young adults also indicated a lack of support, it might be considered that they do not have or they perceive that they do not have support systems that they can turn to for advice and guidance. This lack of support and guidance increase their lack of coping skills, especially with regard to effectively dealing with their emotions.

The researcher will now also point out the most significant causes of relapse as indicated by the respondents within young adulthood.

3.16.2. Young adulthood (25 – 38 years)
Most respondents in this age group indicated the following as predisposing them to relapse:
- Lack of support (88.5%)
- Controlled drug use (80.8%)
- Cravings (80.8%)
- Challenged by too many triggers (76.9%)
- Experiencing negative emotional states (76.9%)
- Stigmatisation by the community (73.1%)
- Dealing with emotions by using drugs (73.1%)
- Losing commitment to maintain abstinence (73.1%)
- Loneliness (72%)
- Boredom (72%)
- Lacking the ability to cope with triggers (70.8%)
- Drug dealers at places they frequently have to pass (69.2%)
- Experiencing a stressful life event (68%)
- Lacking effective coping mechanisms (65.4%)
- Glamorising drug abuse is peer group (65.4%)
- Difficulty in finding employment (62.5%)
- Easy access to drugs (61.5%)
- Experiencing euphoric emotional states (61.5%)
- Dealing with conflict (60%)
- Lack of recreational activities (57.7%)

- Peer pressure (57.7%)

- Social group that still abuses alcohol and/or drugs (56%)

- Social gathering places (54.2%)

- Being approached by dealers after treatment (53.8%)

- Being easily influenced by others (53.8%)

- Experiencing physical pain (53.8%)

- Not attending aftercare support services (50.2%)

- Difficulty in avoiding social gatherings (50%)

Predisposing factors to relapse mostly indicated by this age group as opposed to those indicated by emerging young adults, include: the lack of recreational activities; lack of support needed after treatment; experiencing a stressful life event; cravings; experiencing negative and/or euphoric emotional states; not attending aftercare support services; and physical pain.

With regard to young adulthood, Konstam (2007:1) states that definitive steps to achieve measures of financial, residential, and emotional independence, together with more adult roles are taken. Konstam (2007:8) also states that "the primary goal for young adults is to establish the ability to support themselves independent of their parents." Seeing that opportunities for employment are limited in South Africa, especially for those less educated, young adults are faced with not being able to reach this desired independence. Research has shown that the inability to find employment is extremely stressful and places individuals at high risk for substance abuse (Duncan & Van Niekerk, 2004:91). The researcher anticipates that the young adults that are having difficulty in finding financial, residential and emotional independence might still have a need to rely on support from others to cope with stress and emotions.

It was considered applicable to also explore the respondent's current confidence in their ability to maintain abstinence after treatment. Reasons were also provided to explain their level of confidence.

3.17. CONFIDENCE IN MAINTAINING ABSTINENCE AFTER TREATMENT

The respondents were also asked to indicate whether they felt confident in their ability to maintain abstinence from drug usage after their current treatment for drug abuse.
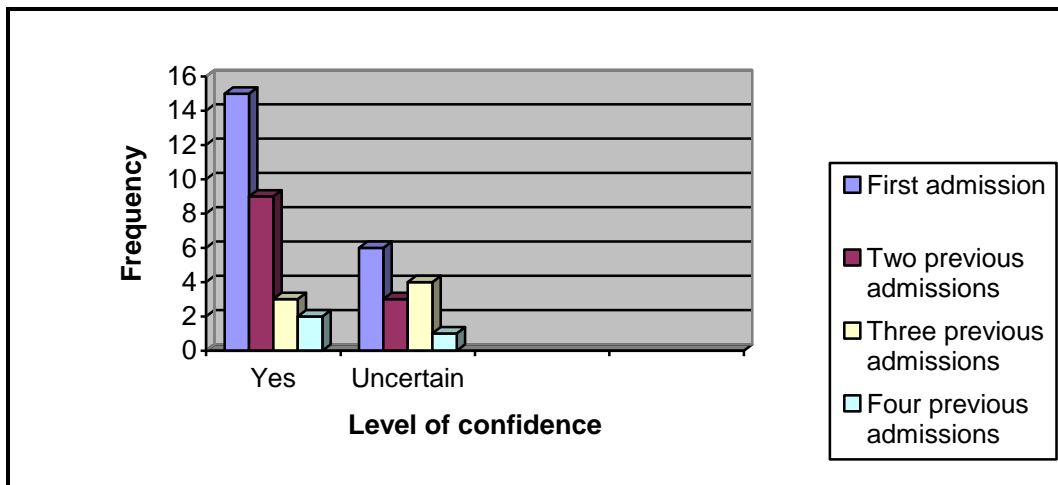
Figure 17: Confidence in maintaining abstinence in relation to the number of treatment admissions

Overall, 24 out of the total 44 respondents indicated that they felt confident in their ability to maintain abstinence after current treatment; 14 indicated that they are uncertain; and only one respondent indicated that he/ she is not confident in ability to maintain abstinence.

It was strange to find that their confidence to maintain abstinence did not increase with the number of previous treatment admissions they had before current treatment. Instead it indicates more confidence after only one admission (see Figure 17). The researcher will attempt to make sense of this finding by relating it to literature. A study done by Janse van Rensburg (1998:83) can be used to explain this occurrence; he states that "one has to contemplate whether a relapse constitutes total failure implying the end of the road for a person attempting treatment. Consider the shame, guilt and self-blaming that would be evident …" Janse van Rensburg (1998:42) is furthermore of the opinion that the demand for total abstinence often leaves the service user with a feeling of despair because of the seemingly unattainable goal eventually resulting in a "more of the same" or "just another relapse" attitude. Following initial treatment the service user might feel more confident because he/ she has not experienced a relapse as yet. After experiencing relapse feelings of shame, guilt and self-blaming occur, they end up being re-admitted for treatment again, eventually spiralling into the attitude of "more of the same" or "just another relapse". In the end this affects their confidence in their ability to maintain abstinence seeing that relapse and re-admission become part of their functioning. After initial treatment, before relapse one might still feel confident if not familiar with the above-mentioned.

Reasons (in sequence of mostly indicated to least indicated) provided by respondents with regard to their confidence in maintaining abstinence include:

- Having efficient support after treatment (family and support groups)
- Having future plans (indicating direction)
- Changed way of thinking and now having a positive mind set
- Will remind self of the consequences of drug abuse
- Feeling confident, capable, determined and proud
- Spirituality improved and will get involved in Christian activities and going to church
- Will avoid 'drug-using' friends
- Restored family relationships
- Recently became a father and wants to take responsibility
- Received effective treatment
- Will occupy idle time to avoid boredom
- Learned responsibility
- Voluntarily received treatment.

It seems as though the respondent's confidence levels are increased mostly by having efficient support. This correlates with the lack of support as a cause of relapse that was indicated by many respondents. Attention was also paid to the reasons why respondents felt that they lacked confidence to maintain abstinence.

Reasons (in sequence of mostly indicated to least indicated) provided by respondents with regard uncertainty about their confidence to maintain abstinence, include:

- Doubting will power to stay abstinent
- Lack of support by family and no support groups
- Losing motivation to stay abstinent
- Boredom
- Did not change mind set and is still contemplating controlled substance abuse
- Loneliness
- Easy access to drugs and exposed to many drug dealers
- Friends are still abusing drugs
- Unemployment

It became apparent that most respondents felt uncertain in their ability to maintain abstinence because they do not believe in themselves and because they lack support that is needed after treatment.

Confidence levels of service users can furthermore be explained by the premises of the adaptation model and eco-systems perspective. Service users become familiar with being able to function effectively within the setting of a treatment centre. The more admissions they experience after relapse, the more their confidence levels are affected by increased feelings of failure, guilt and self-blame (micro-level functioning). Other levels of environments, meso- and macro-level (in communication with the micro-system) can also influence the service users' ability to adapt effectively after treatment. Mentioned previously is that having efficient support (meso-level) was found to increase the confidence levels of respondents.

3.18. SUMMARY

This chapter provided a discussion on the research methodology used for this study. This was followed by the presentation of the research findings and a discussion of the results of this study which was integrated with various literature sources. Integration with the adaptation model and the eco-systems perspective was also presented where applicable.

The final chapter provides a summary of the key findings of the study, and make conclusions and recommendations based on the empirical findings. In the final chapter the researcher formulates guidelines for treatment programmes to include more specific relapse prevention strategies and provides a guide to inform aftercare services that is more applicable to the young African adult within the South African context.

CHAPTER 4
CONCLUSIONS AND RECOMMENDATIONS

4.1. INTRODUCTION

In the previous chapter, the researcher presented empirical research findings through a quantitative study. In this chapter the research study will be concluded. The researcher will indicate how the goal and objectives of the study were met, and subsequently answer the research question. A discussion on the key findings of this study will be followed by recommendations. The recommendations will provide guidelines for improving professional services delivered by treatment centres, specifically during the aftercare and reintegration phase targeted at the young African adult.

4.2. RESEARCH GOAL AND OBJECTIVES

The **goal** of this study was to determine the causes of relapse amongst young African adults following in-patient treatment for drug abuse in the Gauteng Province.

This goal was achieved through the following **objectives**:

Objective 1: To determine which environmental risk factors have an influence on relapse amongst young African adults

Based on the literature review in Chapter 2, environmental risk factors that can increase the risk for relapse include increased availability and accessibility to drugs, and encountering people, places and paraphernalia associated with earlier drug use. During the data collection and succeeding data analysis, the researcher was able to establish environmental risk factors that predisposed relapse amongst young African adults. These findings were presented in Chapter 3 of this study; (refer to Paragraph 3.15.3.1 for environmental risk factors.) This objective was met and the environmental risk factors that were found to be significant amongst the respondents included: availability and accessibility of drugs which is increased by dealers frequenting places where respondents are; being faced with environmental cues/ triggers (such as people, places, things and times); and not being able to cope effectively with these cues/ triggers.

Objective 2: To determine which interpersonal risk factors have an influence on relapse amongst young African adults

In accordance with the literature review in Chapter 2, interpersonal risk factors that can influence relapse amongst young African adults include peer group influence, conflict management, unemployment, including poverty and unemployment linked to idle time and boredom. By conducting this study, the researcher was able to establish interpersonal risk factors that predispose relapse amongst young African adults. These findings were represented in Chapter 3, Paragraph 3.15.3.2. This objective was met and the interpersonal risk factors that were apparent amongst the respondents included: peer pressure with the sub-indication of the social group that still abuses drugs and/or alcohol, drug abuse is glamorised in peer groups, finding it difficult to avoid social gatherings and places such as pubs, bars, clubs and taverns; limited access to services in the community; lack of recreational activities to keep busy; stigmatisation by community members; lack of support after treatment; conflict management; and difficulty in finding employment.

Objective 3: To determine which intrapersonal risk factors have an influence on relapse amongst young African adults

In the literature review in Chapter 2, the following intrapersonal risk factors were included: affect/ emotions, lack of effective coping skills, cravings, self-efficacy, outcome expectancy, motivation, certain personality traits and seemingly irrelevant decisions. The empirical findings presented in Chapter 3, Paragraph 3.15.3.3 indicate that this objective was met by presenting the following intrapersonal risk factors that predisposed relapse amongst young African adults: emotions - both euphoric and negative emotional states, but more so negative emotional states and dealing with emotions; loneliness; lack of effective coping skills; stress management; easily influenced by others; cravings; losing motivation and feeling less committed to staying abstinent; controlled use; and deciding not to attend aftercare services.

Objective 4: To identify additional causes of relapse amongst young African adults

Based on the literature review in Chapter 2, another risk factor for relapse mentioned is physical risk factors. During the empirical study presented in Chapter 3, it was found that physical risk factors do not play a big role in predisposing young African adults to relapse. Some reported experiencing physical pain which caused them to relapse. Other additional causes of relapse amongst young

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African adults included: relationship problems; not using skills acquired during treatment; lack of trust in the family; liking the effects of drugs and wanting to use again. As such, this objective was reached.

Objective 5: To provide guidelines for improving professional services delivered by treatment centres, specifically during the aftercare and reintegration phase

Only after the research findings and interpretations presented in Chapter 3, recommendations can be made. Based on the recommendations, guidelines for improving services rendered by treatment centres and aftercare services can be made. The recommendations will be discussed further in this chapter, following the key findings of the research study.

The research question was as follows: *"What are the causes of relapse amongst young African adults following in-patient treatment for drug abuse in the Gauteng Province?"* It can be reported that this research question was answered during the research process, where the causes of relapse amongst young African adults, have been identified and presented in Chapter 3 of this study. These causes are as follows:

(1)   Availability and accessibility of drugs
(2)   Triggers and lacking effective mechanisms to deal with triggers
(3)   Peer group influence
(4)   Limited access to services in the community
(5)   Lack of recreational activities in the community
(6)   Stigmatisation by community members
(7)   Lack of support following treatment
(8)   Conflict
(9)   Difficulty finding employment
(10)   Emotions
(11)   Loneliness
(12)   Lack of effective coping mechanisms and stress management
(13)   Lack of assertiveness and easily influenced by others
(14)   Cravings
(15)   Losing motivation to maintain abstinence and feeling less committed to staying abstinent
(16)   The perception that drug use can be controlled
(17)   Not attending aftercare support services
(18)   Physical pain

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(19)   Relationship problems

(20)   Not using the skills acquired during treatment

4.3.   KEY FINDINGS

The key findings on the causes of relapse amongst young African adults following in-patient treatment for drug abuse are listed below.

- There seems to be a link between not completing education (not matriculating) and being unemployed. It hence seems that the level of education can be linked to unemployment.
- The age of experimentation ranges between middle childhood and adolescence. During middle childhood individuals are having more frequent interaction with a wide range of people, in more places, whereas during adolescence, individuals strive for autonomy, pulling away from parents and investing more in the peer group. The peer group was determined to be one of the reasons for individuals to start experimenting with drugs.
- *Nyaope* seems to be the most frequent drug of choice amongst young African adults and abuse of this drug becomes problematic after using the drug for eight months to a year and treatment was sought only after two to three years of abusing *nyaope*. The second drug of choice found in the study was crack. The abuse of crack also became problematic after eight months to a year but treatment was only sought after three to four years.
- It appears as though first treatment is mostly received at government institutions.
- It became apparent that aftercare support services are not being utilised or attended. Reasons provided for the lack of attendance include: not having money to attend; lack of family support; lack of motivation to attend; and not having transport to access the services.
- With regard to availability and accessibility to drugs it was found that more males reported on having easy access to drug whereas more females reported being faced with dealers on a frequent basis. Respondents aged 18 to 24 years old indicated easy access to drugs and dealers at places they frequently passed, as factors that predisposed them to relapse. They were also more likely to be approached by dealers after treatment.
- Both male and female young African adults are faced with too many triggers after being released from treatment and it was interesting that females lack coping skills to effectively cope with the triggers they are exposed to after treatment. 18 to 24 years old mostly indicated that they were challenged by too many triggers together with the perceived lack of coping with these triggers.

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Considering the adaptation model, young African adults, especially those in the emerging adulthood phase, have difficulty adapting to the environment which is not a treatment centre.

- In relation to peer group influences, it is mainly the 18 to 24 years (emerging young adults) that is affected. Both male and female young African adults struggle to avoid social gathering places such as taverns, bars and clubs. They are faced with peer pressure to use again and are triggered to use drugs again by glamorising drug abuse in their peer groups. Mostly males are influenced by the thought that their social group is still abusing drugs and/or alcohol. Linked to peer group influence, males were also found to be more easily influenced by others than females.

- More female young African adults in the 18 to 24 year old age group seem to be affected by having limited access to services in their communities which the researcher links to poor service delivery such as housing, water, sanitation and electricity. This might be because females are more likely to need sanitation, because of bodily functions such as menstruation.

- More young male African adults are affected by the lack of recreational activities in their communities. More respondents in the young adulthood phase (25 to 38 years) are affected by the lack of recreational activities, but emerging young adults (18 to 24 years) were more likely to relapse because of boredom. Lack of recreational activities contributes to increased boredom which eventually results in relapse. Boredom was also found to cause more males to relapse.

- Both genders felt that stigmatisation by the community following treatment caused them to relapse. Respondents between 18 to 24 years felt more affected by stigmatisation. This age group also felt that they lost motivation to maintain their abstinence. Stigmatisation is degrading and it affects one's motivation and interest in maintaining abstinence. Both genders were also affected by losing motivation and commitment to maintain abstinence. Abstinence seems to become less attractive when faced with challenges that used to be coped with by using drugs.

- Lack of support following treatment is a significant cause of relapse amongst both male and female young African adults. Both age groups indicated that they lacked support required after treatment, but more so 18 to 24 years old. Relapse can be linked to lack of support following treatment.

- Both genders seem to feel as though they are more capable of coping with conflict when they are under the influence of drugs. Generally, the 18 to 24 age group felt that they could cope better with conflict when under the influence of drugs.

- With regard to employment, it was indicated that much more males compared to females seems to be experiencing difficulty in finding employment following treatment. The younger age group (18 to 24 years) reported having more difficulty in finding employment.

- The indication of dealing with emotions by using drugs was the most significant amongst females but both genders reported relapse because they experienced negative and/or euphoric emotional

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states. More young adults (25 to 38 years) indicated that the experience of negative and euphoric emotional states influenced them to relapse but it seems as though more emerging adults (18 to 24 years) think that they can deal with their emotions by using drugs. This is a certain indication that young African adults experience difficulty in coping with emotions.

- Loneliness amongst both genders was highly indicative as a predisposing relapse. Both age groups reported loneliness as a predisposing factor to relapse, but more so amongst the 18 to 24 years old. In conjunction with loneliness the lack of support and stigmatisation by community members following treatment for drug abuse was significant in that they increase the feeling of loneliness. As discussed before, peer pressure was also rated highly, indicating that young African adults (especially younger, 18 to 24 years) might end up going back to their peer groups to find a sense of belonging which compensates for the lack of belonging they feel in their families and communities.

- Coping skills when faced with stress is lacking amongst both genders, however, more amongst females. Emerging young adults (18 to 24 years) perceive that they lack effective coping mechanisms. Stress, however, affected more respondents aged 25 to 38 years. Drug abuse seems to be the central coping mechanism for young African adults (following treatment for drug abuse) when faced with stress. They recall memories of drugs being stress relievers which eventually give way to cravings. Cravings also being a strong predisposing factor to relapse amongst young African adults.

- More males than females reported that they experienced cravings which caused them to relapse. Mostly respondents aged 25 to 38 years indicated that they experienced cravings that lead to their relapse. According to literature (Doweiko, 2006:399) it is not a craving in itself that predisposes relapse but rather the triggers (drug use cues) that predispose the individual to drug use. It might be that young African adults are thus faced with more triggering factors that lead to cravings.

- Males and females reported that they lost commitment and motivation in maintaining abstinence. Abstinence might become less attractive when the young African adult is faced with challenges that were coped with in the past by using drugs.

- There was a noteworthy high reporting on the thought that drug use can be controlled after treatment by both genders; and especially amongst the younger age group (18 to 24 years). The thought of being able to control drug use eventually spirals into relapse.

- Mostly males indicated that their decision not to attend aftercare support services following treatment caused them to relapse. This, however, was not an important predisposing factor amongst females. Both age groups indicated that their decision not to attend aftercare support services predisposed them to relapse.

- Males are more likely to relapse because of physical pain compared to females. Mostly within the 25 to 38 year age group, physical pain was indicated as causing relapse. Even though females are more sensitive to physical pain, it was found in several studies that hormones assist females in tolerating higher levels of pain.

- Relationship problems were also indicated to be related to relapse.

- Not using the skills that they acquired during relapse was also indicative of relapse.

- Young African adults do not seem to be affected by the following predisposing factors to relapse at all: overcrowded living conditions; living in poverty stricken areas; feeling that their opportunities to be successful in South Africa is limited; feeling oppressed by other races; being presented with the opportunity to experiment with a new drug; change in marital status; lack of financial support; and change in employment status (finding employment or losing employment). Young African adults are only slightly affected by one or more family members abusing alcohol and/or drugs (especially males); not believing in one self; and financial problems (especially young adults aged 25 to 38 years).

4.4. CONCLUSIONS

Through the research study the researcher was able to identify the causes of relapse amongst male and female young African adults following in-patient treatment for drug abuse. The following conclusions can be made:

- Various factors, such as limited employment opportunities, availability and accessibility of drugs, lack of recreational activities, limited services, and stigmatisation, within the communities of young African adults make adapting to the environments outside a treatment centre difficult.

- Young African adults are functioning within environments that are not conducive to recovery. The availability and accessibility of drugs are evermore increasing within their communities.

- Limited access to services and poor service delivery within communities are affecting especially female young African adults.

- By not completing their education, young African adults are placing themselves at risk of struggling to find employment. Employment opportunities seem to decrease for those that are less educated.

- Drug abuse seems to become problematic after using drugs for eight months to a year and treatment is only sought after two to four years of drug abuse.

- Young African adults are lacking basic life skills (i.e., conflict management, stress management, coping skills and assertiveness) that if developed, drug abuse can be avoided. The ability to cope and deal with emotions, stress and conflict is lacking.

- Boredom is increased by the lack of recreational activities and difficulty in finding employment which eventually influence recovery. Due to the lack of recreational activities young African adults frequently spend more time with their peer groups resulting in drug experimentation or relapse.

- Lack of support and stigmatisation by community members can create a sense of loneliness and eventually cause the young African adult to feel less committed and motivated towards maintaining abstinence. Commitment and motivation to maintain abstinence eventually seem to fade during recovery.

- Loneliness can also cause the young African adults to seek comfort with their drug abusing peer group again.

- Cravings and the thought of being able to control drug use after treatment are causes for relapse amongst young African adults following in-patient treatment.

- Skills and knowledge gained during treatment are not being internalised during treatment which contributes to the skills not being applied once discharged from treatment.

- There is a lack of attendance of aftercare support services amongst young African adults, following in-patient treatment. This lack of attendance of aftercare can be associated with a lack of motivation to attend and making the intentional decision not to attend, but also to financial constraints that prohibit them to attend aftercare.

- Physical pain is more likely to relate to relapse amongst young male African adults.

- Emerging young adults (18 to 24 years old) are more likely to relapse than young adults (25 to 38 years old).

- Rehabilitation of people with drug abuse problems must be holistic and address not only the psychological developmental issues of the person but his or her environmental challenges as well (Benshoff & Janikowski, 2000:74), especially seeing that young African adults experience apparent difficulty in effectively adapting to their environments following in-patient treatment.

4.5. RECOMMENDATIONS

Based on the above key findings and conclusions, the recommendations from this study will be made. The recommendations are made to improve professional services delivered by treatment centres and aftercare services to young African adults, making service delivery more specific, in an attempt to prevent relapse amongst the target group. In addition, recommendations are made for future research.

The researcher makes the following recommendations:

4.5.1. Recommendations for treatment centres to improve service delivery to young African adults

- Considering that there is an apparent shortcoming of young African adults completing their education, treatment centres should assist in providing information and referrals to Adult-Based Educational Training (ABET institutions).

- Considering that peer group influence plays a significant role in initial drug experimentation and relapse there is a need for prevention programmes during adolescence in particular (12 to 18 years). Prevention programmes should be on the level of the audience – more audio-visual and making use of dramas and graphical images, which the audience can more easily relate to, in an attempt to prevent drug experimentation from a young age.

- Treatment should aim to divide service users according to their specific developmental phase (emerging adulthood, 18 to 24 years; young adulthood, 25 to 38 years; and adulthood 39 to 60 years) in order to make treatment more specific with regard to challenges faced by different age groups.

- During substance abuse treatment family members should be included in some group sessions with the recovering drug dependent with the aim of providing information on addiction and establishing sufficient and effective support for service users.

- Life skills should be developed during treatment, especially focusing on emotions, considering that there was a high indication of relapse because of the inability to cope effectively with emotions. Social workers in substance abuse treatment should assist the service users to develop emotional maturity by allowing them to feel, acknowledge and manage their emotions.

- The Department of Social Development, in conjunction with the Department of Public Works (e.g. Expanded Public Works Programme), should develop a programme where service users can be absorbed into a system that assists in the reintegration into society and employment opportunities. By being absorbed into training or labour, boredom can be prevented.

- During intervention the researcher would recommend that social workers do intervention from the eco-systems perspective and the adaptation model. It will assist the service user by understanding that his/her environment outside of the treatment did not necessarily change but that he/she as a person should have changed and should use the knowledge and skills gained during treatment to prevent relapse. Benshoff and Janikowski (2000:74) state that the "rehabilitation of people with substance abuse problems must be holistic and address not only the psychological developmental issues of the person but his or her environmental challenges as well." Referral social workers

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should aim to address challenges in the communities, such as stigmatisation through macro interventions, and referral to resources with regard to services.

- During treatment it does not seem as though service users are internalising information and skills provided to them, which prevents successful application thereof after discharge. Cognitive Behavioural Therapy (CBT) could be explored and used to guide therapy seeing that it allows people to practically focus on day-to-day life problems. In accordance with Buchanan (2005:73) CBT can assist with the understanding of behaviour as being a result of behavioural conditioning, combined with the thinking processes. Faulty thinking can make unacceptable behaviour more likely to occur. CBT consists of the acquisition and performance of coping skills used to manage high risks for substance abuse situations, and to enhance the service user's confidence in his or her ability to stay abstinent (Litt, Kadden & Kabela-Cormier, 2009:1837).

- Males and females indicated similarities and differences in the causes of relapse. Treatment programmes can be more specific for service users to benefit more from treatment by including the research findings in the treatment programmes of males and females. Possible guidelines for treatment programmes of males that can be included in current treatment programmes are:
  - ➢ Identifying environmental cues and ways of coping with them in order to avoid frequent cravings
  - ➢ Adequate ways to cope with cravings
  - ➢ Assertiveness training and refusal of drugs skills
  - ➢ The link between drug abuse, crime and gangsterism
  - ➢ Alternative ways of socialising other than going to pubs, bars and clubs.
  - ➢ Appropriate spending idle time
  - ➢ Develop awareness on stigmatisation by community and means to deal with it
  - ➢ Conflict management
  - ➢ Information on skills development workshops and support services in communities
  - ➢ Emotional awareness
  - ➢ Advise against controlled drug use and focus on measures to manage motivation and commitment to maintain abstinence
  - ➢ Benefits and importance of attending aftercare services
  - ➢ Alternatives to dealing with pain.

- Possible guidelines for treatment programmes of females that can be included in current treatment programmes are:
  - ➢ Risks associated with sex work and relationships with drug distributors

- Identifying environmental cues and ways of coping with them in order to avoid frequent cravings
- Adequate ways to cope with cravings
- Develop awareness on stigmatisation by community and to deal with it
- Conflict management
- Alternatives to socialising other than going to pubs, bars and clubs.
- Effective ways of dealing with emotions
- Stress management and coping skills
- Advise against controlled use and focus on ways to manage motivation and commitment to maintain abstinence.

4.5.2. Recommendations for aftercare (and reintegration) support services

- The researcher recommends that the Department of Social Development must be more thorough in monitoring aftercare services seeing that this service was indicated as being underutilised. Social workers in the field of substance abuse should be educated in aftercare services available and a structure for referral of service users should be developed to ensure utilisation of aftercare services. Social workers should be trained with the specific task of delivering aftercare services.

- The aftercare programme should include the development of coping skills and basic life skills such as stress management, conflict management, assertiveness, effective dealing with emotions and problem-solving.

- The family should also be requested to be involved in aftercare services in order to establish support.

- Currently there is a structured guideline for delivering aftercare, which is formulated by the Department of Social Development (2013). This guideline presents structured discussion sessions for adults. It is furthermore recommended that a structured outline is also provided to focus on young African adults.

- The causes of relapse that were found to be significant in this study can be used as an assessment tool during the assessment phase of aftercare, where service users can indicate whether they relate to specific causes of relapse. To assist during the planning phase the indicated predisposing factors should be prioritised in accordance to which factors influence them most. Following the stage of prioritising relapse risks, aftercare plans can be developed to address each risk in order to prevent relapse.

- Aftercare programmes should also provide service users with different recreational activities in an attempt to minimise idle time and boredom.

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- The Department of Social Development should be responsible to develop a referral guideline booklet that captures all aftercare services and support groups available for service users after recovery.

- Barriers that contribute to the non-attendance of aftercare should be addressed by the service deliverers in order to promote attendance amongst service users.

4.5.2. Recommendations for future research

- There is a need for research amongst social workers and other stakeholders that are involved in substance abuse treatment, with regard to reluctance in providing aftercare services in the communities. By identifying the factors or barriers that hinder aftercare from happening the way it is proposed, the ignorance, or logistical problems, with regard to aftercare can be addressed.

- The aim of substance abuse treatment is to assist the service user in relapse prevention. The effects of including skills development programmes in substance abuse programmes should be researched to explore whether skills development might improve treatment outcomes.

- There is a need to identify the factors that hinder efficient family support to recovering drug abusers in order for these factors to be addressed and in turn improve family support.

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Annexure A: Ethical clearance from the Research Ethics Committee of the Faculty of Humanities at the University of Pretoria

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Research Ethics Committee

15 November 2013

Dear Prof Lombard

Project:	**Cause of relapse amongst young African adults following in-patient treatment for drug abuse in the Gauteng Province**
Researcher:	**I Swanepoel**
Supervisor:	**Dr LS Geyer**
Department:	**Social Work and Criminology**
Reference numbers:	**26102766**

Thank you for your response to the Committee's letter of 1 July 2013.

I am pleased to be able to tell you that the above application was **approved** by the **Research Ethics Committee** on 15 November 2013. Data collection may therefore commence.

Please note that this approval is based on the assumption that the research will be carried out along the lines laid out in the proposal. Should the actual research depart significantly from the proposed research, it will be necessary to apply for a new research approval and ethical clearance.

The Committee requests you to convey this approval to the researcher.

We wish you success with the project.

Sincerely

Prof Karen Harris
Acting Chair: Postgraduate Committee &
Research Ethics Committee
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail: Karen Harris@up.ac.za

Research Ethics Committee Members: Dr L Biokland; Prof M-H Coetzee; Dr JEH Grobler; Prof KL Harris; Ms H Klopper; Dr S Molapo; Dr C Panebianco-Warrens; Dr T Simpson; Prof GM Spies; Prof E Taljard ; Dr FG Wolmarans, Dr P Wood

Annexure B: Permission letter requesting to conduct research at treatment centres in Gauteng

Researcher:	Ilze Swanepoel
Tel. Number:	074 441 9328 (Mobile)
	(012) 734 8349 (Work)
E-mail address:	Ilze.swanepoel@gauteng.gov.za

Date: _____

For attention: _____

Re: Research on the causes of relapse amongst young African adults following in-patient treatment for drug abuse in the Gauteng Province.

I, Ilze Swanepoel, the undersigned, am a Social Worker in service of the Department of Social Development at Dr Fabian and Florence Ribeiro Treatment Centre, and also a part-time master's degree student at the Department of Social Work and Criminology at the University of Pretoria. In fulfilment of the partial requirements for the master's degree, I have to undertake a research project and have consequently identified a need to investigate the following research topic: *The causes of relapse amongst young African adults following in-patient treatment for drug abuse in the Gauteng Province*. The goal of the study is to determine the causes of relapse amongst young African adults following in-patient treatment for drug abuse in the Gauteng Province. This research project originated as a result of my observation in practice, in particular, I have noticed that a considerable number of young African adults are admitted for in-patient treatment for their second or third time. There is a definite relapse rate amongst young African adults. The information gathered can be used to formulate guidelines for relapse prevention programmes and aftercare programmes, which are more applicable within the South African context. A copy of the research proposal will also accompany this letter in order to familiarise you with the proposed study.

I request your treatment centre's permission to conduct research with your patients because they are the best informed to speak authoritatively about the topic. I hereby request you to allow me access to your patients, in this study. The decision to participate in this research project is voluntarily. Your patients that qualify to participate in this study based on the criteria will be expected to complete a questionnaire. The patients that I would like to include as part of this research project should comply with the following criteria for inclusion: 1) Male and female young African Adult, aged 20 to 39 years, addicted to illicit drugs, 2) who previously underwent in-patient treatment of 6-12 weeks, 3) relapsed after previous treatment, 4) is currently receiving in-patient treatment at a in-patient treatment centre in Gauteng, 5) English-speaking and literate.

There are no risks and benefits involved by participating in this research project. If, however, debriefing is required after participation in this study it will be provided. Patients might experience some emotional distress while answering the questionnaire, if distress is experienced, the researcher will be available to provide counseling. If further counseling is required, the patient will be referred by the researcher for a debriefing session with a suitable qualified counselor. The counselor that will be

assisting me in debriefing of the patients is Mrs. Desire de Vries, a qualified Principle Social Worker employed in the Department of Social Development. She will attend to those patients needing debriefing at your centre and there is thus no need for travelling on your behalf.

The questionnaires will be kept strictly confidential. Neither, the patient's name, nor the treatment centre's name will appear on the questionnaire, so as to protect identity. The questionnaires will be stored in a safe place and only I will have access to them. The questionnaires will be made available to my research promoter and the statists with the sole purpose of assisting and guiding me with data capturing and statistical analyses. They will also sign an undertaking to treat the information shared by the patient in a confidential manner.

Should you agree to participate, your patients would be requested to participate in answering a questionnaire. The questionnaire will not take more than 40 minutes to complete. I will be available while the patients answer the questionnaire to assist in any queries. The proposed date for the undertaking of the questionnaires is during April 2013 and May 2013. This will be confirmed with your Centre well in advance.

If you have any questions or concerns about the study, feel free to contact me at the following number: 074 441 9328 or during office hours 012 734 8349.

If you are willing to allow your patients to be involved in the study please sign the form below that acknowledges that you have read the explanatory statement, that you understand the nature of the study being conducted, and that you give permission for the research to be conducted at your treatment centre.

Based upon all the information provided to you above, I would like to ask for your assistance to introduce me to your patients who comply with the criteria for inclusion stated above in view of participation in this study.

Annexure C: Permission letter to conduct research study at Wedge Gardens

I [Name: Mrs Adél Grobbelaar] as [Role Title: Complex Manager] of
[Treatment Centre Name: Wedge Gardens] having fully been informed as to
the nature of the research, give my permission for the study to be conducted. I reserve the right to
withdraw this permission at anytime.

Signature: _____   Date: 29/1/2013 .

WEDGE GARDENS TREATMENT CENTRE
RAND AID ASSOCIATION
P.O. BOX 891481
LYNDHURST
2106
TEL: (011) 430-0320

Annexure D: Permission letter to conduct research study at SANCA Horizon

I [Name: ___Sandra Pretorius___] as [Role Title: ___Director___] of
[Treatment Centre Name: ___SANCA Horizon centre Boksburg.___] having fully been informed as to
the nature of the research, give my permission for the study to be conducted. I reserve the right to
withdraw this permission at anytime.

Signature: ___Pretorius___   Date: ___6|3|2013___

HORIZON KLINIEK-ALKOHOL & DWELM SENTRUM
HORIZON CLINIC ALCOHOL & DRUG CENTRE
17 NORTH STREET
P.O. BOX 195, BOKSBURG, 1460
TEL: 011 917-5015 FAX: 011 917-1106

Annexure E: Permission letter to conduct research study at House of Mercy

I [Name: MONICA MASHIANE] as [Role Title: DIRECTOR] of [Treatment Centre Name: HOUSE OF MERCY.] having fully been informed as to the nature of the research, give my permission for the study to be conducted. I reserve the right to withdraw this permission at anytime.

Signature: _____ Date: 13/09/2013

House of Mercy
P.O. Box 1900, 1460, Boksburg
Tel: 011 894-4050/2
Fax: 011 894 8259

Annexure F: Permission letter to conduct research study at Dr Fabian and Florence Ribeiro Treatment Centre

I [Name: Desiree De Unés] as [Role Title: Head of Institution] of [Treatment Centre Name: Dr Fabian Florence Ribeiro] having fully been informed as to the nature of the research, give my permission for the study to be conducted. I reserve the right to withdraw this permission at anytime.
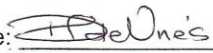
Signature: DeUnés

Date: 27.02.2013

DEPT. OF SOCIAL DEVELOPMENT
DR. FABIAN AND
FLORENCE RIBEIRO CENTRE

2013 -07- 0 5

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Annexure G: Informed consent

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities

Department of Social Work & Criminology

Researcher:	Ilze Swanepoel
Tel. Number:	074 441 9328 (Mobile)
	012 734 8349 (Work)

Participant's name: ……………………………………………………………………………………

INFORMED CONSENT

1. **Title of research project:** Causes of relapse amongst young African adults following in-patient treatment for drug abuse in the Gauteng Province.

2. **Purpose of the study:** The purpose of the study is to determine the causes of relapse amongst young African adults following in-patient treatment for drug abuse in the Gauteng Province.
The information gathered will be used to formulate guidelines for relapse prevention programmes and aftercare programmes, which are more appropriate for the South African context.

3. **Procedures:** I understand that I will be asked to complete a single questionnaire. Should I have any questions whilst answering the questionnaire, I can request assistance and clarification from the researcher.

4. **Risks and discomforts:** There are no known risks and discomforts associated with this study, although I might experience some emotional distress while answering the questionnaire. If I experience distress, I will inform the researcher. I expect the researcher then to be available to provide me counselling. If further counselling is required by me, I will be referred by the researcher for a debriefing session with a suitable qualified counsellor.

5. **Benefits:** I understand that there are no direct benefits for me participating in this study. The results of the study will, however, assist the researcher to gain a better understanding of the

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causes of relapse amongst young African adults in order to inform improved relapse prevention and aftercare programmes.

6. **Participant's rights:** I may withdraw from participating in the study at any time.

7. **Financial compensation:** I will receive no financial compensation from the researcher for my participation in the study.

8. **Confidentiality:** I understand that all information which is collected from me will be kept confidential. However, I give my permission that information collected from me may be used for research and publication; both in South Africa and other countries, but that my identity will not be revealed unless required by law.

9. **Data storage:** I understand that all raw data will be stored for a period of 15 years in the Department of Social Work and Criminology at the University of Pretoria.

10. If I have any concerns about this study or my participation in it I am free to contact the researcher, Ilze Swanepoel, at 074 441 9328.

11. I understand my rights as a research participant and I voluntarily consent to participate in the study. I understand what the study is about, and how and why it is being conducted.

I will receive a signed copy of this consent form.

_____   _____

Signature of Participant   Date

_____   _____

Signature of Researcher   Date

Annexure H: Questionnaire

CAUSES OF RELAPSE IN YOUNG ADULTS FOLLOWING TREATMENT FOR DRUG ABUSE PROBLEMS

Dear Respondent

My name is Ilze Swanepoel and I am a post-graduate student in the Department of Social Work and Criminology in the Faculty of Humanities at the University of Pretoria working under the direction of Dr L. S. Geyer.

I am busy with a Master's Degree in Social Work in the field of Health Care and specifically I am attempting to determine the causes of relapse seen amongst young African adults in the Gauteng Province following in-patient treatment for drug abuse.

You are requested to participate in my research by filling out the following questionnaire. The information gathered we trust will assist in relapse prevention and aftercare services being more specific and based on your needs.

Thank you for your time and co-operation in filling out the questionnaire. Please be aware that absolutely no attempt will be made to identify you personally or couple your answers to you personally. The information supplied by you will be treated with the utmost confidentiality and will be bulked with the answers supplied by other respondents to enable statistical data processing to be conducted at the Department of Statistics at the University of Pretoria.

Thank you

Ms Ilze Swanepoel

The Questionnaire follows on the next page ...

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QUESTIONNAIRE: CAUSES OF RELAPSE IN YOUNG ADULTS FOLLOWING TREATMENT FOR DRUG ABUSE PROBLEMS

Respondent number

V0

Please answer the questions by circling an appropriate number in a shaded box or by writing your answer in the shaded space provided,

SECTION A   Biographical Information

1. What is your **gender**?

Male	1
Female	2

V1

2. What is your **First Language**?

IsiZulu	1
IsiXhosa	2
Afrikaans	3
Sepedi	4
Setswana	5
Sesotho	6
Swati	7
Xitsonga	8
Tshivenda	9
IsiNdebele	10
English	11
Other (please specify):	

V2

3. What is your **date of birth**?   (*Please use dd/mm/yyyy*)

V3

4. What is your **highest** level of completed **education**?

Grade 4 to Grade 7	1
Grade 8 to Grade 9	2
Grade 10 to Grade 11	3
Matriculated	4
Tertiary education (e.g. FET, Tech, University)	5

V4

Question 5   **follows on the next page ...**

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5.   What is your **employment status**?   (*Please indicate a single answer*)

Employed (incl. self-employed)	**1**	V5
Part-time employed	**2**	
Unemployed	**3**	
Retrenched	**4**	
Suspended	**5**	
Full time student	**6**	
Part-time student	**7**	

6.   What is your **income** per month (including grants or pocket money)?

V6

7.   What is your **source** of income?

V7

8.   What is your **marital status**?

Single	**1**	V8
Married	**2**	
Divorced	**3**	
Widow/Widower	**4**	
Separated	**5**	
Co-habiting (living with a partner)	**6**	

9.   Number of people **living** in the house?

V9

SECTION B   follows on the next page...

SECTION B   Perceptions, views and experiences related to drug abuse

The questions in this section ask about your substance abuse history, rehabilitation and relapse

10.   What is (are) your **drug** (drugs) of **choice** and **frequency** of use?

Drug of choice	Once per day	More than 3 X per day	1 to 3 X per week	4 or more X per week		
Heroin ("smack", "H", "skag", "junk")	1	2	3	4	V10a	
Heroin and dagga mix ("*Nyaope*")	1	2	3	4	V10b	
Marijuana ("dagga", "ganja", "grass", "boom", "pot", "weed")	1	2	3	4	V10c	
Mandrax ("mandies", "buttons", "white pipe")	1	2	3	4	V10d	
Mandrax and dagga mix	1	2	3	4	V10e	
Cocaine ("blow", "coke", "freeze", "snow", "sugar", "white powder")	1	2	3	4	V10f	
Crack – smokable form of cocaine ("rock", "stones")	1	2	3	4	V10g	
Cat ("kit kat", "special K")	1	2	3	4	V10h	
Khat (the leave)	1	2	3	4	V10i	
Ecstasy ("E", "love drug", "X", "XTC")	1	2	3	4	V10j	
Crystal Meth ("Tik", "crank", "crystal", "speed")	1	2	3	4	V10k	
LSD ("acid", "black star", "microdot", "paper acid", "superman")	1	2	3	4	V10l	
Other (please specify):	1	2	3	4	V10m	
					V10n	

11.   At what **age** did you **start experimenting** with drugs?

	V11	

Please read the following statements carefully and rank each of them as honestly as possible on the scale provided.

12.   I started **experimenting** with drugs **because**....

	Strongly disagree	Disagree	Agree	Strongly agree		
my peer group introduced me to drugs	1	2	3	4	V12a	
a friend introduced me to drugs	1	2	3	4	V12b	
of my curiosity	1	2	3	4	V12c	
I was looking for excitement	1	2	3	4	V12d	
I heard it will help me cope with stress	1	2	3	4	V12e	
I heard it will help me to cope with my emotions	1	2	3	4	V12f	
I observed its effects on my friends	1	2	3	4	V12g	
I observed its effects on my family members	1	2	3	4	V12h	

Question 13   follows on the next page …

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13. In the space below please indicate other **causes** leading to your **experimentation** with drugs. (*Please do not mention more then three causes*)

	V13a
	V13b
	V13c

14. After initially experimenting with a drug, **after what time** did your drug abuse became **problematic**? (*Please select a single answer*)

First to second week	**1**	V14
Third week to a month	**2**	
After a month to 2 months	**3**	
After 2 to 4 months	**4**	
After 4 to 6 months	**5**	
After 6 to 8 months	**6**	
After 8 months to a year (12 months)	**7**	

15. After what passage of **time** did you **seek help** for your drug abuse? (*Please select a single answer*)

First to second week	**1**	V15
Third week to a month	**2**	
2 – 6 months	**3**	
After 6 – 12 months	**4**	
After 1 year to 2 years	**5**	
After 2 – 3 years	**6**	
After 3 – 4 years	**7**	
After 4 – 5 years	**8**	
After 5 – 6 years	**9**	
After 6 years and more	**10**	

16. Please indicate the possible **abuse** of substances by your **family** members

	Not applicable	Alcohol	Illicit drugs	
Mother	**1**	**2**	**3**	V16a
Father	**1**	**2**	**3**	V16b
Siblings	**1**	**2**	**3**	V16c
Aunt or Uncle	**1**	**2**	**3**	V16d
Nephew or Niece	**1**	**2**	**3**	V16e
Grandparents	**1**	**2**	**3**	V16f

Question 17 follows on the next page ...

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17.   Which of the following does your **social** group abuse?

Not applicable	**1**	V17
Alcohol	**2**	
Illicit drugs	**3**	

SECTION C   *Perceptions, views and experiences regarding drug abuse treatment*

18.   How many **previous** admissions, to a treatment centre, have you had?

	V18

19.   Where did you **receive** your *FIRST TREATMENT* for drug abuse?
(*Please select a single answer*)

A private rehabilitation centre	**1**	V19
A governmental treatment centre	**2**	
A governmental hospital	**3**	
A private hospital	**4**	
A church facility	**5**	
Other (please specify):		

20.   Who **funded** your *FIRST TREATMENT* for drug abuse?
(*Please select a single answer*)

Medical aid	**1**	V20
My employer	**2**	
My family	**3**	
Myself	**4**	
Church	**5**	
Government	**6**	
Other (please specify):		

21.   Who **referred** you to the treatment centre for your *FIRST TREATMENT* for drug abuse?   (*Please select a single answer*)

Friends	**1**	V21
Family	**2**	
Court	**3**	
Welfare organisation/NGO/CBO	**4**	
Employer	**5**	
School	**6**	
Church	**7**	
Other (please specify):		

Question 22   follows on the next page ...

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22. Did you **complete** your previous **treatment** for drug abuse in full?

Yes	**1**
No	**2**

V22 [ ]

23. If you answered "**No**" to *Question 22*, in the space below, please indicate no more than three reasons for not completing your previous drug treatment programme.   (*Please do not mention more then three reasons*)

V23a [ ]

V23b [ ]

V23c [ ]

24. What was the **length** of time of your **previous** drug **treatment**? (**Weeks**)

V24 [ ]

25. How did you **experience** the **aftercare** service?
(*Please indicate only what was applicable to you*)

I did not attend any aftercare	**1**	V25a
I had a lack of financial means to be able to attend aftercare	**2**	V25b
I had no transport available to be able to attend aftercare	**3**	V25c
I had a lack of knowledge about aftercare services	**4**	V25d
I was not referred to aftercare	**5**	V25e
There is no aftercare services provided in my area of residence	**6**	V25f
I had no family support to enable me to attend aftercare	**7**	V25g
Lack of motivation to attend aftercare	**8**	V25h

SECTION D   *Perceptions, views and experiences related to relapse.*

Please read the following statements carefully and rank each of them on a scale of "1" to "4", with "1" indicating "Strongly disagree", "2" indicating "Disagree", "3" indicating "Agree" and "4" indicating "Strongly agree". Please provide your honest rating to each statement.

26. I **relapsed** because....

	Strongly disagree	Disagree	Agree	Strongly agree	
I have easy access to drugs	1	2	3	4	V26a
I live in a poverty stricken area	1	2	3	4	V26b
I have limited access to services in my community	1	2	3	4	V26c
my opportunities to be successful is limited in South Africa	1	2	3	4	V26d
there is a lack of recreational activities in my community to keep me busy	1	2	3	4	V26e
drug dealers are at places I frequently have to pass	1	2	3	4	V26f

SECTION D   continues on the next page

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SECTION D (cont.)   Perceptions,views and experiences related to relapse.
Please read the following statements carefully and rank each of them on a scale of "1" to "4", with "1" indicating "Strongly disagree", "2" indicating "Disagree", "3" indicating "Agree" and "4" indicating "Strongly agree". Please provide your honest rating to each statement.

26. (cont.)   I **relapsed** because....

	Strongly disagree	Disagree	Agree	Strongly agree		
of overcrowded living conditions	1	2	3	4	V26g	
I found it difficult to avoid social gathering places (e.g. taverns, pubs, clubs, etc.)	1	2	3	4	V26h	
community members still look down on me for using drugs	1	2	3	4	V26i	
of pressure from my peer group	1	2	3	4	V26j	
of pressure from a friend to use again	1	2	3	4	V26k	
I am easily influenced by others	1	2	3	4	V26l	
I lacked support needed after treatment	1	2	3	4	V26m	
I thought I could deal better with conflict when I use drugs	1	2	3	4	V26n	
I was presented with the opportunity to experiment with a new drug	1	2	3	4	V26o	
I find it difficult to find a job	1	2	3	4	V26p	
There was a change in my marital status (e.g. I got divorced, got married, lost a partner, etc)	1	2	3	4	V26q	
a significant relationship in my life ended	1	2	3	4	V26r	
one or more of my family members abuses drugs or alcohol	1	2	3	4	V26s	
my social group still abuse drugs and/or alcohol	1	2	3	4	V26t	
in my peer group we glamorised or idealised drug abuse	1	2	3	4	V26u	
I found it difficult to avoid social gatherings	1	2	3	4	V26v	
I was approached by my dealer after treatment	1	2	3	4	V26w	
I experienced a stressful life event (e.g. losing a job, being diagnosed with an illness, etc.)	1	2	3	4	V26x	
I lack effective coping mechanisms	1	2	3	4	V26y	
I started to feel less committed towards staying clean/sober	1	2	3	4	V26z	
I lost my motivation to stay clean/sober	1	2	3	4	V26aa	
I had a craving for alcohol/drugs	1	2	3	4	V26ab	
I was challenged with too many triggers	1	2	3	4	V26ac	
I lacked the ability to cope with triggers	1	2	3	4	V26ad	
I don't believe in myself	1	2	3	4	V26ae	
I experienced negative emotional states (feelings of depression or anxiety)	1	2	3	4	V26af	
I experienced euphoric states (feelings of happiness, excited, optimistic)	1	2	3	4	V26ag	
I thought I could deal with my emotions by using drugs	1	2	3	4	V26ah	
there was a change in my employment status (I found a job, lost a job, was promoted, etc.)	1	2	3	4	V26ai	
I thought that this time I would be able to control my use	1	2	3	4	V26aj	
I decided not to attend after care support groups after my discharge from treatment	1	2	3	4	V26ak	
I experienced physical pain	1	2	3	4	V26al	
I feel oppressed by other races	1	2	3	4	V26am	
I had financial problems	1	2	3	4	V26an	

SECTION D   continues on the next page ..

SECTION D (cont.)   *Perceptions, views and experiences related to relapse.*

Please read the following statements carefully and rank each of them on a scale of "1" to "4", with "1" indicating "Strongly disagree", "2" indicating "Disagree", "3" indicating "Agree" and "4" indicating "Strongly agree". Please provide your honest rating to each statement.

26. (cont.)   I relapsed because....

	Strongly disagree	Disagree	Agree	Strongly agree		
I lacked financial support	1	2	3	4	V26ao	
I had money available to me to use according to my will	1	2	3	4	V26ap	
I felt lonely	1	2	3	4	V26aq	
I was bored	1	2	3	4	V26ar	

27.   Please indicate, in the space below, no more than three causes for your relapse. (*Please do not mention more then three causes*)

	V27a	
	V27b	
	V27c	

28.   Do you feel confident that you will be able to maintain abstinence from drug usage after your current treatment for drug abuse?

Yes	1	V28
No	2	
I am uncertain	3	

29.   Please indicate, in the space below, no more than three reasons for your answer to *Question 28*. (*Please do not mention more then three causes*)

	V29a	
	V29b	
	V29c	

Thank you for your time and co-operation

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