CANNABIS ABUSE: A PHENOMENOLOGICAL STUDY OF THE CAUSATIVE FACTORS AS PERCEIVED BY PATIENTS WITH A HISTORY OF CANNABIS USE, ADMITTED AT BOPHELONG PSYCHIATRIC HOSPITAL IN THE NORTH WEST PROVINCE

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DECLARATION

I declare that this dissertation for the degree of Master of Social Science in Clinical Psychology at the North West University; Mafikeng Campus hereby submitted, has not been previously submitted by me for a degree at this or any other university. This is my own work in design and execution; and all the material contained herein has been duly acknowledged.

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B.S.P. Ramphomane

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TABLE OF CONTENTS

		PAGE
DECLARATION		ii
ACKNOWLEDGEMENTS		iii-iv
TABLE OF CONTENTS		v-vii
ABSTRACT		viii
CHAPTER 1	**ORIENTATION**	
1.1	Introduction	1-5
1.2	Problem Statement	5
1.3	Objectives Of The Study	5
1.4	Significance Of The Study	5-6
CHAPTER 2	**LITERATURE REVIEW**	
2.1	Introduction	7-8
2.2	Factors associated with Cannabis Abuse	8-13
2.3	Summary for the reasons for drug taking	13-14
2.4	Adolescence	15-16
2.5	Adolescence and Drug Abuse	16-17
2.6	Theoretical Perspective on drug abuse	17-19

CHAPTER 3	**RESEARCH METHODOLOGY**		
	3.1	Research Design	20
	3.2	Research Sample	20-21
	3.3	Research Process	21
	3.4	Data Collection Method	21-22
	3.5	Data Analysis Method	22
CHAPTER 4	**RESULTS**		
	4.1	Introduction	23
	4.2	Mental Status Examination	23-24
	4.3	Socio-Demographic Information	24-25
	4.4	Drug Use Information	25-27
	4.5	Family Environment	28
	4.6	Parental Control and Support	28
CHAPTER 5	**DISCUSSION OF RESEARCH RESULTS**		29-33
CHAPTER 6	**CONCLUSION AND RECOMMENDATIONS**		
	6.1	Conclusion	34
	6.2	Recommendations	34-43
	6.3	Limitations	43-44
	6.2	Publication	44

REFERENCES 45-49

APPENDICES

APPENDIX A 50

APPENDIX B 51-53

APPENDIX C

ABSTRACT

A phenomenological study was carried out to find out from patients with a history of cannabis use, admitted at Bophelong Psychiatric Hospital, reasons or factors that caused them to use/abuse cannabis.

An original sample of 30 male patients between the ages of 16-30 years was selected from chronic (rehabilitation) wards of mentally stable patients awaiting discharge. Out of the 30 subjects, 10 protocols were selected for phenomenological explication. An unstructured type of interview was conducted to aid data collection.

According to the data obtained and analysed, youth drug taking is being influenced by peer pressure, the need to escape from reality problems, the need for cognitive enhancement, the desire for improved self-confidence and modelling of parental drug behaviour.

Other significant associated findings were that adolescents who come from single-parent families and low socio-economic status backgrounds are at a high risk of developing cannabis use problems. Male gender was also shown to be a predictive factor towards the abuse of cannabis.

Finally, there is an ongoing need to identify causative and curative factors of adolescent drug use in an effort to reduce this tremendous loss of our resources, particularly the youth. Therefore, in the development of suitable programmes for assessment, treatment, rehabilitation and prevention, it is important not to emphasise any one particular factor as the main and only cause of drug abuse, but to view the different reasons and factors as related to and interacting with one another and forming part of a bigger whole.

CHAPTER 1

ORIENTATION

1.1 INTRODUCTION

A lot of studies on the use of cannabis also known as dagga or marijuana have been conducted in urban settings, especially in western countries (Chabrol, Massot & Mullet, 2004; Salem, Zimmeman & Notaro, 1998; Fergusson, Horwod, Swain-Campell, 2000; Hofler et al., 1999). Few of these studies have been conducted in South Africa, but mainly in urban and semi-urban settlements (De Miranda, 1987).

The present study will attempt to understand the use of cannabis from the perspective of psychiatric patients who are awaiting discharge, who are mainly from a largely rural context characterised by low socio-economic status. There are many challenges facing individuals from rural areas, therefore the study will attempt to find out if the factors associated with cannabis use are similar.

Cannabis is South Africa's commonest illegal hallucinogenic drug of abuse, abused by all population groups (De Miranda, 1987). The young mostly abuse it, but a number of adults have become cannabis smokers over the years. It is obtained from the dried flowering tops and leaves of the plant *Cannabis sativa*. It may range in colour from greyish-green to greenish-brown. Its active intoxicating substance is known as *9-delta-tetrahydro-cannabinol (THC)*, which varies in strength from one to ten percent concentration. In addition more than 60 other chemical compounds found in the cannabis plant, are known as cannabinoids.

Cannabis grows extensively throughout the world in hot temperate climates. In South Africa it grows abundantly in Natal, Transkei, Swaziland and the Drakensberg region. It is usually smoked in homemade or hand-rolled cigarettes. At times it is taken by mouth in the form of cannabis cookies. Its negative effects on physical and psychological health are wide ranging. Also alarming is its potential as a "gateway drug" leading to experimentation with, and addiction to, "hard" drugs such as heroine and cocaine (http://www.icon.co.za/-wraggs/essays/dagga.htp).

Chronic cannabis abuse leads to a general deterioration of physical, mental and social well-being (De Miranda, 1987). There is a marked attitude of indifference, disinterest in life in general and social alienation. There is also lack of purpose and lack of motivational drive, which leads to discontinuation of studies and unemployment. Lifestyles become socially unacceptable and dishonest methods of maintaining an income are rife (theft, prostitution and drug "pushing").

Acute cannabis intoxication (often referred to as being stoned) manifests itself by a feeling of relaxation and well-being. There is a distortion of perception such as time, distance and body image. Inappropriate laughter (giggling) and a distortion of the various senses occur (greater intensity of colours, noise, light and music are often described). The attention span is diminished and there is an impairment of co-ordinated fine movements. An increased pulse and heart rate, some dilation of the eye pupil and dryness of the mouth are experienced. A common feature is congestion of the conjuctiva (redness of the eye), (De Miranda, 1987).

In cases of severe intoxication, acute hallucinations occur. There is marked thought disturbance and paranoid delusions (thoughts of being persecuted), which can lead to severe anxiety and panic states. Feelings of depersonalisation, i.e. the feeling that parts of hands, arms or legs are not attached to the body anymore can also be experienced. *Severe intoxication of this nature may precipitate an acute cannabis psychosis, often*

indistiguishable from acute schizophrenia, and may require hospitalisation (De Miranda, 1987).

One of the goals of this study is to determine the reasons or factors associated with the abuse of cannabis. However, reasons why young people abuse illicit drugs vary. A number of factors may help to account for drug use, including the drug experience itself, the need to appear daring or adult, and the influences of friends and family members.

Previous studies conducted on what triggers young people to take drugs, have found different and in some cases common causative factors. For example, in a longitudinal study by McGee et al. (2000), which was examining the nature of the association between cannabis use and mental health, it was reflected that socio-economic disadvantaged backgrounds, behaviour problems experienced in early school years and low levels of parental attachment in adolescence have a predictive value on the use of cannabis.

Personal, social, and family factors each play a role in adolescents beginning and continuing to use drugs. Some researchers place particular emphasis on peer influences (Sarvell & McClendon, 1988 in Weiner, 1992 & Swaim, Oetting, Edward, & Beauvais, 1989 in Chassin et al. 1993), others are particularly attentive to parental influence (Johnson et. al., 1984 in Weiner 1992) and others stress the role that personal and psychological factors may play in promoting progressive drug involvement (Block *et. al.,* 1988) in (Weiner, 1992).

Gillis (1994), for example, maintains that a desire for acceptance by the peer group has emerged as a salient causal factor in a number of studies. Adolescents have an increasing need to confirm their normality by ' being with it ' in a sense of participating in whatever their friends do. The early stages of drinking and cannabis smoking almost always take place as part of a group activity. Similarly, Weiner (1992) regards peer influence as a social disposition on using drugs. Drug-using peers can influence initial and continuing drug use by modelling it, and by helping to make drugs available.

As for family factors, research findings indicate that parents are likely to influence the drug–taking behaviour of their children by the example they set with their own behaviour and by the climate they create in their home. With respect to modelling, drug taking among young people has found to be directly related to whether and how frequently their parents take drugs (Weiner, 1992). Research further demonstrates that not only is parent drug use behaviour important in shaping adolescent behaviour, but that parental attitudes (that is parental approval/disapproval) regarding drug use will also be related to adolescent drug use (Jones and Heaven, 1988) in (Weiner, 1992).

Regarding climate in the home, psychologically unstable and unconventional parents who are preoccupied with their own affairs, disinterested in their children, and given to permissive or authoritarian forms of discipline are relatively likely to have adolescent youngsters who become involved with drugs. Conversely, well adjusted parents who maintain a well-organised household, nurture and communicate with their children, set and enforce limits in a democratic fashion are relatively unlikely to have offspring who become regular or continuing users of drugs (Barnes, 1984; Brook *et. al;* 1986; Jurich, Polson, Jurich, & Bates, 1985; McDermott, 1984; Shelder & Block, 1990) in (Weiner, 1992).

A study on cannabis use by adolescents found that it is used as a means of escaping from real-world problems and relieving stress and that it reinforces the subject's unwillingness to face these problems (Dusek & Girdano, 1993). Similarly, Gillis (1994) states that the fascination that draws young people to drugs is a progressive need to relieve anxiety or boost self-confidence, when other methods of coping prove inadequate.

In his study on diversity on drug use determinants, Gelfand *et.al* (1988) have come up with the following as correlates of adolescent drug use; curiosity, expectation of positive consequences from drug use, anticipation of adulthood, modelling of the use of alcohol, tobacco, and psychoactive drugs, permissive discipline and friends who are drug users.

Many of the forgoing studies were conducted in the United States and under different social conditions compared to South Africa. The present study is conducted with a view to understand the reasons for cannabis use by the youth from rural areas, characterised by low socio-economic backgrounds, as most of the South African studies on drug abuse were mainly focused on urban and semi-urban settlements. The use of drugs in rural areas has been neglected.

1.2. PROBLEM STATEMENT

Throughout the researcher's internship period at Bophelong Psychiatric Hospital, she became increasingly aware that most of the young male patients, admitted with a psychotic clinical picture, had a history of cannabis abuse. Most of these patients are largely from rural backgrounds with low socio-economic statuses. Therefore, this study will explore the reasons or factors associated with cannabis abuse as perceived by patients themselves.

1.3. OBJECTIVES OF THE STUDY

The primary aim of this study is to determine the reasons or factors associated with cannabis abuse as perceived by the patients themselves, especially from a largely rural environment characterised by low socio-economic status.

1.4. SIGNIFICANCE OF THE STUDY

Currently, a large percentage of young persons who come to the attention of mental health professionals are having problems controlling the use of alcohol and drugs, and frequently, substance abuse is the primary presenting problem (Weiner, 1992). According to the researcher's observation, the majority of the patients admitted at Bophelong Psychiatric Hospital present with the history of cannabis abuse. Statistics obtained from the hospitals' information office reflected about 70% of such cases in 2001.

The present study is therefore significant as it endeavours to understand the factors or reasons associated with the use of cannabis. It is also significant in providing information that might be helpful in the development of suitable and appropriate programmes for the treatment, rehabilitation and prevention of the abuse of substances.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

Drug abuse has become a significant problem of concern in society affecting both young (if not younger) and older people. It is defined by Gillis (1994), as the excessive use of a chemical substance, which results in the impairment of individual's physical, mental or emotional state of well-being. Searll (1989) and Bucher (1976), similarly defines drug abuse as the excessive or addictive use of mood-altering drugs for non-medical purposes with the intent of getting "high" – altering mood or behaviour. The definition for cannabis abuse holds the same.

Across epidemiological studies there is agreement that drug abuse is widespread among adolescents and young adults. Among substances, alcohol and nicotine are generally found to be the most frequently used, followed by cannabis, which is by far the most widely used illicit substance around the world (Bauman and Phongsavan, 1999) in (von Sydow, K. et al., 2002).

Although it is difficult to authenticate the actual extent of drug abuse among young people, research indicates that most adolescents experiment with alcohol and or cannabis prior to leaving school. In addition, Weiner (1992) points out that, among adults with substance abuse disorders, one half (50%) are found to have become drug dependant by the age 21 in the case of alcohol and by the age of 18 in the case of other addictive substances.

Longitudinal studies from the United States, of the natural history of drug use suggest that the major period of onset of cannabis use occurs before age 20 years, with the peak of onset occurring around 16-18 years (Chen & Kandel, 1995; De Wit et al., 1997). Thereafter, cannabis use commences a decline in

the early 20s, although early onset of use may delay the time to cessation of use of the drug.

The use of cannabis is increasing in developed and third world countries. In some parts of the world cannabis use (at least experimental) could already be considered a normative life-event for adolescents and young adults (Anthony et al., 1994) in (von Sydow, 2000).

2.2 FACTORS ASSOCIATED WITH CANNABIS ABUSE

Since the late 1970s, numerous studies about possible causes of cannabis use and abuse have been published. The domains investigated have ranged from biogenetic influences to macro-environmental-societal influences. In a considerable number of both cross-sectional and prospective longitudinal studies, a large number of possible influential factors have been studied across all domains, with no factor or group of factors being successfully identified as accounting convincingly for the initiation of cannabis use and the development of various patterns of use (von Sydow et al., 2002)

Various factors ranging in a continuum from social to intra-personal levels are affecting the use and abuse of cannabis. The following are the factors that can predict the initiation, incident and continuation of cannabis use or frequency of use in adolescents and young adults.

2.2.1 Socio-Environmental Factors

Socio-environmental factors include, male gender; low socio-economic status in childhood; adverse life events.

2.2.1.1 Male Gender

Sex differences have frequently been a source of study in alcohol and drug usage. In the National Survey Results on Drug Use in the USA, more males than females were involved in illicit drug usage. For instance, 42% of male twelth graders use cannabis compared with 33% of females (Johnson et al.,

1999) in (Kirkcaldy et al., 2004). Studies have shown the use of cannabis to be more prevalent among males than females.

2.2.1.2 Low socio-economic status

People with a less advantaged socio-economic situation, measured by socio-economic status, financial situation, and education are at a greater risk of developing higher cannabis use and dependence (von Sydow et al., 2002).

2.2.1.3 Adverse life events

People with traumatic childhood history, stand a greater risk of indulging into the abuse of cannabis.

2.2.1.4 The mass media

Strijdom (1992) maintains that, advertisements that encourage people to use legal drugs, definitely have an influence on people's decision to start taking it. It is also a well-known fact that some pop and rock songs encourage the use of illegal drugs such as cannabis and LSD through their songs of music.

2.2.2 Substance Related Factors

Substance related factors include tobacco use, alcohol use, attitude towards drug use, drug use opportunities, peer's use of nicotine or cannabis.

2.2.2.1 Peer group drug use and / peer pressure

Bucher (1976) asserts that peer pressure is one of the strongest social reasons for people to start taking drugs. It is important to adults and teenagers.

Weiner (1992), similarly argues that the social disposition to use drugs is influenced by the behaviour of an adolescent's peers. Drug-using peers can influence initial and continuing drug use by modelling it, by encouraging it and by helping to make drugs available. The more closely young persons interact with friends who use drugs, the more likely they are to become involved with drugs themselves. The more drugs these adolescents use and the more

important these friends are to them, the stronger this influence tends to be. According to Gelfand, Jenson and Drew (1988), it is very rare to find a teenager who can say no to such powerful social influences.

In their study, Quensel, et al. (2002), it was found that patterns of drug use and / or non-use are shared within the peer group in a common sub-cultural context. This sub-cultural context transmits values and knowledge and circumscribes the possible routes and limits of deviant behaviour. At the same time it also allows for the development of an identity as a group member.

Louw (1991) further explains that the group offers the adolescent who is experiencing problems in his relationship with his parents, warm and friendly companionship, thus providing him with a feeling of security, acceptance and understanding. Peer pressure could cause the adolescent to become involved against his better judgement in reckless and antisocial behaviour. The adolescent's values and judgement are thus, often adversely influenced by his peers. Hence, he experiences identity diffusion when he becomes indecisive about himself and his roles; he does not have the self-confidence to make decisions.

2.2.2.2 Drug use opportunities

Cannabis is often taken because it is readily available and less expensive.

2.2.3 Intra-personal Factors

Intra-personal factors include personality attributes (psychological problems; low self-esteem, loneliness, high unconventionality/ novelty seeking), psychopathology (mental/ mood/ anxiety disorders) and childhood factors (behaviour problems, social incompetence, insecurity).

2.2.3.1 Low self-confidence and social incompetence

Adolescent smokers have been shown to be less stable, less intelligent, less confident and much tense than non-smokers (Freiberg, 1987).

2.2.3.2 Curiosity or Experimenting

According to Gillis (1994), it is natural for an adolescent to want to explore adult ways of behaving and satisfying needs, and the challenges and risks this entails. Edmonds and Wilcocks (1994), further assert that adolescents hear about the effects of drug abuse, but still want to try them. They are unaware of the fact that what begins as a social experience frequently results in a physical and or psychological dependency (Bucher, 1976).

2.2.3.3 Boredom Relief

Many individuals start taking drugs because they are bored with their life. They lack goals and direction in life. Cannabis and other drugs are looked upon as an escape from this boredom (Bucher, 1976).

2.2.3.4 To have a good time

According to Schlaat and Schannon (1986), one of the more frequently given answers to the question of why people take drugs is that they give pleasure- " it is fun and enjoyable ". However, for many other people their life circumstances and predominant feelings are miserable and unpleasant, and the pleasure they derive from the drug might be their only life satisfaction, which again poses the danger of dependence. Similarly, Bucher (1976) states that, drugs give or may make an individual feel relaxed and more sociable.

2.2.3.5 Escape from reality

It is remarkably easy for people to rely on drugs and solve their problems, rather than to solve them by more positive lasting means or healthy coping skills. The person learns that he does not have to feel bad. The moment he experiences negative emotions, he uses his substance to suppress those unpleasant emotions in order to feel better. Strijdom (1992) reflects that, neglected children, like street children openly state that they take drugs in order to suppress hunger, pains and coldness at night. These also bring relief to the emotional pain of harsh treatment by a drunken father or mother at home.

Gillis (1994) asserts that, adolescent period is often accompanied by intermittent periods of stress and tension. Drugs, by creating an artificial sense of well-being, offer a temporary refuge from realities of the real world.

2.2.3.6 Retreat, alienation and social rejection

According to Strijdom (1992), human beings need to belong somewhere, be it a family or another group. An individual who feels isolated or alienated from his or her family and society, naturally reach out to other people and drugs.

2.2.3.7 Psychological problems

A variety of determinants in children and adolescents emerged as risk factors of drug abuse. These include hyperactivity, attentional disturbances, aggression, conduct problems, mood problems adjustment difficulties and other neurotic, psychotic and personality problems (Kirkcaldy et al., 2004) and (Fergusson et al., 2002)

2.2.4 Interpersonal Factors

Interpersonal factors include the description of the current family, for example (low family caring; low parental attachment; low identification with parents; leaving family home by age 18; father smoking), childhood family situation (not having been brought up by both parents; impaired parent-child relationship; conflict-filled family climate; sexual abuse; parental history of alcohol problems; parental illicit drug use).

2.2.4.1 Family structure

Family structure has an influence in the development of psychosocial problems such as substance abuse among adolescents. By family structure we mean the total composites or constituents that together make up a whole termed a family. Family structures include, model families; single-parent families; stepparent families; deceased and divorced parent(s) families; and families with no parents.

Research has shown single parent families to have significant effects of family structure on adolescent development (Salem et al., 1998). According to Papalia and Olds (1989), children from single parent families are faced with unusual stressors. "These homes do not have two adults to share child-rearing responsibilities, to serve as gender role models, and to demonstrate the interplay of personalities" (Louw, 1991).

2.2.4.2 Family process

The family process refers to the nature and quality of family dynamics and relationship, for example, parental support, family conflict. Research indicates that family process plays a more important role than family structure for adolescent development. Patridge & Kotler (1987) in Salem et al., (1998) demonstrated that family process was a stronger predictor of adolescent's self-esteem and adjustment than family structure.

The three domains of family process - parental support, parental monitoring, and family conflict have been found to be particularly relevant for adolescent development. Parenting styles thus can influence adolescent social behaviour (Foxcroft & Lowe, 1995). Low levels of parental support and control are associated with alcohol and substance use (Salem et al., 1998).

2.3 SUMMARY OF THE REASONS FOR DRUG TAKING

The Commonwealth Secretariat (1990) offers a comprehensive knowledgeable framework for the reasons why people take drugs. This framework encompasses most of the critical causes of drug abuse. They are categorised as follows:

Why do people take drugs?

A. They want to change how they are feeling.

It is used,

- To relieve pain (e.g. caused by disease or fatigue).

- To enjoy pleasurable effects
- To obtain new sensory perceptual experiences and
- To enhance feelings of self esteem through the "high" that a drug produces.

B. They are influenced to use it, because

- It is easily available (e.g. inner city areas)
- Mass media has an influence (e.g. advertising for legal drugs, stories in the paper for drug abuse incidents).
- Life for them is appalling as a result of poverty, poor conditions and lack of facilities.
- The price of drugs has dropped.
- They have no feeling of a personal future.
- They escape boredom.
- Peer group pressure (e.g. be in with the in-crowd) and
- The influence of cultural / religious norms.

C. How they were brought up has an influence on their decision to take drugs.

This include:

- Family life experiences.
- The way they were looked after when they were children; and
- Their society's culture / religion.

D. Their personalities determine the likelihood of drug taking.

This includes personality traits like:

- Curiosity.
- Seeking thrills, taking risks.
- A specific way of experiencing independence.
- A specific way of rebelling against the establishment; and
- The desire to hurt himself.

2.4 ADOLESCENCE

The concern of most adults today is that substance abuse by minors is a sign of psychological disturbance. A normally curious teenager may want to experiment with mood-altering substances and may want to use them recreationally at parties. However, when an adolescent "needs" some substance on a regular basis and devotes his or her time to seeking and using the substance, an emotional problem is likely to exist.

Adolescence is the developmental stage between childhood and adulthood. The term "adolescence", derived from the Latin verb *adolescere*, means "to grow up" or "to grow to adulthood". Because of individual and cultural differences, the age at which adolescence begins varies from 11 to 13 and the age at which it ends varies from 17 to 21. It begins during puberty - that is when rapid physical growth begins, the reproduction organs begin to function, sexual maturity is reached and secondary sexual characteristics appear (Louw, 1991).

Psychoanalysts like Freud, describes adolescence as the reawakening of, and increase in the sexual drives accompanying physical changes during puberty, which account for the disturbance of the balance between the id, ego, and the superego, which occurred during the latency stage. The adolescent is thus obliged to control his sexual drives in order to restore the balance between the personality structures and to restore the emotional conflicts (Louw, 1991).

Similarly, Hall's storm and stress theory describes adolescence as a stage of emotional or intra-psychic conflict (a period of intense tension and mood swings). For him, adolescence is characterised by alternating emotions and attitudes, for example cheerfulness versus depression, gentleness versus cruelty and so forth. He further describes it as a period of individualism and rebirth, because of higher and more complex human characteristics begin to manifest themselves (Louw, 1991).

Erikson modifies the psychoanalytic viewpoint by explaining the influence of social factors and to emphasise the formulation of an identity in adolescence. He believes that identity is transformed from one psychosocial stage of development to the next, and early forms of identity influence later forms. However, the development of identity reaches a crisis during adolescence (Louw, 1991).

During this stage which Erikson terms identity vs. role confusion, there is rapid physiological changes with unfamiliar sexual urges. These changes together with social pressure to make occupational and educational decisions, force the youth to consider a variety of roles. The basic task for the adolescent is to integrate the various identifications he brings from childhood into a more complete identity. This reassembled identity is appropriate for the new needs, skills, and goals of adolescence. If the adolescent cannot integrate his identifications, roles, or selves, he faces "identity diffusion". His personality is fragmented, or lacking a core. The psychosocial modality of this stage is to be oneself or not to be oneself (Miller, 1983).

Learning theorists believe that behaviour is learnt, inter alia, through imitation of someone else's behaviour and the reinforcement of certain behaviour patterns by means of reward. According to the learning theorists, society provides little guidance to adolescents concerning certain behaviour patterns, such as how to handle their sexual drives. There is considerable difference between the behaviour expected, approved of and rewarded during childhood, but not during adolescence. The result is, according to this theory, a heightened level of anxiety during adolescence. Thus, the learning theorists also regarded adolescents as a period of storm and stress (Adams, 1980; Muuss, 1975) in (Louw, 1991).

2.5 ADOLESCENCE AND DRUG ABUSE

Most theories suggested that teenage drug use interferes with normative tasks of adolescent development. Adolescence is a critical period for the successful acquisition of adult roles, such as spouse, parent, and provider.

Baumrined &Moselle (1985) in Newcomb &Bentler (1988), hypothesized that substance use during this development period may impede psychosocial maturation, motivate regression and create a " hiatus in identity formation " (p.53). Thus teenage, substance use may interfere with the stage-sequential processes of development. As a result, drug-using adolescents may, as adults, " remain in limbo, suffering from symptoms of diffuse identity, marked by prolonged aimlessness and lack of clarity about goals " (Baumrind & Moselle, 1985, p. 52) in Newcomb & Bentler 1988).

Another viewpoint suggests that drug use is associated with accelerated rather than delayed development (Newcomb & Bentler, 1988). From this perspective, teenage drug users bypass or circumvent the typical maturational sequence of school, work, and family formation and make the transition prematurely into adult roles of jobs and family, without the necessary growth and development for success in the tasks. Thus, teenage drug users may develop a pseudomaturity that ill-prepares them for the real difficulties of adult life. As a consequence, they should evidence greater difficulty, if not failure, in these roles over time.

2.6 THEORETICAL PERSPECTIVES ON DRUG ABUSE

SOCIAL LEARNING THEORY

Social learning theory is a set of concepts, which are said to be relevant for all human behaviour, and apply to a wide range of addictive behaviours such as drug and alcohol use.

Social learning theorists argue that addictive behaviour is a learned habit acquired through a number of psychological determinants of behaviour, namely, antecedents (classical conditioning), consequences (operant conditioning) and mediational influences (cognitions). Numerous social and environmental influences promote the learning of alcohol and drug intake (Raistric and Davidson, 1985). According to Ghodse and Maxwell (1990),

some of the addictive behaviours are learned from parents, peers, books, and television, while others are learned through direct experience.

Raistrick and Davidson (1985), point out that patterns of parental drug use and other aspects of parental environment have been linked to prevalence of drug use among their children. Similrly, Chassin (1993) points out that, it has been repeatedly demonstrated that parental modelling of substance use and ineffective parental control practices are related to adolescent substance use. However, O' Connor (1978) in Raistrick and Davidson (1985) argues that parental attitude to drugs rather than behaviour or general family relationships is the main predisposing factor. He further comments that, it is the perception of parental attitudes by children and the influence of pressure from peers, which are the two single most important factors regulating future drug intake.

Schlaadt and Shannon (1982) describe drug consumption as constituting on occasions a 'group entry requirement'. The association process of the group can shape and direct a wide variety of behaviour, and as the influence of parents, wanes, that of peer group increases. He comments, Plant (1980) in Schlaadt and Shannon (1982), strong social support of peers is needed to convert individuals to the view that certain drug taking is safe, accepted by the peer group and even prestigious.

Ghodse and Maxwell (1990) assert that learning to use a drug heavily may therefore result from exposure to certain drug-oriented environments and the expectation of rewarding consequences. As a heavy drinker or drug abuser begins to experience problems, negative expectations develop, so that there are strong reasons to want drugs and strong reasons to avoid them. This ambivalence reflects on "approach-avoidance conflict" which is experienced as a compulsion to drink or smoke.

Sometimes a state of **'learned helplessness'** supervenes in which no attempt is made to stop drugging because it has been learned from previous experience that it is futile to try. This is an example of impaired cognitive

control, that is, the ability to regulate consumption by drinking, goal setting and making commitments (Ghodse and Maxwell, 1990).

The theory above is adopted for the purpose of this study because it views any behaviour including addictive behaviours to be learned in an environment, either through direct experience or by observation. Thus, drug-oriented environments are the primary predictors of cannabis use. Given the afore-mentioned reasons for cannabis abuse, it is obvious that different factors affect or influence youth cannabis use.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 RESEARCH DESIGN

A qualitative research design was used in this study. The aim of using a qualitative design was to enable the researcher to understand with ease, through a one-to-one interaction, the subjects' perception of the causes for cannabis abuse. Another reason is to provide the researcher with an opportunity to fully explore the perspective of the participant. This design is appropriate for phenomenological studies because they characterised by capturing the " lived experience " of study participants. They try to describe the experiences as they are lived in phenomenological terms. They are also used to understand variables that are difficult to quantify, such as attitudes, religious beliefs, or political opinions (http://writing.colostate.edu/references/research/content/pop 2a.cfm).

3.2 RESEARCH SAMPLE

A sample of thirty (30) patients, between the ages 16 to 30 (mid-adolescence to early adulthood), was obtained directly from chronic wards, of patients awaiting discharge at Bophelong Psychiatric Hospital. The sample consisted of only male patients, with a history of cannabis abuse, admitted and certified under sections 3,4 and 9 of the Mental Health Act 18 of 1973. Only male patients were available during the period of data collection.

A reasonable level of functioning was attested to by the fact that the patients were awaiting discharge based on the mental status examination (MSE). Cognitively and intellectually impaired patients were excluded from the study.

Out of the 30 original subjects, 10 protocols were selected for phenomenological explication. The sample consisted of 10 males, ranging in ages 18 years to 28 years, who had a history of cannabis abuse.

3.3 RESEARCH PROCESS

Before the interviews were conducted the researcher had to establish a good working relationship (rapport building) with the participants. A mental status examination (MSE) was conducted with each subject as part of building rapport and assessing his current mental state and functioning for approximately 15 minutes (Refer, chapter 4). This also enabled the participants and the researcher to get used to one another and to make subject feel at ease with the researcher, so that during the interviews they can easily open up without hiding much, of any information.

Patient's files were also used to confirm some of the information given and to obtain some useful data. During the interviews, confidentiality was emphasised and the subjects were encouraged to relax and also informed that their participation in the research does not prepare, suggest or confirm their discharge or going home. It was also explained to them that participation was completely voluntary and that they could withdraw from the study at any time. After the participants gave their permission, data collection began. The researcher explained the process of research and how the data would be used in the end. After data was gathered, it was therefore analysed and a report was written.

3.4 DATA COLLECTION METHOD

Structured to unstructured types of interviews were used in the study (see Appendix A). The aim of using structured to unstructured interviews was to standardise questions for all the subjects, provide similar guidelines for the interview and to enable the researcher to focus only on the subjective experiences of the subjects, their reasons for abusing cannabis (dagga) and their global perceptions about the substance. Interviews were chosen for this

study because they, as Bailey (1982) states, are flexible, allow the researcher to probe for more information, clarify questions if misunderstood, are inclusive of everybody even those who cannot read and write, and allow for spontaneity and observation of non-verbal behaviour. Personal and individual interviews were employed. This means that the researcher was interviewing one individual at the time and the interview was conducted in a face-to-face situation.

During the interviews, close and open-ended-type of questions were asked. Setswana and English were used as languages for the study, to make the questions as clear as possible and to let the participants fully understand.

The interview structure (guideline) used in this study was adopted and modified from the below mentioned scales to fit the purpose of the study.
http://www.d-u-s.com/indsta qt/risk 6.htm
http://www.drhurwitz.com/html files/Patient Questionnaire.htm
http://www.notperfed.com/Drug Abuse.htm
http://prescriptionabuse.org/problem.html
http://www.psychologyservices.com/answer these questions honestly.htm
http://www.nida.nih.gov/Diagonosis-Treatment/Dast 10.html

3.5 DATA ANALYSIS METHOD

Data gathered through interviews was analysed, interpreted and conclusions drawn by the researcher. Content analysis of each protocol was done through conceptual or theme analysis, by establishing the existence and frequency of concepts represented by words or phrases (http://writing.colostate.edu/references/research/content/com 2bl.cfm).

CHAPTER 4

RESULTS

4.I INTRODUCTION

Drug addiction continues to become a major social problem world-wide, especially in South Africa. Individuals have provided various reasons as to why young people abuse cannabis. In an attempt to understand the causal factors of cannabis abuse, the perceptions of patients were examined.

Out of the 30 original subjects that were interviewed, 10 protocols were selected for phenomenological use, owing to saturation of data. A transcript of each protocol was therefore analysed through content analysis. A conceptual analysis was done by quantifying and analysing the presence of certain concepts and their meanings. Therefore, specific themes were extracted.

4.2 MENTAL STATUS EXAMINATION (MSE)

Since the research participants were psychiatric patients, the researcher had to ascertain their mental statuses before they could give their responses. The MSE was to aid in ruling out perceptual abnormalities, formal thought disturbances nor any behavioural abnormality that would affect the responses negatively. It also helped in establishing rapport. Generally, the patient's mental states were in normal ranges. Each participant's current mental-functioning was reflected by its mental status examination.

4.2.1 GENERAL DESCRIPTION OF THE PARTICIPANTS MENTAL STATUS EXAMINATION

During interview the patients were clean and well groomed in their hospital attire. They had normal behaviour with no psychomotor retardation and could establish good eye contact. They were cooperative and attentive throughout the session. Their mood was euthymic (normal) and affect was in a normal

range too and appropriate. There were no speech or language impediments. Perceptual disturbances were denied and thought content disturbances were not evident. All the patients were fully alert or conscious and were orientated to time, place and person. Their memory, concentration and attention were good. Judgement was good and they had diminished insights into their mental condition or illness.

SECTION A

4.3 SOCIO-DEMOGRAPHIC INFORMATION

4.3.1 Age

The subjects' ages ranged from 18 to 28 years respectively. 60% of subjects assumed the 18-21 years age group cohort, which is adolescence. While 40% assumed the 22-28 years age group, which is early adulthood.

4.3.2 Gender

All the interviewed participants in the study were males.

4.3.3 Race

100% of the subjects were black.

4.3.4 Marital Status

100% of the participants were single.

4.3.5 Highest Level of Education

Out of all the subjects, 40% passed matric or Grade 12 (some are already at tertiary institutions, while others are just at home. They reported that their parents could not afford to send them to school to further their studies). Another 40% was at middle school level, while 10% was still at high school. The other 10% reported to have never attended school.

4.3.6 Geographical Location

Most subjects interviewed came from rural areas of the North West Province. 80% came from the villages, while 20% came from the townships.

4.3.7 Parents or Guardian Living With

40% of participants lived with their mothers (some reported not to have never seen their fathers nor heard about them, while others reported their fathers to have died when they were still young). 20% lived with their mothers and stepfathers. Another 20% lived with their guardians, and 10% lived with both biological parents, that is mother and father.

4.3.8 Socio-Economic Situation

When subjects were asked about their socio-economic backgrounds, 40% reported only one of their parents or guardians to be working as domestic helpers, earning not more than R600 per month. While 30% reported their parents or guardians to be unemployed, they rely on the children's social grants and the grandparents' pension for survival. 20% reported their parents to work in the government as cleaners, and the remaining 10% reported his parent to be a teacher.

SECTION B

4.4 DRUG USE INFORMATION

4.4.1 Age of onset (initiation) of cannabis use

The age at which the subjects started taking cannabis ranged from 14-18 years. 40% of the subjects started at 17 years, 20% at 15 years, another 20% at 18 years, 10% at 16 years and the remaining 10% started at 14 years.

4.4.2 Reason for initial use of cannabis

The subjects provided the following reasons for their initial use of cannabis. 60% cited peer pressure to have influenced their first use of cannabis. Some of the reports were as follows:

- *" I was influenced by my friends. It is not to say that they forced me, it's just that I was too weak to resist the pressure I felt, that I was not doing what my group was doing. They used to tell me how coward I was " reported subject B.*
- *" I decided to start using dagga after I received bad influence from my friends. They gave me negative information about ganja, which sounded positive " reported subject C.*
- *" I was getting bored when I was with my friends who were smoking. I usually felt out of place and always thought they will kick me out of their company " reported subject F.*

20% of subjects cited the wish to escape from reality problems as their reason for their initial use of cannabis. Reports are as follows:

- *" Because I was frustrated by relationship problems. I realised that my girlfriend was cheating me, she had an affair with another guy " reported subject A.*
- *" Because I had stress due to financial problems. I wanted to study civil engineering at the technikon, but I had no money. I was hoping to get some busaries " reported subject I.*

10% of the subjects cited the need for cognitive enhancement as the reason for their initial cannabis use.

- *" I wanted to be clever " subject E reported.*

The remaining 10% of the interviewed subjects cited modelling adult behaviour as their reason to start using cannabis.

- *" I started using dagga because my father and brother were smoking it. Most of the people, especially men in our village at Natal were smoking dagga. Well, I did not see any wrong in doing that ".*

4.4.3 Perceived reasons why young people smoke cannabis

When the subjects were asked why do they think are the main reasons why young people smoke cannabis, different reasons were given. Some subjects cited one reason, others two and others three reasons.

Out of all the interviewed participants, n=3 (30%) perceives peer pressure as the causal factor towards cannabis smoking by young people. Another 30% of the subjects perceive a need for cognitive enhancement as one of the causal factor. 20% reported a need for self-confidence. Another 20% reported modelling of adult behaviour, while the other 20% reported the need to escape from reality problems.

Other causal factors reported are as follows:

- The media, reported 20% of subjects.

" Young people are being influenced by the media, especially television programmes like Yizoyizo, to use cannabis " reported subjects G and I.

- A need to be bold, reported 10% of subjects.

" They smoke to get the courage to engage in criminal activities ".

- Bad self-image or poor self- concept, reported 10% of subjects.

" Some, especially girls use dagga to loose weight, they don't want to become fat. They want to look good ".

- Boredom, reported by 10% of subjects.

" They feel bored because they don't know what to do, there are no recreation facilities ".

- To feel good (pleasurable), reported 10% of subjects.

" They want their bodies and minds to relax and feel good, ".

- Cannabis is cheap and easily available, reported 10% subjects.

" The youth smoke dagga from friends when they have no money to buy hard drugs".

4.4.4 Reasons for continuation or progression into cannabis use

When asked why the subjects were continuing to use cannabis, the same reasons as cited above were provided.

Of all the interviewed participants, 30% continued to smoke cannabis, because of peer pressure. Another 30% continued because of lack of self-confidence. 20% progressed into cannabis abuse, because they want to relieve themselves from boredom. The remaining 20% continued smoking for pleasure.

SECTION C

4.5 FAMILY ENVIRONMENT

The subjects responded to questions pertaining to their family atmosphere as well as to the use or abuse of substances by their parents or any elderly person in the family.

- Of all the interviewed subjects, 70% had an elderly person in the family who was using drugs. Meanwhile 30% of subjects did not have elderly person who was using psychoactive chemical substances by the time of the interview.
- On the one hand, 60% of subjects reported to have grown up in the family were drugs were overtly used. On the other hand, 40% reported to have grown up in a family that was not using drugs.
- 80% of subjects reported their family atmosphere to be good and 20% reported it not to be conducive.
- All the interviewed subjects reported communication to be good at home. They normal talk to one another about general and personal matters.

4.6 PARENTAL CONTROL AND SUPPORT

- 70% of the interviewed subjects indicated their parents to be strict in terms of discipline, while 30% of the subjects reported lenient control.
- One half (50%) of the subjects reported their parents always to be there when they need them. Meanwhile, the other 50% have reported their parents always to be absent when they need them.
- 60% of the subjects reported their parents to give them enough emotional support, while 40% reported not have experienced such kind of support.

CHAPTER 5

DISCUSSION OF RESEARCH RESULTS

This chapter will discuss the findings of the study in an attempt to understand the causal factors or reasons for youth cannabis abuse. The findings will be compared to the findings of previous research studies that were conducted in urban areas. This will help in understanding whether the causal factors for cannabis abuse are the same for all socio-economic settings or not.

PEER PRESSURE

Peer pressure has emerged as a salient causal factor for youth cannabis taking in the present study. Von Sydow et al. (2000), also found peer pressure to have a strong influence in the use of cannabis. This finding also supports, Kirkcaldy et al.'s (2004) study, which revealed that the use of cannabis is mainly influenced by peer pressure rather than experience-seeking attitudes. As Bucher (1976) put it, it is one of the strongest social reasons for people to start drugs.

Weiner (1992) similarly argues that the social disposition to use drugs is influenced by the behaviour of an adolescent's peers. Drug-using peers can influence initial and continuing drug use by modelling it, by encouraging it and by helping to make drugs available. The more closely young persons interact with friends who use drugs, the more likely they are to become involved with drugs themselves. The more drugs these adolescents use and the more important these friends are to them, the stronger this influence tends to be. According to Gelfand & Drew (1988), it is very rare to find a teenager who can say no to such powerful social influences.

Coleman (1980) and Brown, Eicher and Petrie (1986) in Louw (1991), point out that conformation to the peer group is greatest during early adolescence,

possibly to a lack of independence, a lack of self-confidence and a lack of a sense of identity.

The group offers the adolescent who is experiencing problems in his relationship with his parents, warm and friendly companionship, thus providing him with a feeling of security, acceptance and understanding. Peer pressure could cause the adolescent to become involved against his better judgement in reckless and antisocial behaviour. The adolescent's values and judgement are thus, often adversely influenced by his peers. Thus, the adolescent experiences identity diffusion when he becomes indecisive about himself and his roles; he does not have the self-confidence to make decisions

ESCAPE FROM REALITY PROBLEMS

Unique to the present study, escape from reality problems was found to be one of the leading reasons that cause the youth towards taking drugs. It is remarkably easy for people to rely on drugs and solve their problems, rather than to solve them by more positive lasting means or healthy coping skills. The person learns that he does not have to feel bad. The moment he experiences negative emotions, he uses his substance to suppress those unpleasant emotions in order to feel better. Strijdom (1992) reflects that, "neglected children, like street children openly state that they take drugs in order to suppress hunger, pains and coldness at night. These also bring relief to the emotional pain of harsh treatment by a drunken father or mother at home.

Gillis (1994) asserts that, adolescent period is often accompanied by intermittent periods of stress and tension. Drugs, by creating an artificial sense of well-being, offer a temporary refuge from the realities of the real world.

MODELLING OF PARENTAL DRUG BEHAVIOUR

Imitation of adult behaviour was also found to be one of the reasons why young people abuse cannabis. Most of the subjects indicated to be coming from family backgrounds of substance use by the parents. This is consistent with the findings by Kandel (1978) in Weiner (1992), that parents who use drugs on regular basis, in front of their children are likely to foster such use in them.

Similarly, in Weiner (1992) research findings indicate that parents are likely to influence the drug-taking behaviour of their children by the example they set with their own behaviour and by the climate they create in their home. With respect to modelling, drug-taking among young people has been found to be directly related to whether and how frequently their parents take drugs. The more heavily parents use any particular drug, the more likely their children are to use or abuse the same drug.

NEED FOR COGNITIVE ENHANCEMENT

Another significant reason reflected in the present study, that force adolescents to use cannabis, is their need for cognitive enhancement. Subjects reported that they use cannabis because they want to be clever and want their minds to work faster. Weiner (1992), points out that adolescents use drugs as they believe that they enhance social functioning, cognitive and motor capacities.

DESIRE FOR IMPROVED SELF-CONFIDENCE

A need to be self-confident has also emerged as one of the salient reasons that keep the youth hooked to cannabis use. Most of the subjects reported that they use cannabis because it gives them courage to perform, act openly and freely express their emotions (feelings) with confidence. This finding is supported by Turker (1984) in Freiberg (1987), who states that adolescent

smokers have been shown to be less stable, less intelligent, less confident and more tense than non-smokers.

SINGLE-PARENT FAMILIES

Another finding of this study was that, young people who abuse cannabis live with one parent only, a mother to be specific. This means that single parenting is one of the factors that affect youth drug taking. Consistent with this finding, Kirkcaldy et al. (2004) and Salem et al. (1998), found that living with a single mother is being associated with higher rates of all kinds of deviant behaviour and substance use. Papalia and Olds (1989) state that children from single parent families are faced with unusual stressors. "These homes do not have two adults to share child-rearing responsibilities, to serve as gender role models, and to demonstrate the interplay of personalities" (p.323) (Louw, 1991).

Several negative consequences of single-parent families have been reported. For instance, it has been found that juvenile delinquency occurs more frequently amongst children from single-parent families, that they have poor relationships with teachers and friends, and they have a poor self-image (Dornbusch et.al, 1985; Papalia & Olds, 1989) in (Louw, 1991).

PARENTAL CONTROL AND SUPPORT

Other interesting findings in the study were that of high parental control and high parental support was associated with cannabis abuse. Contrary to this finding, Steinberg et al. (1991) in Salem et al. (1998), found authoritative parenting to relate to higher grade-point averages, greater self-reliance, less psychosocial distress, and lower delinquency for youth living with different niches, defined by family structure ethnicity and social class. Several researchers have found that low levels of parental support were associated with alcohol and substance abuse (Salem et al., 1998).

OTHER RELATED FINDINGS

The present study showed that the developmental stages of adolescence and early adulthood are related to drug use and abuse. These results are consistent with the finding of Ruter (1980), that almost all forms of substance abuse, including alcoholism, first become a common problem during late adolescence and earlier adult life. The study further indicated the age of initiation of cannabis use to fall between 14 and 18 years. This finding supports the finding of Chen & Kandel (1995) and De Wit (1997) that the major period of onset of cannabis use occurs before age 20 years, with the peak of onset occurring around 16-18 years.

The present study, consistent with most others, such as that of Mc Gee et al. (2000) & Kirkcaldy et al. (2004), found that male gender predicted incident cannabis use and abuse. Low socio-economic status was also reflected in the study to be associated with youth cannabis abuse. This finding is supported by von Sydow et al. (2002) & Mc Gee et al. (2000), who found out that people with a less advantaged socio-economic situation were at a greater risk of developing higher cannabis use and dependence.

CHAPTER 6

CONCLUSION AND RECOMMENDATIONS

6.1 CONCLUSION

The central focus of this study was to determine the reasons or factors for cannabis abuse as perceived by patients admitted with a history of cannabis use/abuse at Bophelong Psychiatric Hospital.

The research results revealed various reasons and factors that affect the question in context. There is therefore an ongoing need to identify causative and curative factors of child and adolescent drug use in an effort to reduce this tremendous loss of our resources, particularly our youth.

6.2 RECOMMENDATIONS

However, despite some grand efforts, including a number of drug prevention seminars and conferences, drug addiction and drug habituation continue to be major social problems in South Africa.

Dr Donald B. Louria in 1968 stated that, "Laws can be passed, preventive education undertaken and millions spent on rehabilitation, but until this society regains its vigour, direction and integrity, the promiscuous, indiscriminate and illicit use of mind – altering and other dangerous drugs will remain a major social problem" (van der Westhuizen & Fourie, 1988).

Drug addition is very difficult to treat effectively, and relapses are common. However, successful intervention for drug abuse requires a multifaceted treatment approach that relieves psychological distress, promotes positive and supportive peer networks, and fosters a nurturant climate in the home.

Bucher (1976), points out that the goal of any type of treatment program for addicts should include:-

1) Helping the individual to withdraw from dependent drug.
2) Helping addict to understand and work out problems.
3) Helping the addict to function well in society.
4) Helping the addict in solving other drug related problems.

Bucher (1976) points out that different programs utilise a variety of approaches that are all aimed at the same basic goal of restoring the addict to the society. This is to say that there is no uniform method of effecting a " cure" in drug addiction; many other factors such as an addicts life style, education, and stability enter the total picture.

Some addicts will do better in certain programs than in others depending on their personality, length of addiction, and general motivation. Various methods of intervention and prevention strategies recommended will therefore be explicitly and accordingly discussed.

6.2.1 INTERVENTION OF STRATEGIES

6.2.1.1. CONSTRUCTIVE CONFRONTATION

Edmonds & Wilcocks (1994) explain that, one of the factors about addiction that must be recognised is that the addict is usually the last person to admit or recognise that he has a problem. It is therefore necessary for those concerned about the addict to show him what is drugging is doing to him.

The reason for the addict's inability to see the reality of his drugging and its effects, is the formation of a very solid system of defence mechanisms, such as denial, projection, rationalisation, minimizing, selective recall and so forth. These are subconscious processes we all use to protect our fragile egos from emotional pain and anxiety.

Therefore, in order to successfully intervene in the illness of chemical dependency, a process of breaking down the defense mechanisms being

used by the addict needs to take place. This progress is known as **constructive confrontation**, and it consists of three phases.

Phase 1: preparation

Edmonds & Wilcocks (1994) further explain that, being faced with suspicions or direct evidence that a young person is dabbling in, or has become dependent upon psychoactive chemicals provokes strong feelings of guilt, anger and fear in the family members. To react to these emotions by blaming or becoming immobilized by fear, is very destructive and can frequently lead to a situation in which the user becomes even more defensive and communication breaks down completely. Therefore as part of preparing for a contructive confrontation it is a essential that the people involved have dealt with their feelings and can act in the direct, positive and non-hysterical way.

Facts about what is happening have to be decided upon by those close to the user. These facts need to be clear, specific and were possible, first hand so as to prevent the addict from using defence mechanisms. Those people who are being involved in the confrontation progress (parents, peers, and teachers) need to be close to the suspected user and to have some level of influence over him. They also need to know and write exactly what it is that is of concern to them.
For example:-

- Dagga has been found in your jeans pocket.
- Your school marks have shown 10% deterioration.
- We use to be friends but now you are hanging around with people who are drug users.

A leader for the confrontation process should be selected. His role is to open and close the proceedings and ensure that those taking part do not become destructive and the confrontation keeps to its objectives. As part of conducting the confrontation what the outcome is going to be, for examples:-

- For the suspected user to be referred for professional assessment, for clinical tests to be done to establish if he is drugging.

Arrangements for the outcome to be implemented should also be made prior to the confrontation – to avoid delays that may allow the person to rebuild his defences.

It is important that a pre – confrontation meeting be held for those involved to discuss and practise the process. Wherever possible a trained counsellor should be consulted and involved in preparation of the confrontation. He may also be included in the confrontation, should it be deemed necessary.

Phase 2: confrontation

The confrontation should be held in a private place where interruptions well not occur. The leader should open the process by explaining to the suspected user that every one present is there as they are concerned about him (the addict). Each group member would then say something to illustrate this concern. Once very one has finished, the person being confronted, will be given opportunity to reply.

The facts that have been prepared are then expressed to the suspected user by every one present in turn. Facts must be presented in a concerned, structured, non-accusatory and non-judgemental way. Should the suspected user try to defocus from them or deny them, the leader intervenes and reminds him that once every one has finished he will be able to reply.

Usually the process of confrontation has one of two outcomes. The suspected user may break down and admit to ward has been happening or he may continue to deny any use of drugs. If he admits that he is using, the leader, in summarising what is happened, needs to immediately implement the groups pre –arrange plan for follow up. If the addict denies he is using chemicals, the group needs to express that they are still concerned. The y then request the

person to allay their fears by being professional assessed or screened for the presence of drugs as soon as possible.

Phase 3: follow up

The leader of the confrontation process needs to assume responsibility for insuring that the plan agreed to is carried out. He also provides feedback to other participants as the results of the actions taken.

6.2.1.2 TREATMENT

Because addiction is both a psychological and physical illness, medical intervention and professional counselling are vital.

Components of treatment

1. Detoxification.

Edmonds & Wilcocks (1994) further explain that, many drugs will necessitate medication to counteract the possibility of withdrawal or to treat the symptoms of withdrawal. Depending on the type of drug, these symptoms may include sweating, nausea, irritability, headaches, sleeplessness, psychological cravings and so forth. Medication will therefore help the addict

to feel more comfortable while withdrawing. It however does not stop and addict from withdrawing.

It must be stressed that in detoxification the emphasis is on medical care and that it is not treatment, but rather a short-term medical intervention to arrest the addiction. Counselling and group therapy should always follow detoxification.

2. Individual counselling.

Treatment in terms of psychological counselling may begin after the first week, or as soon as the patient is detoxified.

Therapy focuses on the following:

a) Discovering the vulnerabilities that made the addict prone to the effects of drugging and trying to correct these.
b) The teaching and learning of coping skills which were either never present or which became rusty due to the addict's reliance on chemicals to help him cope.
c) The provision of practical guidelines to help the addict avoid a relapse.
d) The promotion of lifestyle changes to promote a constructive, balanced, healthy lifestyle.

3. Group Therapy

This may include:

a. Education groups, such as understanding of the process of addiction, the prevention of relapse and the promotion of a quality sobriety.
b. Education groups, such as, decision making and problem-solving skills, assertiveness skills in general, etc.

c. Self-help or support groups for the addict in recovery such as Narcotics Anonymous (NA), consists of other hope, support and advice. They discusses difficulties being experienced in recovery and may obtain guidance both from the therapist and other addicts who have long-standing sobriety.

4. Counselling and Groups for the Family Members

Hickey (1985) asserts that, dependency on any drug by any member of the family tends to cause general family disruption. The family should always be included in the treatment programme. The reason for this is that they have suffered as much as the addict himself, and need help to recover as well. Secondly they need to be given guidelines as to how to act as a constructive support system to the recovering addict. When parents are not included in their children's treatment, they become angry and hostile because they often feel that they have been excluded from the treatment process. If so, the adolescent also often becomes very distrustful of the adult world and rebellious towards anything that symbolises that world. This can take time and the involvement of parents too soon may create mistrust. Parents are often only involved when the relationship with the adolescent is at such a level that it will not hamper honesty.

However, eventual involvement of parents and other family members is important. The relationships need to be renegotiated for harmony to be restored. Families need help to help the adolescent though their development issues.

Also, parents often need education and information. They need to understand what has been happening to their children and what they can realistically expect in their future. They too need to express their anger, guilt and frustration.

6.2.1.3 PREVENTION

According to Weiner (1992), the best way to treat substance abuse is to prevent it from occurring in the first place. Drug prevention efforts began with the expectation that adolescents who are informed about the hazards of using drugs will keep away from using them. In broad terms, prevention is an effort to stop a problem from developing or arrest the process before any further

deterioration occurs. Prevention takes form in three spheres, primary prevention, secondary prevention and tertiary prevention.

(a) Primary Prevention.

Primary prevention defines those techniques and interventions, which aim at arresting a problem or condition before it's beginning. It anticipates a problem rather than treats one.

Prevention by Social Control.

Prevention by social control has historically been the responsibility of the government and has included such strategies as legislation, pricing policies and control over availability. South African policies and legislation regarding the non-medical use of scheduled and illicit drugs have developed a "prohibition stance" which assumes that non-availability and severe legal penalties will prevent the abuse of these substances.

Prevention by Education.

At this stage, the models which appear most widely used are the alcohol/drug information approach and the affective education approach.

Affective Lifestyle Education.

Affective lifestyle education is not based on the assumption that knowledge determines behaviour, but focuses rather on developmental issues of each life stage. Adolescents do not abuse drugs because they are unaware of the dangers. Their behaviour is influenced by peer pressure, the need to be liked, the need for the effect of the drug and defiance against society. At an adolescent level affective lifestyle education will focus on all of the above-mentioned issues.

The focus is not drugs or alcohol but rather on the experience of the child or adolescent at their specific level of development. It is clear that affective lifestyle education is ongoing and each course should be at least nine months long. The curriculum for adolescents would include the following issues:

- Peer group pressure and friendship.
- Self-concept and self-acceptance.
- Relationship with parents.
- Relationship with boyfriend/girlfriend.
- Depression and coping with this.

Basic drug and alcohol knowledge is included but usually intertwined with other issues, for example, a discussion on what happens if your friends are smoking dagga and you do not want to?
Affective lifestyle education aims to enhance the functioning of the individual and its preventive power lies in the fact that the well functioning individual is less likely to need to abuse drugs.

(b) Secondary Prevention .

Those interventions which are adopted after the birth of a problem, but designed to arrest further development, are deemed secondary prevention efforts.

Here people have already begin to experiment with or use drugs and is designed to prevent the situation from deteriorating. The most effective form of secondary prevention appears to be at a level of group discussion. These young people are often brought together in a series of group meetings in which they are able to discuss what the experience means for them and

received an educational input about substances they are experimenting with and abusing.

The group meetings have a lot of purposes:

- To encourage values clarification about drugs and substance abuse and to encourage more conservative attitudes.
- To develop decision- making skills based on knowing the facts, identifying alternatives and then making decisions.

- Assertiveness training is needed to assist them to cope with the peer pressure related to drugging decisions.

Being in a group often helps these young people establish positive relationships without drugs and allows them to feel a sense of belonging. For these reasons, these "high risk groups" are usually no less than twelve sessions for maximum effectiveness. Parents, schools and church bodies need to examine these relevant areas in order to assist at the level of secondary prevention.

(c) Tertiary Prevention

It is synonymous with rehabilitation, which has been explained under treatment. Rehabilitation programmes usually offer detoxification, individual counselling, intensive group therapy and education sessions. Families are usually expected to attend group and individual therapy sessions.
Above all it is recommended that community rehabilitation institutions be established where drug prevention programmes and services can be offered. All the health professionals or therapist must take part in ensuring the effectiveness of such services. Intensive group and individual therapies must also be run in mental institutions, Bophelong Psychiatric Hospital in particular to deal with drug related issues. Review or follow-up sessions must be conducted with discharged patients having drug related problems. Workshops be run in schools, churches and work places and other sectors.

6.3 LIMITATIONS

The following were limitations of the study as identified by the researcher and author:

- The focus on the study was only on males and blacks.
- Data was only collected from one source- the psychiatric patient.
- The study was restrictive to one psychiatric hospital and one province only.

- The sample was not representative since it consisted of 30 participants only.
- Because the study was phenomenological, theme analysis was subjective, hence the findings could not be generalised.

6.4 PUBLICATION

The final research document will placed in the hospital library at the disposal of the library users, for reference and for the benefit of the entire institution. The Department of Health North West will also be furnished with a copy of the research document.

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APPENDIX A

Dear Participant

I am currently conducting a study, on understanding the causative factors of cannabis abuse.

I would appreciate your helping me with my research. You will be asked some questions to which you are requested to respond as honestly as possible. There are no right and wrong answers. An English and Setswana version of the questionnaire is available.

The provision of the identity of individual respondents will not be divulged and thus be treated with utmost confidentiality.

Through this study, I hope to obtain information that will be useful in understanding the nature of the reasons or factors that compel young people to abuse cannabis. This information will hopefully, also help in formulating a multifaceted treatment approach and prevention towards the abuse of cannabis.

Before we continue, I need you to indicate to me whether or not you agree to participate in this study.

YES	NO

(If participant agrees) : Thank you in anticipation for agreeing to participate in this study.

(If participant does not agree) : Thank you for sparing some time to listen to me. I am sorry though you will not be able to participate in this important study.

Boitumelo S.P. Ramphomane

M Soc Sc (Clinical Psychology)
Department of Psychology
University of North-West

APPENDIX B

INTERVIEW SCHEDULE

SECTION A

DEMOGRAPHIC DATA

I would like to ask you some personal details to start off our discussion:

1. What is your age at present?

   .....

2. Race (observed)

   .....

3. Gender (observed)

   .....

4. What is your marital status?

   .....

5. What is your highest level of education you have achieved?

   .....

6. Which place are you from?

   .....

7. With whom do you stay with at home? (parents or guardian) please explain.

   .....

8. How would you describe your family's financial situation?

   .....

SECTION B

DRUG USE INFORMATION

Please allow me to ask you about your drug taking.

1. At what age did you actually start using cannabis?

   .....

2. Why did you decide start using it?

   .....

3. What do you think are the three (3) main reasons why young people abuse cannabis?

(i).....

(ii).....

(iii).....

4. What to your knowledge is the main reason for your continuation of drug use?

   .....

   .....

SECTION C

FAMILY ENVIRONMENT

1. Do you have a mother, father or any elderly person in your family who uses alcohol or other drugs? Explain.

.....

2. Did you grow up in a family were drugs were overtly used by elders? Explain.

.....

3. How would you describe your family or home atmosphere?

.....

.....

4. Do you normally talk to one another in the family over personal and general matters?

SECTION D

DRUG USE IN RELATION TO PARENTAL CONTROL AND SUPPORT

1. Do you see your parent(s) or guardian as being strict or lenient in terms of discipline?

.....

2. Are your parents always there when you need them?

.....

3. Do your parents give you enough emotional support?

.....

.....

Thank you for reflecting on and carefully responding to these items.

REPUBLIC OF SOUTH AFRICA

NORTH WEST PROVINCE

NWU LIBRARY

Bophelong Psychiatric Hospital
Private Bag X2031
Mafikeng
2745

Tel.: (018) 383-2005
Fax: (018) 383-2142

B.J Oliphant

Ms B. Ramphomane
PO Box 3751
MMABATHO
2745

PERMISSION TO CONDUCT RESEARCH AT BOPHELONG PSYCHIATRIC HOSPITAL

Please be informed that provisional permission is being granted for you to conduct the study entitled: **An Investigation into the Perception of Cannabis-induced Psychotic Patients on Cannabis / Marijuana abuse at Bophelong Psychiatric Hospital in the North West Province**.

Permission is granted subject to the following conditions :-

- That **Financial assistance** by the Department, as per your request, is subject to final approval by the Head of Department.
- That on completion of the study, a **copy of your research / dissertation** shall be submitted to each of the North West Department of Health and Bophelong Hospital.
- That **you acknowledge** the North West Department of Health in your final report.
- That **due ethical consideration** shall always be given throughout the process of conducting the study.

Yours truly

for Chief Executive Officer
Mafikeng / Bophelong Hospital Complex

GENERAL MANAGER
BOPHELONG PSYCHIATRIC HOSPITAL
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26 MAR 2002
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Telephone: (018) 387 5744

Enquiries: Mamiki Mooki

06 November 2002

Ms B Ramphomane
Tel No: 083 597 9017

RE: REQUEST FOR PERMISSION TO CONDUCT A RESEARCH AND FUNDING.

This serves to inform you that permission to conduct a research entitled: ***An investigation into the perception of cannabis/marijuana abuse at Bophelong Psychiatric Hospital in the North West Province,*** and the request for funding, was granted and approved by the Departmental Research Committee at its meeting held on 30 October 2001 subject to the following condition:

i. That on completion of the research project, a copy of your research report will be submitted to the North West Health Department.

You are therefore requested to submit a report on how money was utilized for your research, i.e. for transport, consumables, hourly wages, etc. If you can get receipts for a specific item of expenditure, you must attach it as proof, if not, clearly describe how it was spent. You must also provide progress/final report on your research, to the Departmental Research Committee.

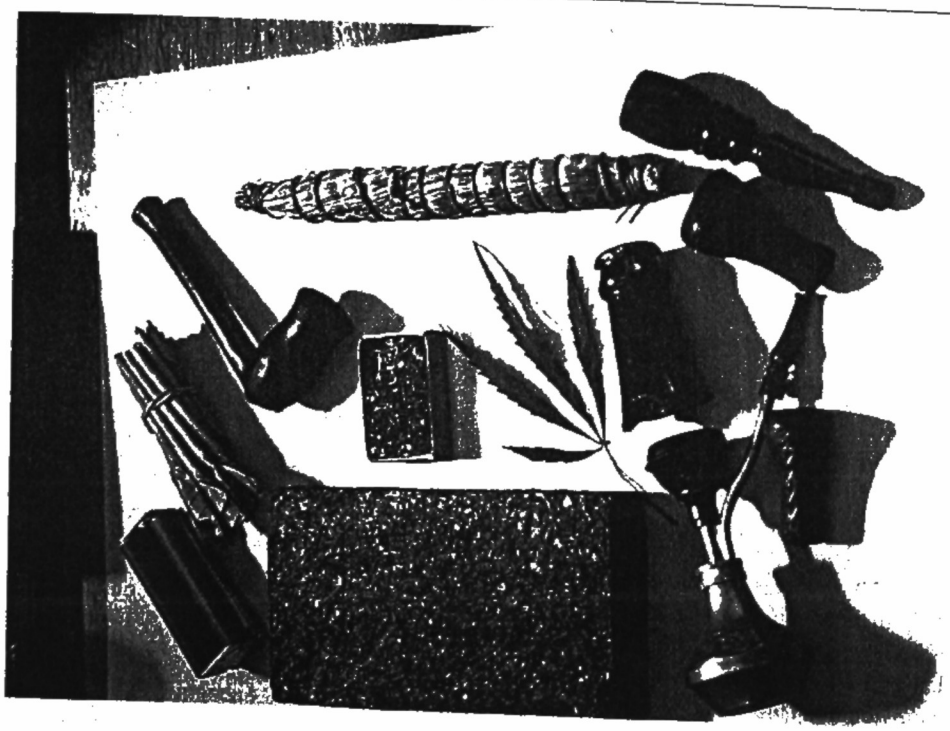
Best regards,

Dr A Verburgh
Chairperson: Departmental Research Committee

AIDS HELPLINE
0800-012-322

Join the Partnership Against AIDS – Our Action Counts

Dagga



MATEKWANE - Kgomo ya bonkgi, Ditlakala, Dikata, Nama ya kgoho, Tjhefu.
Mabaka a tshebediso e empe - ho kgatholoha, ho fedisa mokgathala ho ikutlwa o le morolo le ho ikutlwa o lokolohile ho qoba dinnete tsa bophelo.
Matshwao a supang ho inehela dithethefatsing - mahlo a mofubedu, dintshi tse wang, tlala le lenyora le sa tlwaelehang, ho ba pelo e kgutshwanyane, ho bua haholo, ho se nahane hantle, ho tshehatsheha, ho fokollwa ke pono.
Matshwao a ho ikgula - Ho se phutholohe, ho rata ntwa, tlhobaelo, ho fela pelo, ho hloka ho itaola, borokwana, ho tshwenyeha, phokotseho ya takatso ya dijo, ho opelwa ke hloho.
Dikotsi - Dikotsi tse bakwang ke phokollo ya pono, ho rata ntwa ho bakwang ke botahwa, mokgathala o isang bohlanyeng, tshenyeho ya mmele ka mokgwa wa: bohloko ba matshwafo, kotsi ya ho ba le kankere ya matshwafo, tshenyeho ya dikoromosome, tshitiso ya dihomone tsa pelei, pelei.

MATEKWANE -
riso e e seng ya mel
bo feteletseng go itlhaba l
matlhong, dintshi tse di w
go tshegatshega, go se boi
ntwa, tlhobaelo, go fela pe
dibete, phokotsego ya kel
bone sentle, go rata ntwa l
kgobalo ya mmele e tshwa
makgwafo, tshenyego ya

INTSANGU - I-Gras
Poison.
Ukungasetyenziswa njeng
wonwabile, ukubaleka inya
Ukunqongophala kwegazi
ukulamba okungaqhelekan
ingqiqo iyaphazamiseka, uy
ukuphelelwa bubuthongo, u
ukucaphuka, ubucaphucaph
Iingozi - lingozi zibangelwa
kukusetyenziwa kweziyobis
wemiphunga, umntu ufika e
kwemithambo yokwenza ab

DAGGA - Joint, Grass.
Redes vir misbruik - Vir on
euforie, om van werklikheid
ooglede, onnatuurlike dors
oordeelsvermoë, giggelaanv
Ontrekkingsimptome - Rus
selfbeheer, lusteloosheid, ge
Ongelukke weens verwronge
angstigheid wat lei tot toksie
risiko van longkanker, chron
steriliteit.

Dagga vererger glo skisofrenie

Mannheim (Duitsland). – Daggagebruik kan tot voortydige skisofrenie lyd en dit erger maak in mense vatbaar vir geestesiektes, lui 'n navorsingsverslag wat gister bekend gemaak is.

Die Nasionale Instituut vir Geestesgesondheid sê hy het 232 skisofrenielyers bestudeer en gevind die gereelde gebruikers van dagga het op 'n gemiddelde ouderdom van 17 skisofrenies geraak. Nie-gebruikers het die psigose op 25 ontwikkel.

Bykans 35% van die pasiënte het onstabiel geraak in dieselfde maand waarin hulle dagga begin gebruik het. Daar kan egter nie met sekerheid gesê word dagga veroorsaak skisofrenie in andersins gesonde mense nie. – **Sapa-DPA**

Sunday World

Issue: 16 Jan 2000 Region: National Circulation: not certified

)agga led to psychotic episode or model pupil of posh school

Medical Advice by Dr Steve Toovey

receptionist sounded most ious when she buzzed and ed me to take a call. Normally I not to interrupt consultations h telephone calls, but there was ething in her voice that told this was an urgent one.

The call came from a patient o had recently moved out of weto into suburbia.

At the other end of the line I rd an extremely anxious ther say: "My son Nyana is ting really very strangely, ctor."

I knew that the problem was rious when she explained: "He's raid to come out of his room cause of voices he hears outing at him in the pas-geway."

This was a sudden illness, riking a previously perfectly ealthy teenager. Nyana, enrolled a leading private school had lways been a model pupil, as well s his mother's pride and joy.

"I'd bring him in to you, doctor, but he just won't co-operate. He refuses to leave his room, hiding under his bed in case the voices see him."

I assured the mother that I would be with her as soon as possible, instructing her that in the meantime she was to do nothing to startle or threaten Nyana, even letting him stay under his bed if he so wished. When I reached the Mtetwa's new suburban home, I was ushered through to Nyana's room, where I found him cowering under the bed.

'I know they can see me through the walls'

Realising that it would take some time to get the situation under control, I prepared myself for a long visit. "Nyana, can you hear the voices here in your bedroom?" I said. Recognising me, he gave an almost sensible answer.

"No doctor, but I know they can see me through the walls. They've threatened to kill me if I go out into the passage."

Eventually, after much reassurance, I persuaded Nyana that he would be safe sitting on the bed alongside me, and that if I gave him an injection it would protect him against the voices.

It was obvious that Nyana was suffering from an acute psychotic reaction, this being the term doctors use when someone loses touch with reality. In young people this is usually attributable to either drug abuse or schizophrenia.

As there was nothing in Nyana's earlier behaviour to suggest schizophrenia I strongly suspected that he had been taking drugs, perhaps smoking dagga.

Either way, drugs or schizophrenia, the initial treatment is a large tranquilising injection that restores normality to the nervous system. The next step was admission to a psychiatric hospital.

Urine tests at the hospital revealed the presence of dagga, indicating that Nyana had been led astray at his new school.

Psychotic reactions such as Nyana's are not uncommon with dagga use, often resembling an attack of schizophrenia.

Nyana should make a full recovery from his illness, which should have taught him a lesson, although not the one his mother intended when she enrolled him at an expensive private school.

Signs and symptoms of drug-induced psychosis

- Victims may hallucinate, seeing things that do not exist.
- Victims often complain of hearing voices, some uttering threatening messages.
- Victims have the mistaken but firmly held belief that they are being persecuted.
- Psychotic patients often look anxious and frightened.
- Victims appear strange and distant from family and friends.
- No reasoning or explanation can convince victims that the voices do not exist.
- The psychosis is often reversible on stopping the offending drug.

Drugs that can cause psychotic reaction

- Dagga
- LSD, commonly called acid
- Alcohol in combination with illicit drugs

Issue: 22 Sep 2000 Region: Northern Province
SORRY PUBLICATION RECEIVED LATE

Help your child to stay drug-free

More and more children in South Africa, especially teenagers, are becoming hooked on drugs.

According to the chairperson of the Gauteng Treatment Task Force for Substance Abuse Forum Dr Sean Zeeliy, the root of the problem is that there are no preventive measures which teaches children from early learning school-level about the dangers of drugs.

Most programmes are reactive to the problem, rather than pro-active. However, the book *Help Your Kids Stay Drug-Free*, by Paul Francis, lists a 10-point guide for concerned parents.

♣ How do I know if my child is taking drugs?

Alcohol abuse can cause uncharacteristic humour or unexpected aggression. Taking stimulants often results in bursts of energy followed by extreme tiredness, while hallucinogens can cause paranoia and depressants cause drowsiness and slurred speech.

Erratic eating habits, blotchy patches on the mouth and nose and dilated or constricted pupils are other physical signs. Finding cigarette ends, needless or syringes are move conclusive pointers. If money or objects go missing from your home, your child may be struggling to fund an escalating habit.

♣ Why do youngsters turn to drugs?

Many bright and seemingly well-adjusted teenagers take drugs simply because they yearn to be the life and soul of the party.

Some of the teenagers try drugs to rebel against parental authority, and others resort to them in an attempt to cope with the pain of family troubles such as divorce.

♣ Teach children to cope with peer pressure

One of the most powerful influences on children is their friends. Most addicts are first introduced to drugs by their friends. Self-esteem is vital — with it your child can resist and handle peer pressure.

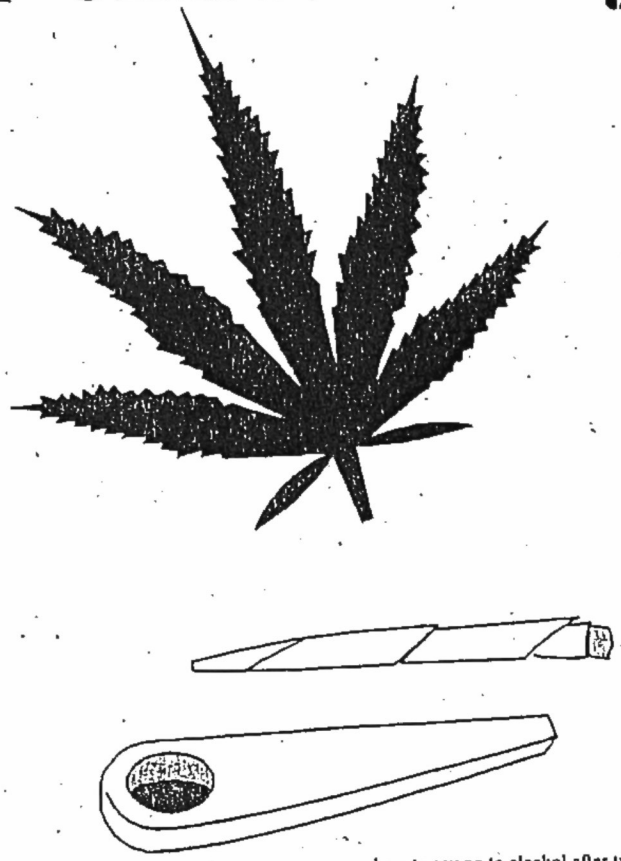
You can help develop it by giving unconditional love. Children whose parents demonstrate their love for them, irrespective of the child's achievements, are less insecure and less likely to seek approval from their friends.

Building them up: tell your children they are wonderful, and mention at least one good thing about them everyday.

Teaching the value of positive criticism: we all have faults and learning to take criticism can help us grow.

♣ Teach children the essential skills

Help youngsters to learn values and to learn to live by these values, whatever the consequences.



Parents need to have view – on authority and power, friends, religion, health and sexuality – and must pass these on to their children.

Well-defined boundaries give children security. They may push against those boundaries to test them, but will feel secure when they do not shift.

In your values put your child in potentially awkward situations, work out how they might cope. For example, if one of your values is not to get drunk and your teenager belongs to a rugby team which regularly gets drunk, help him learn how to say no to alcohol after two drinks.

Many kids take drugs to help them cope with emotional pain. Explain that life is full of difficulties, and that the trick is not avoiding problems, but coping with them.

Keep an open door to your child's friends. If you close doors, you child will not only be more determined to make that friendship work, but you will not know what is going on.

♣ Teach children to accept responsibility for their actions

Teach your children to handle money. Give them pocket money and a choice as to what to spend it on. Teenagers' emotions can soar and plummet on a daily basis. Teant them that making decisions based on moods can be dangerous.

♣ Teach children how to handle alcohol

Teach your child about alcohol — that a little can be good, but that 1 000 people under the age of 15 are admitted to hospital for emergency treatment each year with alcohol poisoning.

Let them try alcohol in stages. When they are older, allow them an occasional low-alcohol drink, and later still, the odd glass of wine.

♣ Help your child to stay tobacco-free

Teach them that smoking is a major health risk. When talking about drugs, always try to include facts on tobacco and alcohol.

♣ Listen to what young people are saying

Children need time with their parents, and, surprisingly, the older they get the more time they need. Growing teenagers face many dilemmas; they need you to be their refugee.

Make time for your children by having a weekly activity that you do together. Listen carefully to what they tell you, and show them you value their opinions.

Share your mistakes and failures, and always give them all the facts, not just the one you select to support your view.

♣ Do not take all the credit — or the blame

If your children do succumb to temptation, you might ask yourself: "Where did I fail?" The answer is: you have not — there is no magic formula for bringing up children, and no guarantees.

Recognise the limits of your responsibility. We cannot always make other people do what we want them to. Focus on the positive things you have done instead of wondering what you have done differently with hindsight.

Confide in good friends. Plucking up the courage to discuss a problem with a trusted friend can immediately reduce the burden and help find answers.

♣ What and when to tell kids about drugs and alcohol

Adolescents will invariably do things you are not happy with, but pick your battles carefully. There is no set of formula for talking about drugs, and no right time to start. Shock tactics do not work.

Pick up a health education leaflet on drugs and teach your children. Find out what and when your school teaches about drugs, and ask your children what they learned in school. — BuaNews (Source: Daily Mail, London)

NEWS CLIP

Servamus

70465

Issue: Mar 2000 Region: National Circulation: not certified

Don't be a STAR in the "DOPE SHOW"

Coma White

There's something cold and blank behind her smile
she's standing on an overpass
in her miracle mile
(coma):
"Your were from a perfect world
a world that threw me away today
today to run away"



A pill to make you numb
A pill to make you dumb
a pill to make you any-
body else
but all the drugs in this
world
won't save her from her-
self

Her mouth was an empty
cut
and she was waiting to fall
just bleeding like a polaroid that
lost all her dolls
(coma):
"You were from a perfect world
a world that threw me away today
today to run away"

A pill to make you numb
A pill to make you dumb
A pill to make you anyone else
but all the drugs in this world
won't save her from herself
-Marilyn Manson-

Madaleen Fourie

NEWS CLIP

Servamus

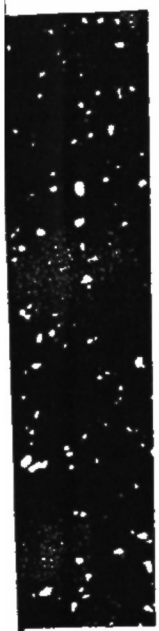
70465

Issue: Mar 2000

Region: National

Circulation: not certified

drugs





Millions are captured worldwide in the downward spiral of drug abuse. Drugs are used by younger and younger children. Drug abuse must be seen as the fruit resulting from a deeper problem. Drugs are seen by many young people as an acceptable and highly effective way of dealing with problems, which actually entails escaping from them. Perhaps the two major factors of influencing experimentation with drugs among young people are lack of affection and attention from parents, and peer pressure. A performance-orientated society asks sometimes more than there is to give. Most parents think that their kids will never get involved with drugs and do not inform or warn them. Often parents themselves are uninformed about drugs. On the other hand the "harmlessness" of a drug is overemphasised by the peer group. As we have seen in this series of articles the effects of drug abuse don't end with the drug abuser but spill over to his/her family, friends and society.



It is important to take note of any marked changes in a person's behaviour patterns, and it is equally important to avoid becoming unduly suspicious or make over-hasty decisions. Avoid making assumptions based on a single isolated characteristic, and keep communication channels open.

Drugs attract paraphernalia like

- The excessive use of mouth sprays, chewing gum and sweets to camouflage the smell of alcohol
- Burning of incense to disguise sweetish marijuana odors
- Continuous use of eye-drops to clear blood-shot eyes
- Sunglasses worn at inappropriate times
- Unexplained tablets, powders or small dry seeds or dagga pips in pockets, handbags or plastic bank sachets
- Cigarette rolling papers or thin, hand-rolled cigarettes
- Inhalant substances such as glue, thinners, Spray 'n Cook, turpentine, lighter fluids, acetone etc
- Unsmoked cigarettes with the filter broken off
- Dagga seeds in ashtrays and on carpets
- Broken bottle necks, dagga pipes or "hubbly bubblies"
- Hypodermic needles or syringes
- Single-edged razor blades (for cocaine)
- Empty cough-mixture bottle or diet pill containers (Thinz)
- Tiny spoons, bent spoons, burnt spoons and tin foil (for heroin preparation)
- Brown marijuana stains or glue stains on the fingers, clothes, handkerchiefs or bed linen.





Identifiable characteristics of drug dependency

Physical indicators

- Red/blood-shot eyes, visual distortion
- Markedly dilated or constricted pupils
- Unexplained, repeated vomiting or abdominal pains
- Indistinct speech
- Excessive perspiration
- Delayed reflex action and lack of co-ordination
- Disorientation, dizziness, trembling of hands
- Regular nosebleeds
- General deterioration of health
- Inexplicable weight loss
- Injection marks/bruising/scabs/sores on arms, legs or private parts
- Yellow stains on hand/fingers as a result of smoking dagga
- Endless cold symptoms (sore throat, coughing).

NEWS CLIP

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Behavioural indicators

- Long uninterrupted sleeping periods or insomnia
- Change in appetite
- Aggressive/hostile behaviour
- Unaccountable mood swings/personality disturbances
- Lack of communication with family
- Lying and dishonesty
- Guilty behaviour; avoiding eye contact
- Disappearance for considerable periods, especially at night
- Sudden change of friends or becoming loners
- Hallucinations
- Theft (money, household articles) or abnormal spending
- Neglect of personal hygiene
- Untidiness, if previously tidy
- Impaired work performance; reduced concentration span
- Lack of motivation (school, friends, hobbies)
- Visits to clubs known as places where drugs are used/abused /sold.

I know someone who is using drugs - what now?

Do not

- get hysterical
- threaten the person physically or emotionally
- promise them rewards if they stop using drugs
- moralise
- punish them
- throw them out of the house
- manipulate them
- play the emotional war game of: "How could you do this to us?"
- believe promises that it won't happen again
- lecture them on the dangers of drugs
- tell the whole world
- blame other people
- call the police
- try to find out where they are getting drugs from.

Positive action

- Try to remain calm.
- Facilitate and communicate supportiveness.
- Seek professional help from your doctor, counsellor, spiritual leader, rehabilitation centres, help lines.
- Join a support group for parents in the same situation.
- Talk to someone about how you are feeling (a counsellor/your doctor).
- Read as much as you can about drugs and addiction.
- Stress your LOVE and CONCERN for your child.



SA's pre-teen drug scene hooked at 11

When primary schools started a drug awareness programme for kids in Grade 5 to Grade 7 this year, parents reacted with shock and disbelief. Surely this is not a primary school problem? Fact is, it's fast becoming one. Marion Scher ventured into the classroom and found addicts as young as 12

'At school they told us dagga was addictive. Rubbish, man, I've been smoking for three years and I'm not addicted. Dagga chills me out, it helps me think straight. When I go to clubs, I take some 'e' [Ecstasy]. Everyone knows it can't hurt you.'

You'd be right if you thought these were the words of a hardened drug addict. But Sean* is a little different from his peers in the drug rehab programme. He's just turned 13.

This story is part of a horrific scenario playing out in primary schools all over South Africa. Primary schools? Yes. Your child's school? Probably. It will never happen to your child? Well, read on and you could change your mind.

'I'll never forget the day I got the phone call from the school,' recalls Angie*, Sean's mother. My first reaction was total disbelief. I insisted they run the test again. The school retested Sean, and again the tests proved positive. They also discovered that Sean had been smoking dagga for quite some time – and that he'd experimented with other, highly dangerous, drugs.

'The parents are usually the last to know,' explains Laura Edmonds, a private social worker and co-founder of Aspen Oak Associates, which specialises in the treatment of adolescents who have alcohol- and drug-dependency problems.

'Drugs in high schools are nothing new – most people know that. What they don't know is just how this problem has filtered down to primary schools. Each year we're seeing younger kids with drug problems. It won't be long before we're seeing 13-year-olds on heroin, which is currently flooding the market.'

Children are developing faster, both physically and mentally, these days, says Laura, but parents still don't think to 'check up' on their 10- or 11-year-olds, the friends they mix with, the places they go to. A girl of 12 or 13 today often has a boyfriend a couple of years older. He takes her to parties and clubs – and she thinks she has to do drugs to fit in and to be cool.

Twelve-year-old Kerry* is sure she's cool. I arrive to interview her at her friend's house in an upmarket suburb of Pretoria. Anonymity is promised – she doesn't want her parents to know.

'I don't do heavy drugs. I only smoke dagga,' she says. Fresh-faced and excited about life, Kerry tries hard to convince me just how safe she is. 'Well at least I've given up cigarettes. I used to smoke 20 a day. But my friends all stopped, so I did too. Most of them smoke a lot more dope [marijuana] than me.

'I had my first joint at my 12th birthday party. Some of the guys were smoking at the bottom of the garden and they asked if I wanted to try some. One of my friends dared me, so I did.

PHOTOGRAPHS: IMAGE BANK, DRUG WISE

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ge: 27 Oct 1999 Region: National Circulation: 110 776

Kerry says it's easy to get dagga. 'The decent stuff costs about R25. That's really powerful. If you don't have any money, they'll take clothes or anything.'

'They' are the dealers. These are not sleazy gangster types – they're in the classroom. A kid who knows an older kid, 15 or 16, who's dealing – that is, working for a dealer and getting his 'stuff' free.

Like all addicts, these kids will do anything to get a 'fix'. 'If the guys are really desperate, they inhale benzene or lighter gas,' continues Kerry matter-of-factly.

'The only thing I'm afraid of is my parents finding out. But I'm careful and always have eyedrops and deodorant on me. My parents haven't got a clue.'

How is it possible that parents and teachers don't know? Kerry's answer is swift. 'You don't touch anything on Sundays. You just chill out. That way your parents don't notice anything.

'Our teachers have no idea what's going on. Guys smoke dope in the toilets and in the playground and never get caught.'

Not all teachers are oblivious to the problem. Highveld Primary in Johannesburg this year started teaching Sanca (South African National Council for Alcoholism and Drug Dependency) drug-awareness programmes from Grade 5, says principal Karen Warder.

'The local high school was encountering almost insurmountable drug problems. Since those children have brothers and sisters at our school, we knew it wouldn't be long before we had a similar scenario,' she says. 'We started testing any child we felt could have a problem.'

The parents' response was total disbelief. 'It isn't hard to see where many of these problems start,' says Karen. 'Dropping the kids off at the mall for the night is an easy way out of responsibility. Most parents have no idea of the power of peer pressure. Children today are looking for a "quick fix". They think drugs are the answer. Kids get pocket money of anything from R200 to R2 000 a month, so finance is no problem.'

Highveld Primary's drug awareness programme may be extraordinary, but other primary schools are following suit. Sanca's Kathy Vos says this year the programme has been taken to 17 Gauteng primary schools.

'Most schools are still reluctant to get help. They see this as an admission that they have a drug problem. Unfortunately, when they do call us in, they'll be in crisis.'

Another principal who's playing a proactive role is Wendy Hibbert from Aurora Private School in Randburg. 'We have children from preschool through to matric, and I knew if I didn't get a proper drug-awareness programme in place I'd soon be looking at a serious problem,' she says. 'So in 1994 we introduced a policy that anyone enrolling their child at the school, from Grade 0 up, had to sign a form agreeing to the programme and to random testing of their child.' The children don't know when the tests will be conducted. The saddest part, says Wendy, is when a child who's tested positive looks at you and says, 'Please help me, m'am.'

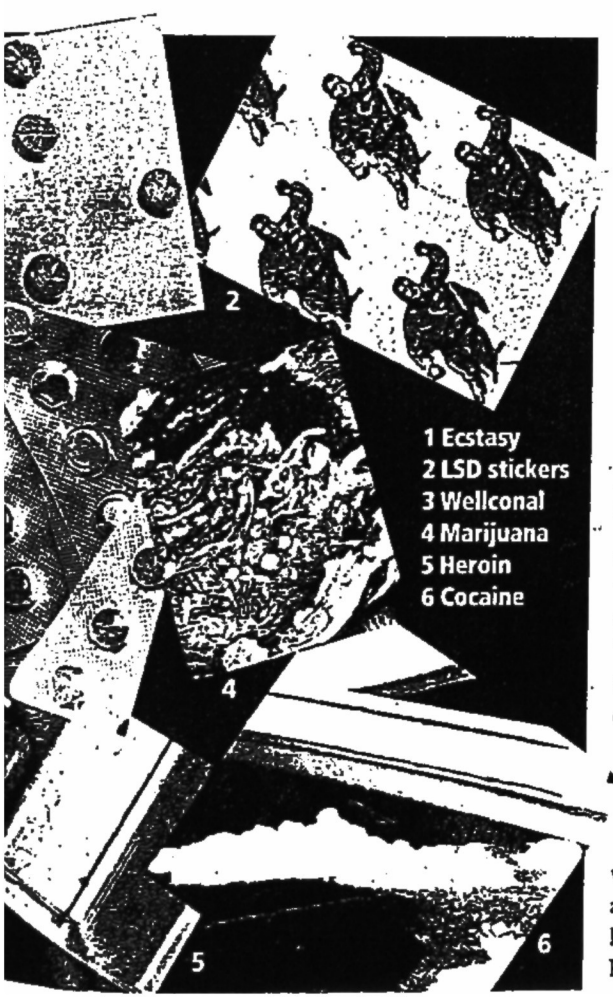
Wendy's determined to create a drug-free environment at her school. This term she's introducing a day when everyone – teachers, pupils, parents, anyone in the school that day – will get tested.

'Our learners know the testing is for their sake,' she says. 'Kids rarely take adults seriously when they tell them not to do something, so at Aurora we use outside help in formulating these programmes.'

The 'outside help' comes from anti-drug campaigners such as Superintendent Lobo das Neves of the police Narcotics Bureau. With 12 years' experience of dealing with drugs in schools he's way ahead of the 'smart kids'. 'Kids naturally experiment – if you can stop that experimental stage, you can stop drug usage,' he says. 'If your school doesn't have a drug programme in place, you're designing disaster.'

Lobo says one of the greatest problems facing kids today is the bombardment of information on drugs, particularly on the Internet. 'On the Net, you can find everything from how to cheat on a drug test to cultivating your own supply of marijuana. These sites put up convincing arguments to kids that drugs aren't bad for them; it's all an adult plot to stop their fun.'

The Narcotics Bureau drug prevention



Some signs to look out for

- Sudden weight loss
- Cough mixture in children's rooms or bags
- A drastic drop in school marks
- General lethargy and sleeping more than usual
- Lack of concentration
- Aggressiveness
- Mixing with a different crowd
- Sneaking out at night to places they don't normally go
- Whispered conversations on phones
- Increase in the use of deodorant and eye drops
- Incense and candles being burnt in bedrooms
- Clothing or anything else going missing from the house

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programme has three parts: one is for the children, another for the parents and the third is for the teachers. Just teaching children the evils of drugs is not enough these days: parents and teachers need to know what to look out for, says Lobo.

Another one-man anti-drug 'road show' is Steve Hamilton, an ex-drug addict. His organisation Riders of the Storm visits schools across the country.

It's vital that parents be aware of the dangers. 'Prevention is better than cure, and you can start by being your child's best friend,' he advises.

I'm sitting with a group of eight Aurora kids who've been through Lobo das Neves's programme. Has the course changed their attitude? 'It's not cool to do heavy stuff,' says Kevin*, a new pupil. 'But I don't believe them when they say if you have one pill you'll be hooked.'

Knowing looks pass around the table. Anyway, we can't really try anything in erm time 'cos we're tested,' says Rory*. 'Yeah, it's not really fair, 'cos if you get chosen to be tested, everyone looks at you real weird,' adds Kevin, obviously hoping he's not next.

'The testing really makes you think,' says Kathy*. 'Should I or shouldn't I? I don't want to get caught.'

'Yes, but then kids from other schools say you're a wuss, and you want to prove them wrong,' adds Kevin.

Where will they be going on Friday night? 'We're going to a garage party. It's great, because the parents don't come out of the house,' says one. How many of them will be drugging? Silence. Finally Kevin answers. 'About half, but not many from our school. They're too afraid.'

What would put him off? 'If my best friend died, maybe.'

'Almost nothing puts these kids off,' explains Sheryl Rahme, spokesperson for Toughlove, a parents' support group. 'You can't explain consequences to kids. They simply don't believe you. You tell them they'll end up in jail or an institution. But, after their first few smokes of dagga, they don't find themselves in jail or institutions. They have a great time. If you haven't got that message through to them before they take that first smoke, you can't tell them drugs are bad.

'Kids who drug become expert manipulators. A parent may notice behavioral changes but will put them down to too much schoolwork or problems within their child's social group. By the time parents come to Toughlove they know they have a problem. Toughlove is run by parents who've been through similar situations. We don't tell people to throw their children out, certainly not if the kids are under 17 or 18. This is when they desperately need their family's help.'

How bad can it get before a parent realises? Julie*, a mother of daughters aged 12 and 14 who tested positive for drugs, explains. 'When I refused to let them go to a club, my eldest daughter grabbed a knife and stabbed me. I'd seen their behaviour changing and ignored the signs. Without the school's help I'm not sure where I would've gone from there.'

Some parents resort to extreme measures to ensure their kids stay drug-free. One anti-drug campaigner says a friend has her daughter tested regularly – not because she doesn't trust her but so she has an 'excuse' when friends put pressure on her to try drugs.

Most campaigners believe information programmes – coupled with strict rules for children caught using drugs – are the only way to go. 'Can you imagine every kid at a rave saying, "I'd better not do any drugs, I could get suspended?"' Wendy Hibbert asks fervently. 'What do other schools say? – "We work on trust with our pupils." Yeah, right . . .'

* Names have been changed

Where to get help

Toughlove: Gauteng ☎ (011) 886-3344; Cape Town ☎ (021) 438-9662
Aspen Oaks: Gauteng ☎ (011) 792-7543
Superintendent Lobo das Neves: ☎ (011) 766-1189
Riders of the Storm: Cape Town ☎ (021) 789-1833; ☎ (082) 680-6707
Stepping Stones Treatment Centre: ☎ (021) 783-4230
Sanca: Gauteng ☎ (011) 482-1070; Durban ☎ (031) 202-2241; Cape Town ☎ (021) 945-4080
Drug Wise: Gauteng ☎ (011) 728-6668

Preventative guidelines for parents

- Keep the channels of communication wide open.
- Encourage home discussion about alcohol and drugs.
- Keep up to date with alcohol- and drug-related issues.
- Know where your children are.
- Check and cross-check their arrangements.
- Know your kids' friends and their parents.
- Don't give your children permission to attend events at venues where they're not usually admitted because they're too young.
- Don't let them go to house parties where there's no sensible adult supervision.
- Encourage your children to have their friends over.
- Set appropriate limits regarding curfews and outings.
- Get involved in talks and activities at your children's school.
- Promote self-discipline and responsibility in your children.
- Never promise or threaten anything you won't carry out.

If you suspect your child is doing drugs . . .

- Don't rant and rave or threaten your child physically or emotionally. Try to remain calm, act positively and be supportive. Shutting your child out or punishing her will only make things worse.
- It's no use blaming other people or trying to find out where your child gets the drugs – the problem is right in front of you. Don't believe promises that it won't happen again and don't promise rewards if drugging stops.
- Lecturing your child about the dangers of taking drugs won't do any good. And don't press the 'how could you do this to us?' button. Instead, seek professional help – your doctor, a counsellor or your child's school.
- Join a support group of parents who are in the same situation; it's important to talk to someone about how you feel. Read about drugs and addiction and, most important, stress your love and concern. Be your child's friend.
- Take a long, hard look at your lifestyle and see if you're a good role model.

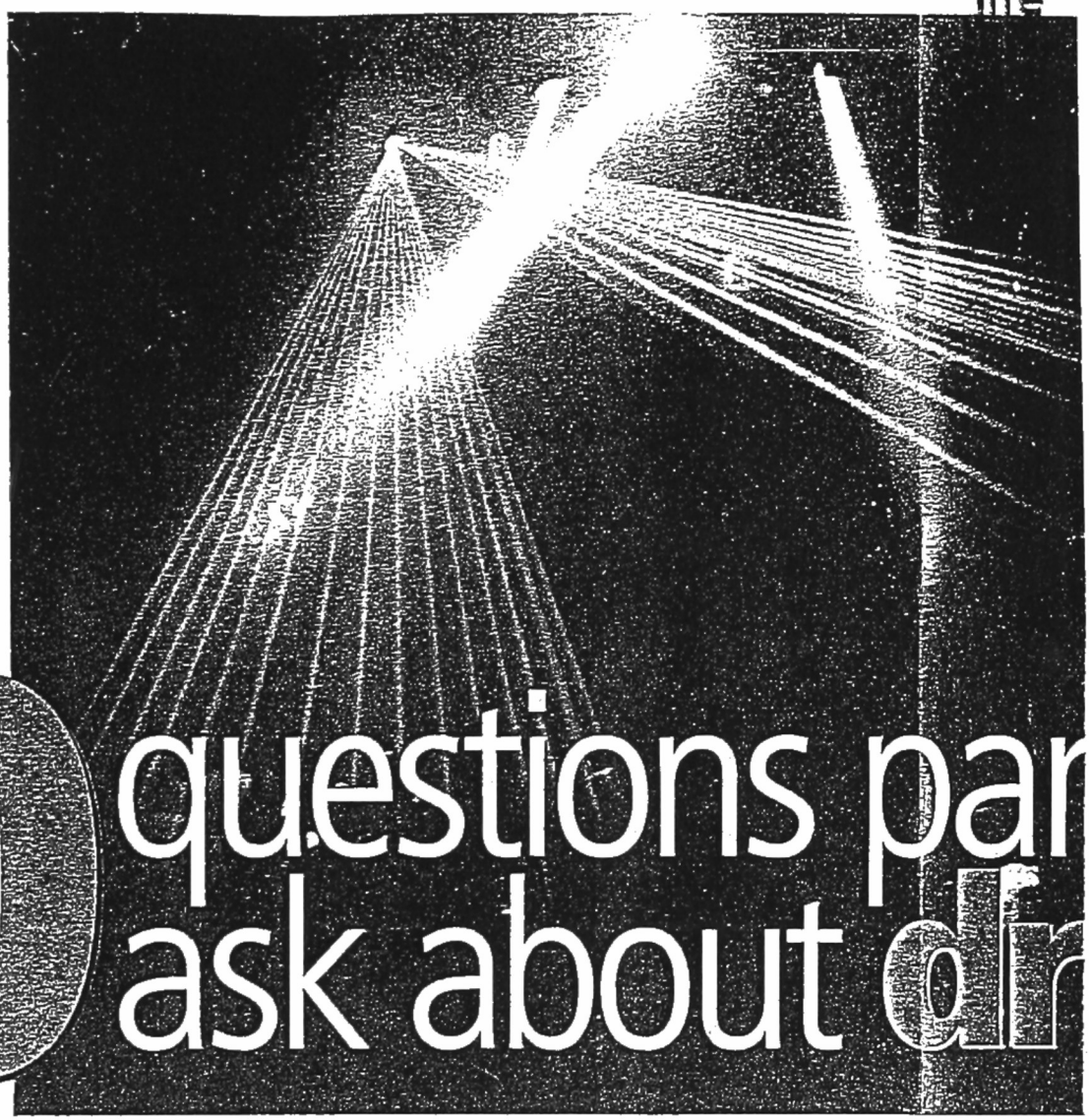
5 CLIP Woman's Value

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Do you know hat's happening at raves? Teenagers and drugs are not a ew combination, but for the current generation of parents there are new fears and nknown dangers



10 questions par ask about dr

As survivors of the hippie generation, any of us who are ow parents of enagers have first-and experience of creational drugs, have at least seen smelt them. But at doesn't tomatically mean e know what our ildren are going rough. Many ildren of primary hool age are likely be exposed to rugs in one form or nother, and some f the most mmonly used rugs, such as cstasy, were not ven around 20 ears ago.

1 Why would my child want to use drugs?

In their natural quest for freedom from adult control, teenagers are often drawn to risky behaviour, but for most young people illegal drug taking is not a part of normal life. The majority of young people who try drugs do not continue to use them, and very few suffer any known long-term harm to their health. Curiosity, the lure of forbidden fruit, the liking of the short-term effects, the fact that friends are experimenting with drugs, their availability, or simply the fact that they are another way of breaking the rules are all contributory factors in what makes drugs attractive to young people.

2 Should I search my child's belongings?

Think about the consequences of collecting evidence behind your child's back and how you would feel if someone you trusted did something similar to you. If a child feels that a parent is genuinely on his or her side, he or she is more likely to turn to the parent for advice or help — break that trust and you may be seen to be withdrawing your support.

3 How can I stop my child using drugs?

You can't. Drugs are widely available, and if a child is determined to use them they'll usually find a way. Passing on information about ways of reducing the risks associated with taking drugs could be a way of helping your child to keep safer; it could also be a way of helping them to consider all the consequences of drug taking, and not just the possible pleasure involved. Establishing frank discussions about drugs means they are more likely to talk to you about it if they find themselves in difficulties.

4 What if they deny using drugs?

Your child may well associate an admission of guilt with disapproval or punishment, and will deny all knowledge of drug use. However frustrating it is, try to resign yourself to the fact that you don't necessarily have to know whether your child is taking something in order to have a conversation with him or her about drug taking and the associated risks. Try to move the focus of the conversation away from what they may be doing and towards what they think could lead them to do it.

Woman's Value
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February 1999 Region: National Circulation: 122 430

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5 I suspect my child is using drugs. How can I tell?

Moodiness, sudden changes in friendships, loss of appetite, lack of interest in appearance and grooming, poor performance at school, unusual tiredness, lying and secretive behaviour are all possible signs of drug taking. Unfortunately, they are also behavioural traits common to most adolescents, regardless of their involvement with drugs.

The fact is that you are unlikely to be able to spot telltale signs of drug use. If you think your child is taking drugs, don't panic, and try not to confront or accuse them. Instead, ask yourself why you are suspicious. Don't leap to conclusions, even if you have found what you believe to be undeniable evidence of drug use. Scorched pieces of foil, the remains of what appears to be a dagga cigarette or joint with a small cardboard tube filter (roach), needles, charred spoons, etc are all associated with drug use, but short of witnessing them partaking in drugs, how can you be 100% sure that they have been used by your child and not a friend of theirs?

Brief yourself with as much up-to-date information on drugs as you can find, and try to have a calm, quiet chat with your child. Reassure them that you want to talk rather than interrogate, and remind them that your concerns are over their health and wellbeing rather than discipline. Most children of school age will already be learning drug awareness, and the more that parents can be involved in learning about this with the child, the greater the likelihood that the child will turn to their parent for support or help when needed.

IAFRIKA PHOTO AGENCY

6 My child uses dagga. Will this lead him to become involved with other, harder drugs?

Dagga is the most commonly used drug. Although a number of dagga users will also take other drugs, it doesn't necessarily follow that dagga provides a "gateway" to more dangerous drugs for the majority of users.

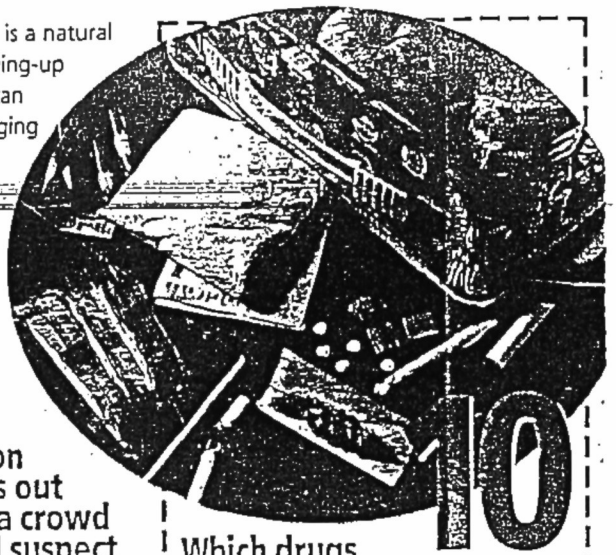
7 I know that my child is using drugs. Am I to blame?

Don't blame yourself, even if your child encourages you to feel this way. Make your criticisms constructive, and ask yourself how your relationship with your child could be improved to allow further opportunities for dialogue and understanding.

Experimentation is a natural part of the growing-up process, which can also involve hanging out with a new crowd, getting interested in fashion, music and sex, as well as trying alcohol, cigarettes or even drugs.

8 My son hangs out with a crowd who I suspect are using drugs. What can I do about it?

Experimenting with different groups of friends is a natural part of your child's growing up. Ask yourself why you don't like the look of your child's latest friends — the best way to keep the channels of communication open and maintaining respect is by trying to treat their friends as you would any other guest in the home. If you have heard or witnessed something among the group that sounds alarm bells, try to open a discussion with your child around the subject of drug use and acceptable behaviour.



10 Which drugs could they be using?

- Dagga (marijuana, cannabis, dope) — the most widely used illegal drug. Usually smoked, sometimes eaten in dope cookies. Looks like a green herb.
- Mandrax (white pipe) — sometimes mixed with dagga. Looks like a white tablet.
- Ecstasy — (E) commonly associated with rave parties. Looks like a tablet. The latest development is a mixture of heroin and Ecstasy.
- Acid — (LSD) also often taken at raves. May look like a tablet, or be licked off printed pictures, often off cartoon characters.
- Heroin — (H, smack) is smoked or injected. Looks like a brownish powder or cake.
- Cocaine — (blow, crack) is sniffed or smoked. Looks like a white powder or crystals.
- Speed (amphetamines) — taken to stay awake for parties or to study. Looks like a tablet, or a powder.

9 Where can I get help for my child if she runs into problems with drugs?

You can get information and counselling through SANCA (South African National Council on Alcoholism and Drug Dependence)

Johannesburg ☎ (011) 482-1070
Durban ☎ (031) 22-2274
Cape Town ☎ (021) 945-4080
Plettenberg Bay — Dot's Plot ☎ (0445) 7-39103
Mossel Bay ☎ (0444) 911-462
George ☎ (044) 884-0674
Knysna ☎ (0445) 82-5260
Bloemfontein ☎ (051) 447-7271



WS CLIP

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CAN YOU FORCE SOMEONE YOU LOVE TO DITCH DRUGS?

NO, BUT IF YOU HAVE THE STOMACH FOR IT THERE IS A WAY TO GIVE THEM A REALITY CHECK – IT'S CALLED INTERVENTION. IT'S CAUSED CONTROVERSY AMONG THERAPISTS BUT IT MAY BE AN ADDICT'S LAST HOPE

N ANDREW*, a location for a film company, began ring unpredictably, Jill* sus- d he was doing coke again. assured her he was clean e they got married but now, years on, she recognised igns. He'd become moody, were arguing continually, e'd started disappearing for s. Jill tried telling him he ed help but he insisted he in control. In fact, he said, if wasn't always bugging him, ouldn't need to 'de-stress'. eling frustrated and helpless, vatched Andrew sink deeper addiction and denial until, esperation, she went to a nsellor for advice. The coun- or suggested an intervention, Jill persuaded Andrew's bro- , two of his close colleagues l an old friend to join her in fronting him.

Following the advice of her nsellor, Jill had set certain nditions: if Andrew wasn't pre- ed to get help, he would have move out. Andrew opted to ve. A few days later he told Jill 'd go for therapy only if she k him back. Jill, supported by group, was now in a powerful sition: she told him there uld be no negotiation until he nt for treatment. A few weeks er, Andrew, desperate to come me, agreed to get help. He is w in an outpatient programme an addiction clinic.

Unfortunately, tidy situations e these are rare. Unaware of y options, most people in the same situation stoically wait for the addict to reach rock bottom when, hovering between life and death, he or she agrees to go for rehabilitation. But rock bottom may be too late.

How would you feel if you'd done nothing to help your partner, a relative or a friend, and then that person killed a pedestrian while driving drunk, or was shot by a dealer who'd been kept waiting too long for payment? Would you ever forgive yourself? Would you ever stop wondering what might have happened if...?

WHEN INTERVENTION WORKS

If you're not willing to risk waiting, an intervention might be the answer. Essentially a constructive confrontation, an intervention involves a group of family members and close friends who are concerned about someone they love. Briefed beforehand by a counsellor, they face the person on neutral ground. Combining a firm message with a tone of love and respect, they let him or her know that they care but can no longer be supportive unless there is a change in behaviour. The person is asked to accept help immediately.

For the person confronted, this unexpected, emotional and often embarrassing experience can be an effective wake-up call. For the group, it's a way of turning their individual helplessness into focused, constructive group action. 'Intervention helps a family get out of its enabling role,' says Anita Badenhorst, clinical manager of the Chemical Dependency Unit at the Crescent Clinic, Cape Town. 'Families often believe that if they stop putting pressure on the addict, he'll stop. They get roped into supporting his habit – giving him cash, for example, so he won't buy on credit and get himself into trouble with the dealer – with disastrous consequences. They become as powerless as he is.'

Because addicts are ruled by denial, relatives and friends often realise the severity of the situation long before they do. 'When confronted in a one-on-one discussion, he will justify his behaviour by saying he's only hurting himself,' says Badenhorst. 'He'll blame it on his job, wife or family, which may once have been factors but become irrelevant once physical addiction has set in.'

Badenhorst believes the only way to break down the denial, to force the addict to admit he has a problem and get him to seek help voluntarily, is by confronting him as a group. Faced with people who know him well, he is more likely to take their message seriously. She suggests children should participate in interventions, since addicts find it more difficult to make excuses to them.

'Many people aren't happy to force involuntary treatment on the addict,' says Badenhorst, 'but ▶

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Intervene properly, you / don't have to.' During ervention, the relative realises he's hurting around him and agrees the family go ahead rganise treatment.

t it isn't always that 'Sometimes he'll com- with the treatment and e after one session to nish" them. He may also ome angry and hostile, o side-step responsibility storm out, but I advise ilies to do whatever they to get the addict to ee to one meeting with a rapist. It could be their t chance.'

KEN INTERVENTION ALS

adenhorst believes an inter- ention, whether successful r not, empowers the family. I ask clients how they would feel if something happened to their relative. If they intervene, at least they know they've tried. Even if the addict is furious that they've been conspiring behind his back, they can tell him they'd rather have an angry relative than a dead one.'

But we're not all capable of hardening ourselves sufficiently to see an intervention through to its uncertain conclusion. If you and your family doubt you'll be able to turn a relative away because he's refusing treatment, it may not be the right choice for you.

It's also not the right choice if you don't support tough-love tactics. Some therapists also think they're wrong, believing that any form of intervention violates the individual's freedom.

Says Anne-Marie Rencken-Wentzel, a Johannesburg psychologist, 'As soon as you set conditions, you become judgmental. I believe the best way to help addicts is with a non-judgmental approach. It's difficult when he keeps letting you down, and it's easy to remind him of everything you've done and what he should be doing in return. But setting conditions doesn't work with addicts – they will always find a way round them. You have to get them to take responsibility and realise that only they can ring the changes.'

David*, a medical intern, was 26 when he came to see Rencken-Wentzel about his stress problems. He was drinking very heavily, and his supportive parents and sister had taken it upon themselves to check him into addiction clinics. Despite having been admitted several times, it seemed to have had no effect on him.

INTERVENTION STEPS

THIS IS WHAT HAPPENS DURING AN INTERVENTION:

- First, the relatives assess whether an intervention is necessary. Sometimes a private discussion with the person in trouble, followed by one or two sessions with a therapist, will work. If the family members agree that their relative's life is out of control and that the stress is affecting their lives, it *is* necessary.
- Family members and close friends gather to discuss their plan of action with an interventionist, usually a psychologist or counsellor. They decide who will be involved and what plan of action they will follow. The therapist discusses with them what to expect, and will help them develop ways of dealing with possible responses from the relative. The number of preparation sessions depends on the urgency of the situation: if there's time, it's recommended that up to six sessions be set up; however, if the relative is heading for a crisis, everything can be condensed into one session.
- On intervention day, the family gathers in neutral territory, usually at the counsellor's rooms, and confronts the relative. In a loving, caring way, they ask him or her to accept help. If the help is refused, they set conditions and ultimatums.
- The group meets for one or two follow-up sessions with the counsellor.

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entzel counselled the
p taking responsibility
behaviour. Although
ger to intervene, she
m to offer David un-
love and pledge their
ile letting him decide
to rehab – in effect
him to take responsi-
imself. It took a few
David to realise – he
evelation – that now
uld change unless he
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self into a clinic.
unconditional love

TO KEEP OUT

RE TIMES TERVENTION ISN'T ENDED:

powerful tool for reaching
engaged in self-destructive
e behaviour such as drug
lcoholism, depression and
ders, as well as less com-
oms including gambling,
ddiction and sexual compul-

and support touches addicts emotionally and is often the turning point,' says Rencken-Wentzel. 'However, this doesn't imply that you need to support their habits. You don't have to fork out money for his drugs or drink. Decide what you are and are not prepared to do, and then do it in a consistent manner without feeling guilty.'

HELP FOR THE HELPERS

If you're considering any form of intervention, preparation, with professional guidance, is essential. The Intervention Center in America, which organises family interventions for various problems, particularly alcoholism and drug addiction, warns that interventions are difficult and delicate matters. It says they should not be undertaken without the advice of a professional and, except in special cases, without the professional present at critical times. Trying to accomplish it on your own could waste time and possibly worsen the situation.

It's important too that you feel comfortable with your interventionist, and understand and agree with what you're being asked to do. If not, stop the proceedings immediately and find someone else. □

* NAMES HAVE BEEN CHANGED

WHERE TO GO FOR HELP

THE CRESCENT CLINIC ☎ (021) 762-7666

HOUGHTON HOUSE ☎ (011) 728-0850

DURBAN ALCOHOL & DRUG CENTRE ☎ (031) 202-2241

FOR YOUR LOCAL SANCA DRUG AND ALCOHOL HELP CENTRE, CONTACT THE HEAD OFFICE ☎ (011) 482-1070

siveness. But, according to Johannesburg therapist Helen Lever, an intervention is not advisable when there is a chance that it could make a potentially dangerous situation worse.

The case of woman abuse, she feels, requires the most caution. 'It's a difficult situation for the families of abused women. They often feel guilty and think they should be doing more. But the abused woman has been so disempowered by her partner's behaviour that an intervention may take control away from her completely. If coerced into leaving him when she isn't ready, she will go back to him, and he may punish her with extreme violence. You also run the risk of alienating her.'

Instead of descending on her and delivering an ultimatum, Lever advises offering unconditional support. Set up an escape route for her to use when she's ready; tell her your home is available 24 hours a day if she needs a refuge, and give her numbers of therapists or organisations that could offer support. Keep expressing concern so that she knows you're there for her, and ask questions about the situation as a regular reality check.

'When you're desperate, it's easy to act impulsively,' says Lever. 'Don't. If you do decide to intervene, get professional input to help her strategise her leaving, and make sure the abuser doesn't get wind of it.'