Lay community healthcare workers' perspectives concerning the origins, dynamics and recovery from substance addiction

By

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Lay community healthcare workers' perspectives concerning the origins, dynamics, and recovery from substance addiction.

I declare that the above dissertation is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

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Summary

This research report focuses on lay community healthcare workers' perspectives on the origins and dynamics of substance addiction and recovery. Individual, semi-structured interviews were conducted with five lay healthcare workers from a rural community on the West Coast of South Africa. These individuals were recruited using purposive sampling. Thematic analysis was used to render six central themes, relating to the origins and dynamics of, and recovery from substance addiction as a presentation of unresolved historical or intergenerational trauma, seen against Engel's biopsychosocial model. These were related to the importance of the formative years, trauma exposure and contributing stressors, catalysts, both inhibiting and acting as incentives to change, motivational elements, resilience characteristics and conscripted silence. The last theme, conscripted silence, not exclusively, but specifically, strongly supports a relationship between alcoholism or substance dependence and unresolved historical trauma. These findings are in line with the results of the literature review.

Keywords: addiction, alcoholism, biopsychosocial model, co-dependency, family systems, historical trauma, intergenerational trauma, lay community healthcare worker, substance dependence.

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Chapter 1: Background

As background to the research project, this chapter introduces the reader to the researcher's motivation for selecting the topic, and context for the research, describing the scope and impact of alcoholism and substance dependence in the Western Cape. The rationale for the research is outlined and theoretical definitions of key terms in the research reports is given. The problem statement is formulated, followed by the aims and objectives of the study. The chapter ends with an outline of the dissertation.

Alcoholism and Substance Dependence in the Western Cape

In the Western Cape, the relentless increase in alcohol and substance abuse and dependency has been identified as one of the greatest concerns by the Provincial Department of Social Development (Harker, Kader, Myers, Fakier, Parry, Flisher, Peltzer, Ramlagan & Davids, 2008). The destructive nature of substance abuse impacts society on many levels causing immediate social problems such as violence, crime, accidents, injuries and risky sexual behaviour, but it also has far reaching impact on social welfare in terms of academic progress, physical and mental health and the fracturing of families and communities (Bowen, 1974; Bushman & Cooper, 1990; Challier, Chau, Predine, Choquet & Legras, 2000; Coleman & Strauss, 1983; Galea, Nandi & Vlahov, 2004). A research review of substance abuse research projects conducted in the Western Cape between 2000 and 2008 combined with two Nelson Mandela / Human Sciences Research Council (HSRC) household surveys, a local survey conducted by the HSRC in Cape Town and a survey of educators as secondary analysis, showed that the Western Cape had the highest prevalence of risky drinking out of all provinces, had the highest lifetime prevalence of substance use disorders (18.5%), had the highest lifetime prevalence of alcohol use among males (70%) and the highest lifetime prevalence of alcohol use among females (39.2%), out of all nine provinces (Harker et al., 2008).

Some researchers argue that the ineffectual interventions for alcoholism and substance dependency is due to the lack of understanding of the aetiology of alcohol and substance abuse as a historical trauma response (Brave Heart, 2003; Heart & DeBruyn, 1998). Historical trauma response is observed all over the world in numerous colonized indigenous groups such as the Lakota and other Native populations (Brave Heart, 2003; Heart & DeBruyn, 1998), as well as in Jewish Holocaust survivors, Japanese survivors of American internment camps, African Americans, Irish Americans, Armenian refugees, Swedish immigrant children whose parents were torture victims, Palestinian youth, the people of

Cyprus, Belgians, Cambodians, Israelis, Mexicans and Mexican Americans, Russians, the survivors of the Apartheid regime in South Africa and many other cultural groups and communities that share a history of oppression, victimization, or massive group trauma exposure (Mohatt, Thompson, Thai & Tebes, 2014). All colonized groups share histories of alcohol, either used as currency for trade (Brave Heart, 2003) or currency for work (Legget, 2016; London, Sanders & Te Water Naude, 1998). Dysfunctional drinking styles of the colonizers were role models for the indigenous groups, reminiscent of the chilling portrayal of internalized colonialization as portrayed by Eric Blair, better known as George Orwell in his socio-political allegorical novel "Animal Farm" (Darmawan, 2018). In addition, indigenous cultures restricted mood-altering substances to ceremonial use, which were almost always prohibited and often completely eradicated by the colonizers. In this, and many other ways, cumulative emotional and psychological wounding over lifespans and across generations, originating from unresolved historical grief, gains expression in maladaptive behaviour patterns such as alcoholism and substance abuse (Brave Heart, 2003).

In the South-African context, the political landscape is characterised by a history of colonialism and apartheid. Apartheid, which was typified by the enforced political, economic and social legitimised segregation of people along racial lines, was enforced from 1948 until 1994 under the rule of the National Party. Two of the laws that had a huge impact on the people of South Africa were the Population Registration Act of 1950 and the Group Areas act of 1950 (Mitchell, 2001). In the Western Cape specifically, the Population Registration Act defined people of mixed racial and ethnic heritage as "Coloured," and thus racially defined, the Coloured People of South Africa were oppressed and marginalized and to this day still struggles with underlying identity issues. But more harrowing was the Group Areas act, which allowed government to forcibly remove families from their beautiful homes and farms, fracturing communities, neighbourhoods and families. This terrifying instantaneous lowering of standard of living, contributed to increased social problems such as alcoholism and substance abuse, gangsterism and mental health difficulties (Dannhauser, 2008; Pillay, 2014). Unfortunately, the end of apartheid did not bring the necessary restitution to the Coloured communities and it has become commonplace for people disillusioned with the new South Africa to express their disgruntlement by saying that '*first we were not white enough and now we are not black enough*' (Adhikari, 2004, p. 168).

The apartheid era's oppression not only created trauma under the oppressed people, but the perpetrators had to pay their own price and still carry the scars from this time. The then white minority's "Bush War" or "Border War" was the Black majority's liberation

struggle. “Bush War” or “Border War” are terms used to refer to the war waged on the South African borders with Angola, Namibia and Mozambique, but it was an extension of the civil war waged within South Africa between her people (Baines, 2008). Between 1967 and 1994, approximately three hundred thousand South African white males over the age of 18 were conscripted by the South African Defence Force. As far as most of these conscripts were concerned, there was no option other than to follow these orders to perform national service, as failure to do so meant harsh penalties. The alternatives were either conscientious objection, which meant a long jail sentence, or to flee the country. This obligation did not end with national service as conscripts were assigned to citizen force or commando units after their national service. This meant that they were liable for periodical call-ups for camps that might have included deployment in the “operational areas” from 1974 or later, tours of duty in the so-called townships from 1984 onwards (Baines, 2009).

Although most served willingly, others did so reluctantly with little enthusiasm. And at the end of the war, these men were left, not only with the inescapable trauma of their own violence, but the feeling of having been betrayed. The conscripts had very little access to psychological support as Baines (2008) relates how a group of young servicemen, after being involved in one of the fiercest engagements in Angola, were given a pep talk by a ranking officer on a parade, a prayer by a chaplain, and a superficial group counselling session before being sent back home to resume life as a civilian. Many could not understand why they have sacrificed so much only to be asked to surrender to the ones they considered to be “the enemy” (Baines, 2008). There is no doubt that the national service generation paid a heavy price for defending the National Party’s system of white rule. Many of them died, many came home broken, physically and emotionally. During the Truth and Reconciliation Commission (TRC) many of these conscripts chose to remain silent. Although all white males in South Africa were conscripted, only five who had been active in military operations outside of South-Africa gave evidence at the TRC (Gibson, 2009). According to Baines (2008, p. 220) many chose to remain silent because: “Some reported that the lack of public knowledge about the war created suspicion of their stories, while others were summarily dismissed as sympathy seekers or outright liars.” Bains (2008, p. 221) goes on to say that “In this way, the TRC left the experiences of ordinary soldiers largely invisible. Not merely forgotten but wished away.” This was also true for liberation struggle veterans or “ex-combatants” who were not situated within the South African state agencies of safety and security, including Umkhonto we Sizwe (MK), Self Defence Units (SDUs) and the Azanian People’s Liberation Arm (APLA) (Gear, 2002).

Despite the massive number of obstacles faced by individuals in the rural communities of the Western Cape, they cope, function and grow, endure and thrive. The population on the rural West Coast of South Africa is predominantly comprised of two of South Africa’s socio-political groupings namely “Coloureds” and “Whites.” People on the West Coast are indeed colourful; in language, in history and in the living of epic, unwritten, adventure-story-lives, in a harsh and unforgiving environment. The West Coast of South Africa is classified as semi-arid where summer turns the land to sandy desert and the warm bergwinds blow about white dust as the temperatures soar. The hardy indigenous plants that do survive the heat, often gets burnt in the seasonal fires that sweep over the sandy earth. But winter brings rain, and the seemingly barren land sprouts flowers and burst into a floral paradise such as no other. Much like the tiny seeds, lying hidden in the sand, waiting for the rain, the hardy individuals living on the West Coast, carry within themselves a deep promise of greatness, often, like the flowers they live amongst, being more beautiful after being drenched in flame. This research report relates accounts of recovery from alcoholism and substance dependence, through the voices of individuals from the West Coast of South Africa involved in community-based organizations, with an interest in unresolved historical trauma framed by the biopsychosocial model of substance dependence.

Rationale

Alcoholism and substance addiction are social dilemmas affecting thousands of people across South Africa and the world. The destructive nature of substance abuse impacts society on many levels causing a myriad of socioeconomic problems every day, but it also has impact on the future, as lack of academic progress, poor physical and mental health and the fracturing of families and communities exclude any hope of overcoming the problem (Harker et al., 2008). The low success rates in curbing the epidemic of addiction and maintenance of rehabilitation may be due to the lack of understanding of the aetiology of alcohol and substance abuse in the South African context as a presentation of unresolved collective historical trauma (Brave Heart, 2003). There appear to be community-based support systems that form organically, outside of the influence of government and other external systems, from within all communities. The researcher could trace very little research based on or incorporating the perspectives of lay community healthcare workers on the topic of substance abuse in the South African context.

This research therefore focuses on the lay community healthcare workers' perspectives on the origins and dynamics of substance addiction and their views on the

recovery process, and possible relationship with unresolved historical or intergenerational trauma, framed in the biopsychosocial model. The findings are available to other researchers to encourage more research and aid the design of intervention strategies based on unique strengths of individual communities instead of using generic models designed without considering the implications of contextual differences in families and communities. This research also hopes to illuminate the contribution of the lay community healthcare worker as an underutilised resource in academic research.

Theoretical definitions of key terms

Alcoholism:

Alcoholism is a disorder that is related to addiction to drinking of alcoholic substances or the compulsive behaviour resulting from alcohol dependency. Today most scientists agree that alcoholism is genetic and heritable in nature (Bennett & Wolin,1990; Bezuidenhout, 2008; Bowen, 1974; Cadoret, O'Gorman, Troughton & Heywood, 1985; Chassin, Flora & King, 2004; Enoch, 2008; Hesselbrock, 1995).

Biopsychosocial model

The biopsychosocial model is a theoretical framework developed by George L. Engel and Jon Romano in 1977 as a response to the biological or disease model, theorising that health and wellbeing are the results of an interplay of elements from any individual's biological, psychological and social worlds. This model also incorporates the five P's namely predisposing, precipitating, perpetuating, protective and predictive factors. Today this model is used in many disciplines including psychology (Borrell-Carrió, Suchman & Epstein, 2004).

Co-dependence:

Sheridan and Green (1993) describe compulsive dependence, or co-dependence as a series of maladaptive, compulsive behaviours learned by family members to survive in a family experiencing severe emotional pain. In most cases alcoholism or substance dependence is at the source of the family pain. Co-dependent behaviours are a set of coping behaviours which are passed from generation to generation - whether there is dependency or not, to survive. Although the first alcoholic or dependent person may have been a grandparent or grandparent, family members develop behaviour patterns throughout the next three or four generations that help them deal with emotional pain transmitted from the original dysfunctional nuclear family.

Coloured:

The use of the term “Coloured” is controversial. From a theoretical perspective the noun ‘Coloured’ or ‘Coloureds’ is an ethno-political grouping for South Africans of mixed ethnic origins namely European, Asian, and various Khoisan and African ethnic groups of southern African origin that was formalised as legislation by amongst others, the Population Registration Act of 1950 by the National Party during apartheid (Posel, 2001). As “There was no pretence at formal, scientific rationality in the classification process.” (Posel, 2001, p. 58) Coloured people do not all share the same ethnic background, as racial classifications were made purely on ‘appearance’ and ‘acceptance’ (Posel, 2001).

When looking at the term “Coloured” from a social perspective there are fragments of layers of meaning and context superimposed on one another, as Ms Phyllis Dannhauser (2008) explains in her doctoral dissertation: “The so-called 'Coloured' community has traditionally inhabited that shadow-world between definitions of race and class. Notions of community, culture and identity have been tenuous, negotiated in an environment of exclusion and stereotyping. In post-apartheid South Africa, the construction of a unified 'imagining' of community and individual identity has become fraught with problems of race, struggle credentials, politics, and past history. The difficulty in imagining a communal identity is compounded for the Coloured community in South Africa by the fact that race has always been used as a marker of difference” (Dannhauser, 2008, p.2). Although the term “Coloured” may have acquired a derogatory connotation, this is certainly not intended when used in this dissertation.

Family Systems Theory:

Family systems theory holds that individuals cannot be understood in isolation from each other but must be considered as part of their family, since the family is an open, emotional unit. Families, in turn, are systems of interconnected and interdependent people, none of whom can be understood isolated from the system. According to Bowen (1974), the architect of this theory, a family is a system where each member has a role to play and rules to comply with. System members are expected to interact with each other in anticipated ways, depending on their role, which is determined by certain relationship agreements. This behaviour allows patterns to form within group boundaries, as the behaviour of a certain family member is influenced by and influences other family members’ behaviour in predictable ways, essentially by being who they are. The system is constantly striving for equilibrium; maintaining the same pattern of behaviour within a system can lead to

equilibrium in the family system but also to dysfunction. For instance, if a mother is an alcoholic and cannot control herself, the child may need to take on more responsibility to do the things the mother is incapable of doing. This role-reversal may stabilize the system but, in the process, it may push the family towards a different equilibrium which may lead to dysfunction as the child may not be able to maintain this overachieving role over an extended period of time (Bowen, 1974). A strong link has been identified in the literature between disrupted family relationships and alcohol and substance dependence on the role of family relationships in the creation and maintenance of alcohol and substance dependence related problems (Brown & Abrantes, 2006; Stanton & Shadish, 1997; Velleman & Templeton, 2003).

Historical Trauma:

The term Historical Trauma was first coined by the Native American social worker and mental health expert Maria Yellow Horse Brave Heart in the 1980s and refers to the accumulated emotional damage caused by a traumatic incident or event. This damage can be inflicted on a single person, a group of people or even an entire generation (Heart & DeBruyn, 1998). Historical trauma theory finds its roots in three theoretical frameworks of social epidemiology: The Psychosocial theory, which explores the roots of maladaptive behaviour as a result of physical and psychological stress that originates in the individual's environment; The Political-Economic Theory, which considers the impact of political, economic and structural factors such as unjust power relations and class equality; and the Theory of Social-Ecological Systems, which examines the dynamic interrelations of life-course factors that underlie the symptomatic behaviour presented by individuals, called the Historical Trauma Response (Sotero, 2006).

Intergenerational Trauma:

Intergenerational trauma refers to psychological trauma that is transmitted by complex post-traumatic stress disorder mechanisms as well as neurological and epigenetic pathways, from the first generation of trauma survivors to the second and further generations of the survivors. Researchers believe that this phenomenon occur both individually and collectively (Bombay, Matheson & Anisman, 2009).

Lay Community Healthcare Worker:

In the context of this research the lay community healthcare workers are mostly laypeople without any formal training, are not family members of the individuals they assist and care for and are often not receiving any remuneration for their services. They frequently,

have not been recruited but have stepped forward, out of their own accord, to create community systems of care to assist in, alongside or outside of existing community care structures.

Substance Dependence:

Substance dependence or addiction as a clinical diagnosis has come under scrutiny since the previous publication of the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1994. In the 1994 edition of the DSM, DSM-IV, there were two categories: substance abuse and substance dependence. DSM-5 combines these two categories into one called "substance use disorder." In order to be diagnosed with the disorder an individual will meet the following criteria, which will also then determine the severity of the disorder either as mild, moderate, or severe, depending on how many of the diagnostic criteria are met. The eleven DSM-5 criteria for a substance use disorder include:

1. **Hazardous use:** Used the substance in ways that are dangerous to self and/or others, i.e., overdosed, driven while under the influence, or blacked out.
2. **Social or interpersonal problems related to use:** Substance use has caused relationship problems or conflicts with others.
3. **Neglected major roles to use:** Failed to meet responsibilities at work, school, or home because of substance use.
4. **Withdrawal:** Experienced withdrawal symptoms when substance use ceased.
5. **Tolerance: H**ave to use more of the substance to get the same effect.
6. **Used larger amounts/longer:** Started to use larger amounts or use the substance for longer amounts of time.
7. **Repeated attempts to control use or quit:** Attempted to cut back or quit entirely unsuccessfully.
8. **Much time spent using:** A large amount of time dedicated to using the substance.
9. **Physical or psychological problems related to use:** Substance use has led to physical health problems like liver damage or lung cancer, or psychological issues, such as depression or anxiety.
10. **Activities given up to use:** Skipped activities or stopped doing activities previously enjoyed in order to use the substance.
11. **Craving:** Experienced cravings for the substance.

To be diagnosed with a substance use disorder, and individual will meet two or more of these criteria within a 12-month period. If two or three of the criteria are met, it is

classified as a mild substance use disorder. Four to five is considered moderate, and if six or more criteria are met, the individual has a severe substance use disorder (Hasin, O'Brien, Auriacombe et al., 2013).

Problem Statement

Alcohol and substance abuse are serious problems in the world and in South-Africa with literature confirming that the Western Cape being most affected by this on economic, social and psychological levels (Harker et al., 2008). The low success rates in curbing the epidemic of addiction and maintenance of rehabilitation may be due to the lack of understanding of the origins and dynamics of, and recovery from alcoholism and substance dependence in the South African context, as a presentation of unresolved collective historical trauma (Heart & DeBruyn, 1998; Sotero, 2006). There appear to be successful community-based support systems forming organically, outside of the influence of government and other external systems, from within all communities. Despite this, very little, none that the researcher could find, research is available on the perspectives of lay community healthcare workers on the topic of substance abuse in the South African context. It is therefore imperative to broaden the understanding of this topic to develop and improve effective, context compatible intervention strategies in order to prevent future addictions, improve recovery rates and maintenance of sobriety after rehabilitation. As the construct of addiction cannot completely be described by any single model among any of the frameworks of the biological, social or psychological theories, it has been decided to frame this research in Engel’s biopsychosocial model of addiction. As data for this research have been gathered using real-world accounts from lay community healthcare workers to deepen the understanding of alcoholism and substance abuse as possible presentation of collective historical and intergenerational trauma and the necessary resilience factors contributing to overcoming of adversity in this context, it was felt that a qualitative approach will best serve the need to gain an in-depth understanding of the participant’s viewpoints.

Aim and Objectives of this Study

Aim of the Study

The aim of the study was to explore the perceptions of lay community healthcare workers from a rural West Coast community, concerning the origins and dynamics of, and recovery from substance addiction with an interest in the transference of intergenerational historical trauma seen against the theoretical framework of Engel’s biopsychosocial model.

Objectives of the Study

The objectives of the study were:

- To record and relate the accounts of lay community healthcare workers in rural communities about people who have recovered from alcoholism or substance dependence.
- To investigate these accounts and explore them for emerging motifs, elements or influences, patterns or signs relating to the origins, dynamics and recovery from substance addiction.
- To note possible evidence of unresolved historical or intergenerational trauma in these accounts.

Research Questions

1. What are lay community healthcare workers' perspectives on the origins and dynamics of substance addiction and recovery?
2. Do the accounts of volunteer community healthcare workers support a relationship between alcoholism or substance dependence and unresolved historical or intergenerational trauma?

Outline of the dissertation

Chapter 1: Background

Chapter 1 serves as an orientation and context setting for the dissertation. This chapter provides a background introduction, the rationale motivating this study, a short definition of theoretical terms identified as keywords and a brief discussion of the study in terms of aims and objectives.

Chapter 2: Literature review

Chapter 2 provides a literature review on the various theoretical approaches underpinning the theory of alcohol and substance dependency, culminating in the theoretical framework for this study, namely Engel's biopsychosocial model (Borrell-Carrió, Suchman & Epstein, 2004). This chapter includes discussions on the impact of apartheid on the "Coloured" and White racial groupings, historical trauma, liberation psychology and the mechanisms of intergenerational trauma transmission such as co-dependence and the relationship of these mechanisms with substance abuse. Finally, protective and preventative factors that can contribute to resilience and the overcoming of substance dependency are discussed. This chapter end with the problem statement dictating this research.

Chapter 3: Research Methodology

Chapter 3 describes the research process in terms of the selected research paradigm, research design and methodology. The methods of qualitative data collection, data analysis and data interpretation are described and explained with reference to this study. The chapter includes a discussion of the measures taken in establishing the trustworthiness of this study. This chapter also includes a description of thematic analysis and the advantages and disadvantages thereof. Finally, it reviews the ethical considerations relevant to this study, the challenges encountered during the study and clarifies the significance of the study.

Chapter 4: Data Analysis and Results

Chapter 4 reviews the data collected from the individual semi-structured interviews in the form of the separate themes that was extrapolated from the data with reference to the biopsychosocial model using deductive analysis, as well as the single theme that emerged as a result of inductive analysis.

Chapter 5: Discussion

In Chapter 5 the interpretation and discussion of the findings based on the data analysis are provided, separated in the six themes as identified in the analysis.

Chapter 6: Limitations, Strengths, Recommendations and Conclusion

In this chapter the conclusions, limitations and recommendations for further research are listed and discussed.

Chapter Summary:

This chapter served as the background to the study. It outlined the researcher's motivations and rationale for choosing to study lay community healthcare workers' perspectives concerning the origins, dynamics and recovery from substance addiction in the context of a rural community on the West Coast of South Africa. Theoretical definitions of key terms used in the research report was given as well as the problem statement, aims and objectives of the study. The chapter ended with an outline of the dissertation.

Chapter 2: Literature Review

This chapter aims to contextualize the study in the available literature, by gradually creating a theoretical framework for alcoholism and substance dependence, stepping through the three domains of the biopsychosocial model independently, first looking at biological, psychological and social models in isolation. The converging and diverging stances of these theories on the origins and dynamics of, and recovery from addiction are finally encapsulated in the biopsychosocial model, that ends the literature review.

Introduction

Alcohol and other forms of substance abuse are considered major public health problems in the Western Cape. The historical context of collective group trauma amongst the Western Cape communities of South Africa and their respective experiences thereof are important to consider in the aetiology of and recovery from alcohol and substance abuse. Traditional intervention programmes tend to be problem behaviour focussed and underplay the cultural and historical contexts, such as colonisation, conflict, and oppression, of the communities where they are applied. Alcoholism or substance dependence is typically thought of as an individual problem. Biological and psychological models focus primarily on the individual. However, it is very necessary to consider the impact alcoholism or substance dependence has on the family and the community as a social system, and in turn, what effect the family and the community have on the alcoholic or substance dependent. In the late 1970s, alcohol or substance dependence treatment providers began to consider the limitations of the one-dimensionality of these models, typically just treating the alcoholic or substance dependent (Kaufman & Kaufman, 1979). As the emerging practice of treating alcoholism or substance dependence was embraced within the context of social networks and family relationships, alcohol, or substance dependent partners, co-alcoholic or co-dependent members, and other family members were included in the treatment process. This practice yielded fewer relapse incidents and longer sobriety periods. The success of this treatment model therefore indicates that alcoholism or substance dependence exists within a wider political, cultural, and historical framework (Bezuidenhout, 2008). Nevertheless, the role of socio-cultural factors in alcoholism and drug dependence is a subject of considerable disagreement.

Some researchers believe that, while socio-cultural influences that, for example, decide drinking habits and behaviour, they have no real influence on whether the person is predominantly an alcoholic or a substance dependent (Brown & Abrantes, 2006). On the other hand, there is convincing evidence that socio-cultural factors such as poverty, racism,

sexism, homophobia and the transmission of negative family patterns between generations can have significant impacts on an individual's likelihood of becoming an alcoholic or substance dependent (Chassin, Flora & King, 2004; Chassin, Pitts & Prost, 2002; Galea, Nandi & Vlahov, 2004; Vimpani 2005). It is therefore little wonder that several diverging theories of substance dependence exist in literature. The theories discussed below, though varied, are by no means to be seen as exhaustive.

Substance Dependency Theories

Drug and alcohol abuse and dependence have significant social effects on communities around the world with the result that these psychological constructs have been thoroughly studied and a large number of theories have been proposed, seeking to define the underlying motivations and mechanisms of alcoholism and drug dependency. As the understanding of these structures has become clearer and as technology has improved, theories about substance dependence have undergone many changes over the years, especially in the genetic and neuropsychological field (Nestler, 2004).

Biological Models

Genetic Theories of Substance Dependence:

Theorists who support *genetic theories* believe that substance dependence is the result of biologically inherited mechanisms underlying the predisposition to become a substance dependent (Enoch, 2008; Heyman, 2013; Patriquin, Bauer, Soares, Graham & Nielsen, 2015). Recent research on alcoholism, substance dependence and trauma transmission has become more centred on fundamental neural and epigenetic processes, driven by rapid progress in neuropsychological technology research and development (Law & Tsang, 2019; Verdejo-García, Alcázar-Córcoles & Albein-Urios, 2019). Transgenerational and intergenerational trauma transfer refers to trauma that is transmitted through several complex post-traumatic stress disorder (PTSD) processes through second and future generations of survivor descendants from the first generation of trauma survivors. There are many ways in which this trauma is presented, the most damaging of which is maybe alcoholism and dependency on other drugs. There is a body of scientific evidence indicating that memories transmitted genetically can be carried by their DNA from the experiences of any of an individual's ancestors. The orbitofrontal cortex and the anterior cingulate gyrus are traditionally the most frequently involved frontal cortical areas in substance dependence. (Goldstein & Volkow, 2002). These regions are neuroanatomically connected with the limbic structures, that are associated amongst others with emotion and memory.

Chronic exposure to substance abuse resulting in long-term brain structural changes lead researchers to conclude that genetic alteration may contribute to the addictive phenotype (Robison & Nestler, 2011). This would indicate that environmental information at the behavioural, neuroanatomic, and epigenetic levels can be inherited across generations. Therefore, it is possible to inherit certain information biologically through chemical changes which occur in the individual DNA strands. Optimal family influences, however, appear to be important factors in protecting against the creation of adolescent alcohol or substance abuse (Foxcroft & Low, 1992), while harmful family influences produce the opposite effect (Rossow & Lauritzen, 2001). Children from alcoholic or drug-dependent families are often victims of physical and sexual abuse, neglect, and chaotic family environments, which in turn makes them more vulnerable to substance abuse and dependency because of the stressors in their lives (Kumpfer, 1987).

To connect the literature to the context of this research report, namely the Western Cape, one can look at a report based on a study of self-reported alcohol consumption and binge drinking conducted by Vellios and Van Walbeek (2018), wherein it was reported that drinking was highest among White (54.1%) and Coloured (45.2%) individuals in South Africa, placing these two racial groupings at the top of the ranking scale in South-Africa in terms of alcohol abuse. These two racial groupings make up the majority of the population of the Western Cape (Vellios & Van Walbeek, 2018). As adoption studies comparing biological vs environmental factors report three to four times higher rates of alcoholism where a biological parent was an alcoholic, in children raised by their own parents (Goodwin et.al., 1973; Valliant, 1983; Valliant & Milofski, 1982) and two times higher in children of alcoholic parents not raised by their biological parents (Vaillant, 1983) one can potentially see that the Western Cape as a region will be severely affected by alcohol and substance abuse problems.

Vaillant (1983) felt it was necessary to also consider nongenetic effects in order to critically evaluate these findings. The most significant of these was ethnicity: In his study, Irish Americans were seven times as likely to be dependent on alcohol as those of Mediterranean origin. Controlling for such large ethnicity impacts, he thought, would substantially reduce the 2 to 1 ratio in alcoholism (for subjects with alcoholic relatives compared to those without) even as other potential environmental factors leading to alcoholism (in addition to ethnicity) would still remain to be controlled for. In a study conducted with Milofsky (Vaillant & Milofsky, 1982) Vaillant identified two other genetic causality tests. This study disconfirmed Goodwin's (1979) theory that alcoholics with

alcoholic ancestors – and thus a perceived genetic predisposition to alcoholism – eventually develop drinking problems sooner than others do. Lastly, Vaillant found no tendency to choose moderate drinking versus abstinence as a solution to drinking problems associated with numerous alcoholic relatives, although it was associated with the ethnic group of the drinker (Vaillant & Milofsky, 1982).

Critics of genetic theories of substance dependence which propose genetic mechanisms based on concordance rates, where the same trait is present in the genes of both members of a pair of twins as models of substance dependence, do not provide an ideal fit model for substance dependence. For example, Vaillant (1983) found that AA members' self-reports that the first time they drank they immediately succumbed to alcoholism were false, and that severe drinking problems developed over periods of years and decades. Goodwin, Crane and Guze (1971) showed that by moderating their drinking, alcoholics can overcome their dependence, indicating that they do not conform to a purely genetic model, either.

Metabolic Theories of Substance Dependence.

Metabolic theories proponents claim that drug dependence is the product of molecular, cellular adaptations in response to persistent substance exposure (Robison & Nestler, 2011; Wong & Fernandes, 2011). Alternatively, opponents of the genetic hypothesis say that the hereditary susceptibility to alcoholism takes the form of some higher statistical likelihood risk of drinking problems emerging. In this view a hereditary propensity dictating an excessive alcohol response is not causing alcoholism. They suggest the presence of biological irregularities such as the inability to detect the level of blood alcohol (BAL), leading to alcoholics having less drinking effect and drinking more without feeling the impact of the elevated BAL (Goodwin 1980; Schuckit 1984). Alternatively, Schuckit (1984) proposed that alcoholics inherit a different style of alcohol metabolization, such as producing higher acetaldehyde levels through drinking. Finally, Porjesz and Begleiter (1982) indicated that alcoholics had abnormal brain waves before they ever drank, or that drinking can cause unusual brain activity for them. However, all these theorists have indicated right from the start that their results are preliminary and require replication, particularly through prospective studies of people who become alcoholics.

Evidence to the contrary is available: Several studies have found that sensitivity to BAL, peak BAL after drinking, and elimination of blood alcohol are unrelated to family histories of alcoholism (Lipscomb & Nathan, 1980; Pollock et al., 1984). Other negative evidence for both BAL discrimination and metabolic hypotheses is provided by the case of

Native Americans and Inuit People. These groups are hyperresponsive to the effects of alcohol, responding to alcohol in their systems immediately and intensely, and yet have the highest alcoholism rates in the United States (Baldwin, Maxwell, Fenaughty, Trotter, & Stevens, 2000). The argument of alcoholism inheritance from the opposite theoretical direction— that these groups succumb more readily to alcoholism because they metabolize alcohol too fast, likewise fails to succeed. Groups who share the alcohol hypermetabolism exhibited by Native Americans and Inuit people, such as the Chinese and Japanese, have among America's lowest rates of alcoholism (Caetano, Clark & Tam, 1998). Thus, this disjunction between obvious metabolic characteristics and drinking habits appears to contradict substantial metabolic determinism in alcoholism.

Psychological Models

Conditioning Theories and Adaptation Theories.

In the psychological domain of substance dependence, theorists argue that the cognitive style of the individual, intrapsychic conflicts, defence mechanisms, coping strategies, methods of therapeutic intervention and personality traits determine the likelihood of the individual becoming dependent on a substance. These are all-encompassing of the two broad categories of adaptation and conditioning. Where adaptation theories investigate the social and psychological processes of substance dependence (Burkett & Young, 2012; Heyman, 2013), conditioning theories are based on the idea that cumulative strengthening from drugs or drug-related activities is causative of dependence (Bevins & Murray, 2011; Kourrich, Calu & Bonci, 2015). Both these groups of theories therefore acknowledge the contribution of the social and biological domains on the development of substance dependency.

Motivational Theory:

Researchers who support the motivational theory of alcohol and drug dependency conclude that an individual makes a conscious decision to use any substance or alcohol based on whether they think that the positive effects of using the substance outweigh those of not using the substance (Cox & Klinger, 1988). Given their psychological approach to the problem of substance dependence, these researchers also assume that it is not only psychological factors that determine their decision, e.g. past experiences with the substance, but that these decisions are always modulated by their neurochemical reactivity to alcohol, therefore also incorporating the effect of the biological realm on the individual’s substance use (Cooper,1994).

The Strength model of Self-Control

This model has been developed by researchers studying personality characteristics that influence the probability of substance dependence. Because self-control is often considered important in leading to performance, research has confirmed this model in several realms of addiction, in that self-control can empower an individual to override an impulse and make a healthier choice. Surprisingly enough, blood glucose is a major player here, connecting the psychological domain with the biological domain. (Baumeister, Vohs & Tice, 2007).

Social Models:

Historical Trauma Theory:

Literature is fraught with historical patterns of causation that resulted in abuse of individuals and the Coloured community as a collective by governmental and non-governmental actors. The apartheid era policies of classification or self-classification, along with land dispossession and displacement that came because of forced relocation policies fractured Coloured community identity. Continued discrimination added to the historical group trauma as the Coloured population were subjected to countless unthinkably harsh indignities including the segregation of amenities and public places such as schools, churches, restaurants, beaches and theatres, and the forcible relocation of over half a million Coloured people after the Group Areas Act of 1950 (Mitchell, 2001).

The history of the Coloured communities of South Africa left a heritage of dispossession, displacement, discrimination, disrespect, disillusion, and despair. The Khoisan had their homelands invaded by cattle herding African tribes and Arabs slave traders from around 1,500 years ago, and by white colonists over the last few hundred years. Since that time, they faced continuous mass trauma in the form of discrimination, eviction from their ancestral lands, murder and oppression amounting to a massive though unspoken genocide (Diamond, 1987). Trauma continued as the end of apartheid brought little restitution, as the 1994 Land Restitution Act does not provide for land that was lost to communities before the 1913 cut-off date. Because, in the early 19th century, Khoisan communities were dispossessed of most of their land, first by migrating African tribes and later by European colonialists, the Native Land Act of 1913 made no mention of Khoisan land confiscation (Mitchell, 2001).

Traditional lifestyles and cultures of distinct communities were often altered by intermarriage with different ethnic groups, especially in the Western Cape. There is evidence

of intermarriage both between Khoikhoi and San populations with colonial slave populations, as well as with Afrikaans-speaking farmers and white colonials (Patterson et al, 2010). It is important to consider the historical context of slave heritage of the Coloured community to appreciate the shaping of Coloured community identity.

The South Africa population is comprised of broadly five groupings; 'African,' which makes up 79.2% of the total population, 'Coloured' which makes up 8.9% of the population, the same percentage as the 'White' grouping with a further 2.5% identified as 'Asian or Indian' and a final 0.5% classifying themselves as "other" ("South Africa's", 2014). One expects statistical equivalent numbers in all aspects of society; unfortunately, that is not the case.

Prison population statistics show that 18% of the prison population is 'Coloured' compared to 79% 'African', 2% 'White' and 1% 'Asian or Indian' (Jules-Macquet, 2014). When looking at teen pregnancies, figures do not look much better: According to Panday et al (2009) teen pregnancy among Coloured girls are 60 out of 1000 (6%) compared to 71 out of every 1000 (7.1%) African girls. The white population which is statistically equal in numbers to the Coloured population, experience only 14 pregnancies for every 1000 teenage girls. Is this purely due to socio economic circumstances or is there something more to these figures?

When looking at the Afro-barometer the Coloured population is by far worse off than any of the other population groups in South Africa. Unemployment among Coloured people rose from 15.8% in 1998 to 22.5% in 2005, while unemployment dropped by a half a percent among the African population of South-Africa. Coloured people also have the second highest illiteracy rate in South Africa at 23.9%. Although the post-Apartheid government implemented various programs to fight inequality, the Coloured population never benefitted from this (Amberger, n.d.).

Coloured communities are heavily burdened by gang violence (Pillay, 2014) and statistical figures suggest that Coloured people are twice as likely as any other ethnic group to be murdered, and twice as likely to be incarcerated (Leggett, 2016), while an article summarising the findings of a national population based survey, being part of the Coloured population group was found to be a risk factor for having alcohol problems in both men and women (Peltzer, Davids & Njuho, 2011).

Historically many of the Coloured population have worked on wine farms. Many academics believe that the so-called 'dop system' that existed till very recently, where workers were paid part of their wages in wine, explains why alcoholism is rife in parts of this population grouping (Legget, 2016; London, Sanders & Te Water Naude, 1998). Maria

Yellow Horse Brave Heart theorises that alcoholism is a self-destructive act closely connected to depression in colonized individuals because of internalized oppression and unresolved grief. This internalized oppression, she believes, stems from identifying with the oppressor, as the oppressed are seeing themselves through the oppressor's eyes (Heart & DeBruyn, 1998). Massive historical trauma has been visited upon the Coloured communities of South Africa with little restitution by the post-apartheid government, leaving this population grouping with a challenging cultural identity, maladaptive self-image, and alcohol dependence as legacy.

Historical trauma theory holds that communities who have been subjected historically to long term mass trauma, for example slavery, colonialism, genocide and war, exhibit higher levels of unwellness and impairment of normal physiological function, perpetuating several generations after the traumatic events occurred (Sotero, 2006). Historical trauma response is the collection of symptoms or behaviours presented as a result of historical trauma. These typically include depression, self-destructive behaviours, suicidal thoughts and gestures, low self-esteem, anger, anxiety, difficulty identifying or expressing emotions and substance or alcohol dependence (Heart, 2003).

Family Systems Theory and Co-dependence:

A relationship has been identified between coping behaviours related to alcohol, and psychological and relationship distress (Kahler, McCrady & Epstein, 2003). When alcohol or substance abuse occurs in a family system, all behaviour within that family system is affected (Lederer, 1991). Lederer suggested that some markers distinguish alcoholic families from other families, for example: reciprocal behavioural extremes between family members, lack of normal models, and power imbalances within the family system. Typical psychological factors affecting the alcoholic or substance dependent and their families include alcohol or substance dependence stigma, emotional withdrawal, guilt, and craving (Nace, Dephoure, Goldberg & Cammarota, 1982). Velleman and Templeton (2003) expand on the impact of the alcoholic or substance dependent on family roles in communication, social life, and finances. They use examples such as financial stress, through purchasing of alcohol or drugs, shame and embarrassment caused at family and other social gatherings due to unacceptable alcohol- or substance induced behaviour, new roles that must be allocated because the addicted family member is unable to function effectively on a day to day basis, and avoiding contact with outside world, in an attempt to hide the dysfunction of the family caused by the alcoholic or

substance dependent. This dysfunctional environment creates huge amounts of stress and potential trauma.

There is a body of literature that focuses primarily on co-dependence as one of the dominant patterns in alcohol-and drug-addicted families (Foxcroft & Low, 1992; Velleman & Templeton, 2003; Zaidi, 2015). Co-dependency was first defined in assessments of how the alcoholism of a family member of anonymous Alcoholics influenced non-alcoholic family members. The co-dependent “feels compelled to fix the problems that result from the chemical dependence and to protect the addict from its consequences” (Schäfer, 2011). The term later came to include not just an alcoholic family, but exposure to life in any dysfunctional family. In a broader scope, the factors operating on the dysfunctional family, can be superimposed on the community as a whole, where the family's dysfunction extends to the community as a collective.

One of the main premises of historical trauma theory, as discussed in the previous section, is that the psychological and emotional results of traumatic experiences are passed on to the next generations through neurological, environmental and social pathways that cause an intergenerational trauma cycle (Sotero, 2006). These behaviours, although designed to relieve pain, create pain. They constitute a deeply embedded "cognitive set" upon which co-dependence disorders are based. Whether or not there was drug dependency in the nuclear family, co-dependence is a deeply rooted compulsive behaviour born out of a dysfunctional family environment (Schäfer, 2011; Sheridan & Green, 1993).

Many co-dependents themselves develop dependencies, continuing the destructive pattern within their own families. As with historical trauma, intergenerational trauma is transmitted by maladapted social and behavioural patterns created in response to the alcoholic or substance dependent child or spouse's traumatic experience. This behaviour becomes part of the family’s norm and is transmitted as learned behaviour from generation to generation (Sotero, 2006; Schäfer, 2011).

The concept of co-dependence reflects a systemic point of view, in that the systemic point of view is no longer focused on interaction, but on meanings and co-creation and meaning attribution within systems. The co-dependent's aetiology lies not in the interaction between family members but in the meaning of the interaction as interpreted by the co-dependent, such as the idea that his or her feelings do not count, for example, where the alcoholic or substance-dependent parent, who is supposed to be the stronger partner in the relationship, becomes the victim of the victim (Sheridan & Green, 1993). The systemic approach calls attention to the meanings that everyone involved in the particular family

system, give to psychological problems. The meaning given by the co-dependent to the alcohol abuser's maladaptive behaviour creates the illusion that the co-dependent is not worthy and can function independently from his own perspective (Morgan, 1991).

For dysfunctional families, caring for and being affected by the person who has the alcohol or drug abuse problem is normal for the family members. As the member’s problem become more serious and unresolved, the family members become more affected and react intensely to the tumultuous environment, displaying behaviours and experiencing emotions similar to individuals suffering from post-traumatic stress disorder (PTSD). This is a reactionary process in which the family members experience the trauma of seeing the alcoholic or substance dependent destroying himself. As a result, they become compulsively dependent on similar behaviour patterns of their own, such as work addiction, eating disorders or unhealthy relationships, creating a cycle of trauma transmission from generation to generation (Brown & Wolfe, 1994; Schäfer, 2011).

Theoretical and clinical writings paint a picture of the alcoholic or substance dependent family system that is dominated by dysfunctional characteristics such as family disruption (Kaufman & Kaufman, 1979; Velleman & Templeton, 2003), family violence (Bushman & Cooper, 1990, Coleman & Strauss, 1983; Kaufman, Kantor & Strauss, 1989), loss of employment and financial instability (Liddle, Dakof & Gayle, 1995; Velleman & Templeton, 2003), marital breakdown (Kosten, Jalali, Hogan & Klebber, 1983), and physical and psychological abuse (Bushman & Cooper 1990; Kaufman, Kantor & Strauss, 1989; Rossow, 2001).

In Bowen’s family systems theory these dysfunctional family dynamics reflect one of three major factors pertinent to whole family functioning. The first factor is cohesion, which refers to the amount of closeness or distance within families. According to the family adaptation and cohesion scales (FACES) there are four levels of family cohesion ranging from extreme low cohesion to extreme high cohesion namely disengaged, separated, connected, and enmeshed (Olson, 2000). Studies of cohesion reveal both overly close (enmeshed) and overly distant (disengaged) dynamics in alcoholic or substance dependent families. Family members react to the alcoholic or substance dependent with particular behavioural patterns. They frequently enable the dependence to continue by shielding the dependent from the negative consequences of his or her actions. Such behaviours are referred to as co-dependence.

Co-dependents lack boundaries and are at the enmeshed extreme of the cohesion scale. At the other end of the scale the family member of the substance dependent is abhorred

by the behaviour of the addict, in the case of a child they may lose respect for the adult dependent. The substance dependent's lack of emotional support and interaction with the child or spouse will also cause a breakdown in communication and interaction and the family member may spend more time away from the substance dependent, possibly looking for and finding support from outside of the family system, leading to the other extreme of disengaged (Morgan, 1991).

The second factor is *adaptability*, or the ability to adjust to different situations arising in daily family life across the family cycle. According to the FACES III here are four levels of adaptability namely rigid, structured, flexible and chaotic (Joh, Kim, Park & Kim, 2013). In a family where there is substance dependence, research found that the adaptability levels are either rigid or chaotic – also at the extreme ends of the scale. An adaptive system is an open system. In families with substance abuse and dependence, shame and feelings of guilt (on the side of both the abuser and the family members of the abuser) may prevent them from interacting with society, causing the family system to become a closed system. Within the family, communication strategies can become fixed in stereotyped patterns of interaction, which can reduce the degree of openness in a family system. Minuchen (1979) theorises that these families could become closed systems where coping mechanisms no longer function. As an open system, the family can rely on outside input (environmental intrusion) to aid in its elaboration of structure and differentiation of function and roles to cope with adapting to challenging situations, however, as a closed system the family – with less or limited input (informational exchange) from its environment (social structures and support) respond by becoming either more rigid or more chaotic. Adaptability also requires effective communication and conflict resolution skills – which is absent in the closed system.

The last factor according to Sheridan and Green is *competence* or the overall capacity to fulfil various family level tasks in a way that is supportive of the individual growth of family members. In the family of the substance dependent in the presence of co-dependency, possible neglect and even abuse, there is little chance for the family structure to be supportive of the individual growth of its family members. Instead research shows that individuals from families where there is substance abuse and dependence react to seeing the loved one destroying him or herself by becoming compulsively dependent on similar destructive behaviour patterns of their own, due to their own feelings of low esteem, lack of trust and detachment (Sheridan & Green, 1993).

It is therefore quite clear that alcoholism or substance abuse and dependence can adversely affect the family system and that the dysfunctional family systems created in this

way can promote, and maintain, alcoholism or substance abuse and dependence (Kaufman & Pattison, 1981). Bennett and Wolin (1990) calls alcoholism a family illness, saying when alcoholism is diagnosed for one of the members of the family, it is very likely that it has previously appeared in prior generations and that it will surface again in the next generation.

Family studies support *intergenerational trauma theory* by showing that first-degree relatives of alcoholics or substance abusers or dependents are three to five times more likely to develop alcoholism or substance abuse or dependence problems than individuals from families where there is no alcoholism or substance abuse (Schukit, 1999). Even when adopted into a non-alcoholic or substance dependence free family, children of parents who are alcoholics or substance dependents face a higher risk of dependence, suggesting a genetic component to dependence as well (Cadoret, O'Gorman, Troughton & Heywood, 1985; Hesselbrock, 1995). Seilhamer (1991) states that "there is a general consensus that children of alcoholics are more likely to experience a host of psychosocial difficulties, as well as an increased risk for adult mental health problems, such as depression, substance abuse, and antisocial behaviour."

Although genetic predisposition appears to be a contributing factor to intergenerational transmission of alcoholism and substance abuse and dependence, unhealthy family dynamics and other socio-cultural factors such as poverty also has a strong influence (Greenberg, 1981). Social factors that affect early development within the family, for example lack of mutual attachment, ineffective parenting and a chaotic home environment, have been shown to be crucially important indicators of risk (Coyer, 2001, NIDA, 1997). However, the strongest social predictor of alcohol and other substance abuse or dependence has been shown to be substance and alcohol misuse by parents and friends (Challier et al., 2000). Nevertheless, whether one utilises socio-biological genetic explanations or social and contextual explanations in order to understand and explain alcoholism, substance abuse and dependence, literature supports inter-generational transmission of alcoholism, substance abuse and dependence.

Opposition against substance dependence and alcoholism comes from academics who cites the Jewish population as counterargument: Jewish populations, who have collectively experienced severe historical trauma, are shown to be among those population groups having extremely low rates of alcoholism and substance dependence (Kaplin, 2014; Ullman, 1958). In this case contributing substance dependence to the underlying conditioning and adaptation factors associated with historical trauma no longer holds sway. A study conducted by Zimberg (1977) proposed that the sociocultural attitudes that equates Jewish identity with

sobriety in contrast to drunkenness among non-Jews seems the major factor that accounts for the low rate of alcoholism and substance dependence among Jews. Both Kaplin (2014) and Zimberg (1977) found that alcohol and substance dependence problems increased when Jews lost their Jewish identity through less involvement with traditional religious practices, or in situations where it is difficult or impossible to maintain a Jewish identification. From this it is therefore clear that a more comprehensive model was needed to underwrite the complex causal mechanisms involved with alcohol abuse and addiction that can comprehensively explain why some individuals can use substances without progressing to dependence while others abuse or become dependent on substances.

Theory of liberation psychology: the psychic corollaries of colonialism

In their book "Towards Psychologies of Liberation" Mary Watkins and Helen Schulman proposed that it was the wider historical landscape marked by tragic dismissals and attacks imposed by one group on another that shaped the societal context in which individual psychologies, and therefore psychological disorders, are formed (Watkins & Shulman, 2008). They stated that although globalization and colonisation has changed structures of power and privilege, such as inequality, poverty and violence continue, albeit in new forms and intensities, it has been detrimental to most peoples of the world. They believe that liberation psychology's most important function is to create awareness of the cultural and historical meaning of oppression and how to think about it. This includes the impact of cultural pathologies, such as poverty, the impact of Western capitalism on third world countries and the poor and working classes in First World countries, urbanization, population mobility, family fragmentation, class inequality, poor and inadequate housing and education, gender inequality, racism, homophobia, torture, rapid social change and -disintegration, war, genocide, forced migration, unemployment and the failures of social and community support structures, have on the mental health of individuals (Watkins & Shulman, 2008). They believe that it is only by liberating the theoretical contributions of psychoanalysis from the consulting room, away from an exclusive focus on subjectivity, that the unconscious consequences of colonialism and globalization can be fully understood in the context of community life. This understanding can help break past pathologic cycles and contribute to a less wounded present and future. Liberation psychologists believe it is essential to understand individuals' three possible positions during oppression that of the victim, the perpetrator and the bystander. And while each of these positions produces unique invisible patterns, they are not always exclusive to each other. In the Nazi concentration camps, for example, it was

common for a deathcamp prisoner to be involved as a survivor, bystander and sometimes accomplice to the perpetrator in all three of these. The liberation psychologist has the obligation to understand that very ordinary people resisted the urge to turn away from what they are seeing, so that they could be witnesses to what is happening, rejecting the safety and neutrality of being a bystander as well as the power of perpetrating violence on others (Watkins & Shulman, 2008). Extermination camps are extreme examples but today many people are living within systems that may victimize them in certain instances and in others provide them with privileges borne on the victimization of others, all the while being bystanders to oppression (Watkins & Shulman, 2008).

Liberation psychology also reflects on the way victims of injustice retain collective trauma memories that either allow or disallow different types of discourse. It is important to see that when comparing fatalism literature in Latin America and colonialism in Africa with trauma literature developed primarily in Europe and North America, one finds that Latin American and African literature focuses on collective wounds, trauma suffered by groups, whereas European and North American literature tends to focus on individual and family abuse (Griffin, 1992). Finally, liberation psychologists are learning how to create safe listening environments. Listening is part of the work of overcoming traumatic experiences and one cannot assume that there is a space of safety for empathic witnesses. "In your country," Ignacio Martín-Baró, a Spanish-born Jesuit priest and social psychologist remarked to a North American colleague, "it's publish or perish. In ours, it's publish and perish." (Martín-Baró & Martín-Baró, 1994, p2) In November 1989 a Salvadoran death squad extinguished his eloquent voice, raised so often and so passionately against oppression in Latin America. (Lapsley & Karakashian, 2012; Martín-Baró & Martín-Baró, 1994).

Psychological wounds of the victims of oppression:

Collective trauma: Mary Watkins and Helen Schulman (2008) wonder if the individualism and alienation that has become the norm in modern urban environments may simply be the end-product of the traumatic disruption of communities over time. Collective trauma leads to a gradual disintegration of belief in the community as an important source of support and space of belonging, and as isolation sets in, a deep distrust of the world at large develops. Symptoms include numbness and a sense of loss and hopelessness that can be brought about by the collective trauma of cultural marginalization such as racism, poverty, forced removals, crime, insufficient health care and education. There are many individuals and communities who face marginalization but have the resources of resilience that allow

them to overcome adversity, but others do not and fall into patterns of despondency, violence, helplessness, psychic numbing and dissociation. Survivors of collective trauma often exhibit severe alexithymia, an inability to respond emotionally and cognitively to events in the present, along with anhedonia, the inability to feel and express happiness. There is often an over exaggeration of the routine, everyday details of their lives, lack of initiative and automatic obedience. As the impact of the trauma lingers the symptoms can increase to progressive constriction of cognitive processes, including memory and problem solving (Watkins & Shulman, 2008).

It was only when post-traumatic stress disorder (PTSD) was officially recognized by the American Psychiatric Association in 1980 when it was listed in the third edition of the Diagnostics and Statistical Manual of Mental Disorders (DSM III) that it was documented as a way of thinking about the catastrophic effects of certain experiences. Initial diagnoses were restricted to military personnel and accident survivors and later to victims of domestic violence. But as clinical evidence was collected over the decades, traumatic psychological suffering was linked with social violence. Unfortunately, there were still those caught up in the medical model of treating individuals, disconnecting the individual from the social, political, or environmental contexts that give rise to post traumatic symptoms (Watkins & Shulman, 2008).

Fatalism: Ignacio Martin-Baró, who literally dedicated his life to the people of El-Salvador in Latin America, defined fatalism as the way in which the poorest of the poor come to experience their lives as being controlled by cosmic or spiritual forces and therefore predetermined and completely out of their control. In meeting daily difficulties in this fatalistic stance, hopelessness creates a kind of psychological myopia, or near-sightedness, narrowing the time to the present. Memory is lost and any sense of being able to plan for or influence one's own future based on personal wants and needs is abandoned in pessimism (Martín-Baró & Martín-Baró, 1994; Watkins & Shulman, 2008). Literature of the day told Martín-Baró that fatalism was seen as passed on from parent to child, contributing to the maintenance of poverty. In this way, where the causes of this fatalistic stance are not critically questioned, the oppressed are blamed for bringing about their own misery. But he disagreed. Watkins & Shulman (2008, p. 111) quote him as saying:

> *Fatalism is a way for people to make sense of a world they have found closed and beyond their control: it is an attitude caused and continually reinforced by the oppressive functioning of overall social structures. Marginalized children in favelas, or champas, or other shantytowns of Latin America internalize fatalism not so much*

> *because they inherit it from their parents as because it is the fruit of their own experience with society. Day by day they learn their efforts in school get them nowhere; the street does not reward them well for their premature efforts at selling newspapers, taking care of cars, or shining shoes; and therefore it is better not to dream or set goals they will never be able to reach. They learn to be resigned and submissive, not so much as the result of the transmission of values through a closed subculture as through the everyday demonstration of how impossible and useless it is to strive to change their situation, when that environment itself forms part of an overall oppressive social system. Hence, just as marginalization is caused by a socioeconomic system to which the marginalized, as marginalized people, belong, the attitudes and values of a culture of poverty are being continually caused and reinforced by the normal functioning of this social system, which includes the poor as members.*

Martín-Baró therefore saw fatalism as symptomatic of the internalization of social domination and to disrupt this internalization would disrupt the rationale by which minority rule by a powerful elite is justified. And although these symptoms of depressive feelings of inferiority, worthlessness, hopelessness, inability to affect the future while gradually abandoning the past, and too often, the eruption of violence born of futility are suffered by an individual, they are created socially and shared communally, linking psychology with distinct social structures (Watkins & Shulman, 2008).

As the liberation social psychologist ultimately aim to create structures to counter these symptoms individuals like Paulo Freire, an educator and author of “Pedagogy of the Oppressed” and Michael Lapsley, a liberation theologists and founder of “The Institute for the Healing of Memories” in Cape Town, understood that these memories and symptoms will only be alleviated and recovery ameliorated amongst others who are suffering similarly. In these spaces an individual can see that their “fate” was shared and together people could begin to read personal experiences in the light of a shared history. It is only through this recovery of historical memories through the sharing of stories that an individual can again begin to imagine ways in which to intervene creatively to change their own situation over time with and in support of others (Aronowitz, 2002; Lapsley & Karakashian, 2012; Watkins & Shulman, 2008).

Internal Colonization: Practising psychiatrist and revolutionary philosopher Frantz Fanon, born in Martinique, showed in his publications such as “Black Skin, White Masks” that the debilitating personality and identity effects of trying to understand oneself, that might

normally be understood within a purely psychological framework, is far better explained in political terms, that is, with reference to understandings of violence, power and subordination (Hook, 2004; Watkins & Shulman, 2008). While Fanon spoke to the psychological dynamics of “the black man,” his theories were relevant to all humans caught in the dehumanising racist objectification that marked colonialism. He explained how, what the colonials represented, became both what was rejected yet emulated, in thought and action. The metaphor created by George Orwell in “Animal Farm” illustrated this internalised colonialism when the animals first rejected the farmhouse, refused to trade the products they worked hard to produce and held to the seven principles, the most important being that all animals are created equal, only to have the ruling elite animals eventually occupy the house, trade the animal products for alcohol, and creating the one new law which stated: “All animals are equal, but some animals are more equal than others,” in their imitation of their oppressor. Seeing that which was part of the oppressive system, as their reward for success (Darmawan, 2018, p.9). Fanon posits that an integral part of internalised colonialization has to do with seeing through the eye of the oppressor, for example equating whiteness with beauty and intelligence (Hook, 2004; Jacobs, Levine, Abney, & Davids, 2016; Watkins & Shulman, 2008). The oppressed culture’s originality becomes buried and the colonialized elevate their colonizer’s culture above that of their own. With this comes the loss of indigenous cultures, histories and languages. The very things that bind communities together and sustain pride and resilience like traditions and rituals are forgotten, in the least, more often made to be seen as ridiculous or unworthy, or most commonly vilified as being evil and unholy. Albert Memmi, a Jew who lived in French-colonised Tunisia, was a philosopher and author of the book “The Colonizer and the Colonized” in which he describes how colonialization scars both the colonized and the colonizer (Sartre, 2006). For the colonized, he said, colonialism is a “social and historical catalepsy” (Memmi, 2013, p.146) where through internalised colonialism the colonized people’s culture, history and languages are stolen from them and like the Indigobirds who lays their eggs in other bird’s nests, the colonizers make the oppressed adopt their language, culture and clothes. In this way, not only is the colonialized people’s past stolen but their future is denied, locking the oppressed people into a present reality where they look at themselves through the eyes of the oppressor seeing themselves as weak, backward and evil, and slowly they become assimilated into the society of the oppressor, with the illusion of reaping the benefits of the oppressor’s system (Sartre, 2006; Watkins & Shulman, 2008).

Resistance to Westernization: Amin Maalouf, a French Lebanese author, who grew up in war-torn Beirut is best known for his award-winning novel "Samarkant" although he writes both fiction and non-fiction. His novels are marked by his experiences of civil war and migration and his main characters are often torn between countries, languages, and traditions, and as with many authors, his works are social commentaries on issues of importance to him. For example, in his book "The crusades Through Arab Eyes" he provides an Arab perspective on the crusades, especially the Western Christian crusaders who are seen as "barbarians" and are considered cruel, savage, ignorant and culturally backward. Possibly the most politicised of his writings is his non-fiction work "In the name of identity: Violence and the need to belong" in which he discussed the Arab identity crisis (Maalouf, 2001). In it he explains how resistance to Westernization is part of the effect of the traumatic displacements that is part of colonisation and globalization and the aftermath of the Lebanese civil war, where the Western quest for superiority left generations of Arab nationals with a sense of defeat and self-betrayal. Having to admit that their ways were out of date, everything they produced inferior, their attachment to tradition and religion nothing more than superstition and their military glory just a memory. How can they not feel that their identities are being threatened if they have to speak other people's languages if they want to survive, living in a world that belongs to others, obeying rules made by others in a world where they are orphans and outcasts. According to Watkins and Shulman (2008) Maalouf understood that religious fanaticism was not the Middle East's first response to colonialism, it was only when other reasonable paths were blocked that Arab men started growing their beards, as their traditions would have them do, and their women started wearing their Abayas and Burkas with pride and as signs of silent protests. This reclaiming of identity helped restore the psyches injured by colonialism and globalization.

Albert Memmi confirms this in "Decolonization and the Decolonized" explaining how cultures under attack identify more adamantly with their traditions, often not discerning between elements which provide connection to the past and resilience for the future and those that may have to be revised or questioned, in this way, whatever has been broken down is revered irrespective of the suitability or appropriateness and in this way fundamentalism is fuelled (Memmi, 2013; Sartre, 2006; Watkins & Shulman, 2008).

Belated Memories: Watkins and Shulman (2008) states that one of the features of collective trauma is that the memory and understanding of the trauma is often delayed and that this inability to see, to recognize and acknowledge the trauma can be placed in the framework of colonialism, where for centuries colonialists avoided seeing the suffering they imposed.

They felt that in contexts where violence and inequality were normalised, an unconscious-agreed-upon collective amnesia sets in amongst the privileged that is part of the pathology of collective trauma. And since there is no framework of cultural reference within which to place testimonies about traumatic events, there is nobody to witness and to listen to the stories of the victims, reinforcing the conditions that contributed to breaks in narrative. The divide between the privilege and the disadvantaged becomes embedded and the marginalised becomes permanently ‘other’, irreversibly different, and therefore dangerous and criminal. The task of resurrecting the collective memories in situations of collective trauma then becomes the sacred duty of the next generations, a labour that echoes through the family lines of both victims and perpetrators (Watkins & Shulman, 2008).

Theories with a stronger focus on recovery

As relapse after recovery from substance dependence or alcoholism is an especially concerning aspect of substance dependency negotiated by an interplay of biological and psychosocial factors, some models introduce predictive factors, relating specifically to factors predicting a favourable prognosis for positive change, as well as potential obstacles to positive change. As evidence from the literature study suggests that biological, genetic, personality, cognitive, social, cultural and environmental factors interact to produce the alcoholic or the substance dependent individual, multiple factors must be addressed in prevention and treatment programs. Traditional treatment and intervention programs tend to focus on the problem or the dysfunction in the family or community, which may cause both the individual and the people providing assistance, to overlook the individual’s own inherent abilities and resources (Appelt, 2006).

A social stress model of substance dependence

According to the social stress model of substance dependence, the likelihood of an individual engaging in alcohol or drug abuse is a function of the stress levels experienced by the individual and the extent to which it is offset by the particular stress modifiers present in the individual’s life, for example social networks, social competence and emotional resources (Lindenberg, Gendrop & Reiskin, 1993). In this way this model also provides a framework for detecting protective factors that may contribute to resiliency when confronted with compelling influences to engage in substance abuse or when confronted with triggers which may lead to relapse after recovery (Rhodes & Jason, 1990). Theorists believe that humans have an innate desire to connect and bond with something and that substance dependence occurs due to a lack of bonding (Wodak, Drummond, Reinarman & Cohen, 2002). Oxytocin,

a hormone released through physical bonding and connection, is important for stress resilience and wellbeing (Ishak, Kahloon & Fakhry, 2011; Heinrichs, Baumgartner, Kirschbaum & Ehlert, 2003). If an individual experience a lack of bonding, their physical and mental health are negatively impacted and they may find this connection in substances or another form of dependence (Wodak, Drummond, Reinarman & Cohen, 2002).

In the introduction to their book on transformative dialogue tools and processes for change, Marianne Bojer and her colleagues (2008) state that people have an inherent desire to solve their own problems. Communities are very capable of finding their own solutions to the problems they face. When programs or interventions are imported, or imposed from the outside, they frequently meet resistance and often fail. This could be because these solutions are generic and not uniquely appropriate in the given context, but more than likely it is due to a lack of ownership from a community who hasn't been allowed to participate or been consulted in the decision-making process, and therefore cannot be blamed for being suspicious of any individuals or organizations outside of their system, especially considering the Coloured community's history of discrimination, disrespect and disillusionment from external agents (Bojer, Roehl, Knuth & Magner, 2008).

Asset Based Community Development

In response to this, asset-based-community-development (ABCD) strategies has gained support from community development practitioners for community driven development in both urban neighbourhoods and rural communities as an alternative to the needs-based approach to community development that is deeply entrenched in government and non-government service delivery (Mathie & Cunningham, 2003). In particular, ABCD draws attention to social assets: the gifts and talents of individuals, and the social relationships that provide protective factors needed to reinforce resilience. It is in this aspect that ABCD has gained movement in the field of mental health to utilise local resources and strengths to support capacity-building and facilitate community empowerment by collaborating with individuals from the communities themselves to identify needs and create solutions. This supports the contemporary trend to design intervention strategies based on strengths instead of deficits (Appelt, 2006). Marianne Bojer and her colleagues go on to say that meaningful change can only come about by talking to and listening to each other. These skills of talking and listening are inherent to us, we are storytelling animals. We are made of stories. For generations, the human species have used stories to help them understand mysteries, remember important rules and to solve problems. In the summary of her TEDx

talk, Andrea Gibbs wrote that it is through listening to each other's stories that humans learn to understand each other better and find commonality with others. Through sharing stories, individuals share their passions, hardships, embarrassments, joys, griefs and the overall human experience. People connect using stories, and that makes us feel less alone in the world (Gibbs, 2014).

LINC model and ARISE protocol

Judith Landau (2007) and her colleagues developed two programs based on social support, that has been applied successfully in cases of addiction namely the LINC model and the ARISE protocol. In the LINC or 'Linking Human Systems Community Resilience' model, rather than implementing artificial infrastructures for assistance, the LINC program empower trusted community leaders to serve as natural agents for change. These 'group connections' provide a connection between outside practitioners, families and communities, particularly in circumstances where it is not possible to allow outside involvement, or where outside involvement is not trusted (Landau, 2007). Where the LINC model focus on enhancing resilience the ARISE (A Relational Sequence for Engagement) protocol has the aim to empower family members of resistant alcoholics to encourage and motivate them to enter rehabilitation programs (Landau, Stanton, Brinkman-Sull, Ikle, McCormick, Garret, Baciewics, Shea, Browning, & Wamboldt, 2004).

A spiritual model of addiction and recovery

There are researchers who feel it necessary to expand the biopsychosocial model to the 'biopsychosocial-spiritual model'. Critics of this model feels that moral and spiritual concepts are value laden and culture specific or simply consider the 'spiritual' part of this model already included in the socio-cultural (social) part of the biopsychosocial model (Horvath, Misra, Epner & Cooper, n.d.). In the biopsychosocial-spiritual model there is a higher power who is seen as the one who governs, guides, directs, or intervenes on behalf of human beings. Spiritual models assume substance dependence occurs because of a separation from this higher power. Moral causes of dependence presume there is a "correct" morality based on a particular set of values. Deviation from those values results in dependence (Horvath et.al., n.d.). However, several researchers report positive correlation between levels of spirituality and prognosis for substance dependence recovery and maintenance. For example, in a study conducted by Avants, Warburton and Margolin (2001) examining the association between support and comfort derived from religion or spirituality and abstinence from illicit drugs involving a sample of 43 HIV-positive injection drug users, entering a

methadone maintenance program, they found that individuals with high ratings of perceived spiritual or religious support were abstinent from illicit drugs significantly longer during the first six months of methadone maintenance than were patients with lower ratings. This, they believed, was an indication that strength of religious and spiritual support was a significant independent predictor of abstinence. They therefore concluded spirituality to be an important dimension of patient experience to assess in future substance dependence treatment outcome research (Avants, Warburton & Margolin, 2001). A qualitative study conducted in Amman, Jordan, exploring whether the biopsychosocial-spiritual model of substance dependence was relevant to an substance dependent treatment population in an Islamic country involving a sample of 25 male in-patients in a substance dependence treatment centre, found that, despite some differences in emphasis, the biopsychosocial-spiritual model of substance dependence delivered a good fit, specifically given the relative importance of religion in the Islamic culture (Al Ghaferi, Bond & Matheson, 2017). The most prominent example of the spiritual approach in substance dependence recovery therapy is the 12-step program from Alcoholics Anonymous (AA) and other 12-step groups.

The moral model of substance dependence and recovery

The moral model of substance dependence and recovery is closely related to the spiritual model of substance dependence. Dependence, according to the moral model is caused by moral failure. A failure to do what is right. Similarly, recovery consists of strengthening one's will to do the right thing. The moral model is very prominent in the way in which the criminal justice system approaches substance dependence (Horvath, Misra, Epner & Cooper, n.d.). The Moral Reconation Therapy (MRT) is cognitive-behavioural treatment approach that has been utilized since 1985 and is based on the moral model of substance dependence recovery. This program is traditionally implemented in correctional systems, conducted in groups employing workbooks, homework assignments and have requirements for performing specific behaviour (Little, 2005). In a meta-analysis of nine published outcomes studies related to the effects of Moral Reconation Therapy on recidivism (in criminal justice outcome research, the term *recidivism* is typically used to describe offender rearrests, reconvictions, or actual reincarcerations) including sample statistics from a total of 2,460 MRT-treated individuals and 7,679 individuals in control groups, a statistically significant reduction in recidivism was found (Little, 2005).

The biopsychosocial model

In 1977 George L. Engel and Jon Romano proposed the biopsychosocial model (Borrell-Carrió, Suchman & Epstein, 2004), feeling that biological, psychological and social models, all approaching substance dependence in a one dimensional plane, do not adequately address the biomedical, pharmacological, psychological and social interplay of factors operating on the dynamics surrounding dependence (Griffiths, 2005). They strived for a more holistic approach considering that each individual has their own unique genetic makeup, environmental exposure, thoughts, feelings and history. As a holistic approach the biopsychosocial model considers the "5 P's;" Predisposing, Precipitating, Perpetuating, & protective factors and predictive factors when looking at addiction (Borrell-Carrió, Suchman Epstein, 2004). *Predisposing factors* are areas of vulnerability that increase the risk for the presenting problem. Examples include genetic and metabolic predisposition for alcohol or substance dependence. Precipitating factors are typically thought of as stressors or other events that are related to the current symptoms and may be causing the symptoms. Examples include conflicts about identity or separation-individuation that arise at developmental transitions. Perpetuating factors are any conditions in the patient, family, community, or larger systems that exacerbate rather than solve the problem. Examples include unaddressed relationship conflicts, lack of education, financial stress, and occupation stress or lack of employment. Protective factors include areas of competencies, skills, talents, interest and supportive elements such as family, friends and role models. Protective factors counteract the predisposing, precipitating, and perpetuating factors (Griffiths, 2005).

The biopsychosocial model posits (See Table 1) that all of these factors operate in each of the three domains, as there are genetic, developmental, medical and temperamental elements from the Biological domain predisposing an individual to addiction, for example, but also intrapsychic conflicts, defence mechanisms and other elements from the Psychological domain and relationships and environmental risk factors from the Social domain that all play a part in predisposition. The same applies to Precipitating, Perpetuating, Protective and Predictive Factors. These domains overlap and are not exclusive (Griffiths, 2005).

Table 1: Biopsychosocial worksheet used in clinical settings (Clinical Supervision, n.d.)

Bio-Psycho-Social Worksheet

Note: This bio-psycho-social assessment organizer is used for noting historic & current factors that explain Mateo's present situation and state of need. Knowledge is used to answer clinical questions and plan a case formulation.

Key Factors	Biological Domain	Psychological Domain	Social Domain	
Explaining a Person's Life Circumstances/ Problems	**Genetic, developmental, medical, tempera-ment, biological effects of substance use**	**Cognitive style, intra-psychic conflicts, defense mechanisms, self-image, meaning of symptoms**	**Social-relationships family/ peers/others**	**Social-environment cultural/ ethnicity, social risk factors**
1. Predisposing → (Vulnerabilities that tend to increase risks of the presenting problems)	[E.G: Family psychiatric history, toxic exposures in utero, birth complications, developmental disorders, regulatory disturbances, traumatic brain injury] • • •	[E.G: Insecure attachment, problems with affect modula- -tion, rigid or negative cognitive style, low self-image] • • • •	[E.G: Childhood exposure neglect or abuse, late adoption, temperament miss-match, marital conflicts] • • •	[E.G: Poverty, low SES, teenage parenthood, poor access to health or mental health care] • •
2. Precipitating → (Stressors and life events having a time relationship with the onset of symptoms and may serve as triggers)	[E.G: Serious medical illness or injury, increasing use of alcohol or drugs] • • • • • •	[E.G: Conflicts around identity or separation-individuation arising at developmental transitions, such as puberty onset or graduation from high school] • • • •	[E.G: Loss or separation from close family member, loss of friendships, interpersonal trauma] • • •	[E.G: Recent immigration, loss of home, loss of supportive services] • •
3. Perpetuating → (Ongoing life challenges and sources of needs)	[E.G: Chronic illness, functional impairment caused by cognitive defects or learning disorder] • • • •	[E.G: Use of self-destructive coping mechanisms, help-rejecting personality style, traumatic re-enactments] • • • • •	[E.G: Chronic marital/family discord, lack of empathy from parent, inappropriate parental expectations] • • •	[E.G: Chronically dangerous neighborhood, trans-generational problems of immigration] • • •
4. Protective → (Functional strengths, skills, talents, interests, assets, work, supportive elements of the person's relationships)	[E.G: Above-average intelligence, easy temperament, special talents or abilities, physical attractiveness, factors related to emotional intelligence] • • • • •	[E.G: Ability to be reflective, ability to modulate affect, positive sense of self, adaptive coping mechanisms, other skills that build resiliency] • • •	[E.G: Positive parent-child relation-ships, supportive community and extended family, family resources] • • • •	[E.G: Community cohesiveness, availability of supportive social network, well-functioning team] • • • •
5. Predictive → (Potential for change, areas most amenable to change as well as potential obstacles to positive change)	[E.G: Sustained good health -or- worsening illness, persisting pattern of sobriety or addiction] • • •	[E.G: Adaptive to unfolding life changes -or- resistant to current change efforts] • • •	[E.G: Supportive friends and family members -or- destructive friends or toxic family relationships] • • •	[E.G: Positive supports for life changes -or- ongoing unsolved social issues or legal matters] • •

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Chapter Summary:

This chapter presented a literature study related to addiction in terms of the three domains of the biopsychosocial model, namely the biological, psychological, and social domains. Two biological theories, metabolic and genetic theories were considered together with criticisms. Genetic theory holds that substance dependence is inherited or passed down through generations, neuroanatomically through epigenetic mechanisms. The frontal cortical areas most frequently implicated in substance dependence are neuroanatomically connected with the limbic structures, that are associated amongst others with emotion and memory. As research shows that chronic exposure to substance abuse result in long-term changes in neural structures, researchers believe that in this way, genetic alteration may contribute to the addictive phenotype. Therefore, environmental information is transmitted through chemical changes that occur in individual DNA strands. In a similar way, Metabolic theorists believe that chronic exposure to substances causes cellular changes leading to biological anomalies such as the inability to sense Blood Alcohol Levels. However, many theorists supporting Biological models listed the limitations of their models and felt that contributing factors such as ethnicity (social factors) and personality (psychological factors) should be considered in the aetiology of addiction.

In terms of psychological theories of addictions, conditioning and adaptation theories were listed, as well as the motivational theory of substance dependence and lastly the strength model of self-control. In all of these theories, overlaps between the domains were clear. In social theories of addiction such as historical trauma theory, family systems theory and addiction in terms of liberation psychology, the influence of psychological and biological factors also became clear, such as the biological components involved in intergenerational transmission of trauma by means of epigenetics and the psychological contributors to the family systems model for example co-dependant personalities.

In social theories of addiction, the social stress model was discussed as a more positive model focussing on preventing addiction and supporting recovery and maintenance of abstinence, as a fifth p, namely predictive factors, are introduced as factors linked to a favourable prognosis for recovery. The ABCD model and Judith Landau and her colleagues' LINC model and ARISE protocol were discussed as further social theories, all three also more focussed on prevention of addiction and support of recovery. This then lastly lead to the discussion of the spiritual model of addiction, whose critics feel that morals and spiritual concepts are value laden, and that the spiritual aspects of addiction are already encompassed in the social and psychological domains of the biopsychosocial model. However, several

research projects reported the biopsychosocial-spiritual model of substance dependence to be a good fit, especially in a religious context. As part of the spiritual model of addiction the moral model of addiction was discussed, and it was reported that research support this model as effective in preventing repeat offences, also being more focussed on the recovery from addiction and maintenance of recovery.

As the three domain clearly showed to be overlapping and without being comprehensive enough, the biopsychosocial model was discussed as an answer to the apparent gaps and overlaps in the other models, listing the so-called 5 Ps linked to the model, namely predisposing factors, precipitating factors, perpetuating factors, protective factors and predictive factors. See Table 1 for an example of the biopsychosocial model used typically for case formulations in clinical settings (Clinical Supervision Implementation Guide, n.d.). From the literature review it would then appear that the biopsychosocial model delivers a comprehensive picture of the aetiology of substance dependence, the origins of addiction, and the factors necessary to prevent addiction and predict maintenance of recovery.

Chapter 3: Research Method

This chapter exemplifies the research framework by discussing the philosophical foundations and describing the research design chosen for this study. The aims and objectives of the study and research questions are then stated again. Data collection, including the sampling method and size, is explained as well as the chosen method of analysis. Finally, ethical considerations and potential challenges during data collection is highlighted and the chapter ends by outlining the significance of the study.

Research Design

This research project employed a *qualitative approach* from an *interpretive paradigm* to obtain raw data through *semi-structured interviews*, which were then organized and interpreted using *thematic content analysis*.

Qualitative Approach.

Qualitative research focusses on understanding the quality or meaning of lived experiences through rich description (Braun & Clarke, 2006). It is a very useful approach to aid in developing an understanding of complex social environments and the meanings that people in those environments bring to their experiences. Merriam (2009) said researchers with the overall purpose to understand how people make sense of their world will make use of a qualitative approach. Qualitative research allows deeper insight into, and understanding of people's attitudes, behaviours, value systems, motivations, aspirations, cultures, and lifestyles by gathering non-numerical data to illuminate deeper meanings (Gachutha, 2006). Below then the philosophical underpinnings forming the framework of the research methodology for this research project.

Interpretive Paradigm

Interpretivism attempts to understand the world as it is by exploring the subjective experiences of individuals. To do this they use meaning (versus measurement) oriented methodologies, such as interviewing or participant observation, that rely on a subjective relationship between the researcher and subjects. Interpretivists differ from the other researchers on assumptions about the nature of reality, what counts as knowledge and its origins, beliefs, and their role in the research process. (Fosnot & Perry, 1996). Paradigms are all-encompassing systems of interrelated practice and thought that define research in three dimensions namely ontology, epistemology, and methodology (Terre Blanche, Durrheim, & Painter, 2006). The interpretive paradigm can therefore best be described in terms of related assumptions on ontology, epistemology and methodologies used as follows:

Ontology:

The interpretivist philosophy, based on the relativist ontology, holds that reality is socially constructed, and that there are as many insubstantial realities as there are people constructing them. Reality, therefore, is mind-dependent, and is a personal or social construct. Without consciousness life is meaningless, and as the interpretivists suggests that humans try to make sense of the situations they are in, and in this way social phenomena, from the most basic such as best friends and birthdays, to the most complex such as gender identity, religion and race are the results of, sometimes collective, human interpretation (Scotland, 2012). In this way people create certain social phenomena that are not absolute but are relative to the individual or community experiencing it (Terre Blanche, Durrheim, & Painter, 2006, p 273-274).

Epistemology:

Where *ontology* deals with the 'what' of research, epistemology deals with the 'how' of it (Terre Blanche, Durrheim, & Painter, 2006, p 504). Ontology and epistemology relate to each other in that a researcher's specific ontological beliefs dictate his or her epistemological beliefs; What the researcher believes about the nature of reality will dictate what kind of relationship they think the researcher should have with whatever is being studied. In other words, *epistemology* relates to the relationship the researcher has with his or her research (Reber, Allen, & Reber, 2009, p. 267; Terre Blanche, Durrheim, & Painter, 2006, p 6). The *interpretive* paradigm in research is concerned with gaining an in-depth understanding of the lived experiences of individuals from a subjective perspective (Weed, 2005). As interpretivists believe that knowledge is socially constructed and mind-dependent, they believe it to be subjective. They feel that the only truth lies within the human experience, and although some truths are universal, what is true or false is ultimately culture bound, and historically and context dependent. Within this context, the stories and belief systems in communities find space as legitimate knowledge (Scotland, 2012).

Axiology:

Where 'how does one know what is real?' is answered by *ontology* and 'what values are assigned to reality?' answered by epistemology, 'how does one write about it?' is answered by axiology (Aliyu, Singhry, Adamu, & Abubakar, 2015). Since interpretivists hold that reality is uniquely constructed and mind-dependent and knowledge subjective, social inquiry will inevitably be value-bound and value-laden. These values inform the paradigm one chooses for inquiry, the choice of topic for the study, the methods chosen to collect and

analyse data, and how the findings are interpreted and reported. As an interpretive researcher, one admits to the value-laden nature of the study and report one's values and biases related to the topic under study that may interfere with neutrality (Aliyu, Singhry, Adamu, & Abubakar, 2015).

Methodology:

The research method is the strategy of enquiry employed by the researcher. The purpose of interpretative research is to understand people's experiences. Interpretive research typically takes place in a natural setting where the participants live their daily lives. The purpose of the study articulates the assumptions of the interpretivist researcher in attempting to understand human experiences (Scotland, 2012). Assumptions about the diversity of realities inform the research process, where, for example, research questions may not be established at the start of the study, but may evolve as the study progresses (Weed, 2005). Research questions are generally open-ended, descriptive, and non-directional typically including a broad opening question followed by a small number of more pertinent questions. (See Appendix A for the complete list of interview questions). The opening question is normally a statement of the problem that is examined in the study in its broadest form, posed as a general issue, so as not to limit the inquiry (Weed, 2005). This study employed *thematic analysis* to interpret the data gathered to report on the perceptions of five lay community health workers, on the origins, dynamics, and recovery from substance dependence. The coding framework for thematic analysis can either be developed by reading through the interviews and identifying themes 'inductively' from the data or 'deductively,' by applying a pre-existing framework from theory or from another study, or from reading literature (Braun & Clarke, 2006). For this study, the biopsychosocial model informed the study and the themes were initially developed deductively based on the five P's from the model. However, a sixth theme was developed 'inductively.'

Aim and Objectives of this Study

Aim of the Study

The aim of the study was to explore the perceptions of lay community healthcare workers from a rural West Coast community, concerning the origins and dynamics of, and recovery from substance addiction with an interest in the transference of intergenerational historical trauma seen against the theoretical framework of Engel's biopsychosocial model.

Objectives of the Study

The objectives of the study were:

- To record and relate the accounts of lay community healthcare workers in rural communities about people who have recovered from alcoholism or substance dependence.
- To investigate these accounts and explore them for emerging motifs, elements or influences, patterns or signs relating to the origins, dynamics and recovery from substance addiction.
- To note possible evidence of unresolved historical trauma in these accounts.

Research Questions

1. What are lay community healthcare workers' perspectives on the origins and dynamics of substance addiction and recovery.
2. Do the accounts of volunteer community healthcare workers support a relationship between alcoholism or substance dependence and unresolved historical trauma?

Participants

Five participants have been selected from a rural community on the South African West Coast as the research sample. A sample is a smaller part of a population, which is intended to represent the entire population (Robinson, 2014). According to Terre Blanche, Durrheim and Painter (2006, p. 133) a sample will be representative of a population if elements in the sample have been randomly selected from a ‘sampling frame’ from everyone in the population. This study employed *non-probability purposive* sampling. This sampling method is used when researchers want to study a clearly defined sample and respondents are selected based on specified characteristics of a population based on the objective, or purpose, of the study (Reber, Allen, & Reber, 2009). The objectives of this study focused on the experiences of a group of people in a very specific field, namely lay community healthcare workers from rural communities on the West Coast of South Africa. Non-probability purposive sampling, therefore, does not involve a completely random selection of participants, and it is well suited for this study.

Inclusion criteria:

The inclusion criteria for the sample group was to have been lay community healthcare workers who have been or are involved in community care for at least four years or more. Research participants would ideally have been demographically diverse in terms of age and gender, however for this research project the researcher selected mature participants ranging in age between early 40s to early 60s. The reason for the age demarcation was that

the relating of their experiences around alcohol and substance dependant recovery, even if the person involved is not related to them, could be traumatic, as more mature individuals are in general more resilient (Gooding, Hurst, Johnson & Tarrier, 2012), emotionally and psychologically older research participants should not only be less affected by relating accounts around alcohol and substance dependant recovery, but also have more years of experience to strengthen their impressions and opinions.

The sample selection criteria therefore was mature individuals between the ages of 40 and 60, who are lay community healthcare workers, male or female, without any psychological or psychiatric problems, who are working or have previously been actively involved in a rural community for at least four years or more. Through her work as volunteer counsellor at the community school and with the Victim Empowerment Program (VEP) the researcher contacted lay community healthcare workers she either worked with as a volunteer, or knew about, through her involvement with the local school where she volunteered or through the VEP. Five lay community healthcare workers, four females and one male, were recruited this way. One of the participants identified as "Coloured" while the other four identified as white.

Data collection

Data collection procedure.

This research was approved by the Ethics Committee of the Department of Psychology of the University of South Africa. Research participants were recruited, and interviews arranged. The researcher discussed and implemented the informed consent form with the participants at the interviews, ensuring every participant was aware of the voluntary nature of their participation and that they could withdraw at any time. Once the researcher has confirmed that the participant was comfortable with being recorded, she commenced with the interviews. Each participant was asked to relate a story of a member of their community who has successfully recovered from addiction. As the interview progressed, and at the end of the interview the researcher asked additional questions to clarify or gain additional information. (See Appendix A for the complete list of interview questions). The interviews, varying around approximately one hour, were conducted in the 'Victim-friendly room' of the local police station, because it is a friendly neutral space, familiar to most participants as VEP volunteers. The interviews were recorded and transcribed by the researcher. The original and back-up audio files, as well as the original and back-up transcription files were password protected.

Data Collection Method.

Interviews are the most common methods of data collection used in qualitative research. Through interviews the researcher can explore the views, experiences, beliefs, and motivations of individual research participants (Gill, Stewart, Treasure, & Chadwick, 2008). This research project employed semi-structured interviews. *Semi-structured interviews* are well suited for the exploration of the perceptions and opinions of participants regarding complex or sensitive issues as they have been shown to allow for probing by the researcher to gain more information and clarification (Barriball & While,1994). This makes it a very effective method to capture rich detailed accounts of participants’ experiences. The researcher aimed to gather as much specific information about the participants’ experiences and appraisals through the interviews. During the interviews the participants were asked to tell the researcher about their experiences as lay community healthcare workers and were asked to tell her a true story of an individual from their community who has overcome alcohol and substance dependence that they have either worked with, or have close knowledge of (See Appendix A for the complete list of interview questions that were used in this study with the participants).

Establishing Trustworthiness

In his article on quality control in qualitative research William Stiles (1993) asks how does one design, conduct and report trustworthy qualitative research? What procedures and criteria can one use to evaluate research that is language based and not numerical, that relies on empathy, is contextual, poly-dimensional, nonlinear, and emancipatory? Qualitative researchers agree that there are four aspects of trustworthiness that must be established: credibility, dependability, transferability, and confirmability (Korstjens & Moser, 2018; Pandey & Patnaik, 2014).

Quality through confirmability and reflexivity

The nature of qualitative research is such that each researcher brings a unique perspective to a study. Confirmability refers to the degree to which the results of a study could be confirmed or corroborated by others. In qualitative research confirmability occurs when credibility, transferability, and dependability has been established. In addition, reflexivity is a fundamental part of ensuring the transparency and quality of qualitative research (Korstjens & Moser, 2018).

Credibility:

Where confirmability can be compared to objectivity in quantitative research, credibility can be compared to internal validity and is concerned with the credibility or believability of the results, asking if the results present a plausible interpretation of the participants' original views. There are various strategies that researchers employ to ensure credibility for example prolonged engagement, persistent observation, triangulation, and member check (Korstjens & Moser, 2018). The context in which the research was conducted for this study posed a potential challenge, as local colloquialisms in the Western Cape introduce subtle nuances in the conversations which could get lost in transcription, threatening the plausibility of the interpretation of the participants' original views. To negate this the researcher employed the strategy of persistent observation, where she constantly re-examined her transcriptions, as she listened and re-listened to the recordings after the first transcriptions, whilst developing the codes and the themes. She then analysed and revised these themes, listened to the recording again and studied the data again, until she was satisfied that the results provided the intended depth of insight she was looking for. Although all five interviews were conducted in English as the participants indicated that to be their preferred medium, they often used Afrikaans words or other colloquialisms, as is common in the Western Cape. Where this was the case the researcher provided a brief explanation of these words or expressions.

Transferability:

This aspect of quality control of the research study speaks to the level to which the results of the study can be transferred to other contexts or settings with other participants and can therefore be compared to external validity in quantitative research. Transferability is obtained through employing "thick description" (Korstjens & Moser, 2018). In this study the researcher gave a detailed account of the descriptive data, such as the context in which her research was carried out, the setting, the sample size and -strategy as well as inclusion criteria, interview procedure and the semi-structured interview questions. However, Korstjens and Moser (2018) states that the so called "transferability judgement" can only be made by other researchers reading the report, as their research settings are not known.

Dependability:

Dependability in turn can be compared to reliability in quantitative studies and therefore concerns the stability of the results of the study over time. Dependability includes an aspect of consistency and neutrality and requires the researcher to ensure that the

interpretation of the data is not based on personal preferences and viewpoints but instead needs to be grounded in the data. The strategy to ensure dependability is known as an audit trail (Korstjens & Moser, 2018). In this study the researcher kept notes from the start of the project up to the emergence of the results, both on the process and on her reflective thoughts, to ensure that her interpretations are such, that all are supported by the data she received from the participants.

Reflexivity:

Reflexivity support the process of establishing dependability. Qualitative research must be reflective, meaning that the researcher needs to maintain a sense of awareness of herself, her stance on the research topic and the way in which her presence in the context of study may inform the data. This awareness involves maintaining a two-fold analytical focus, firstly on her relationship to the research, and secondly on how the phenomenon under study could be a commentary on herself. In this way the results of the study unfold without bias or expectation. Reflexivity can be compared to construct validity in quantitative research, and therefore requires a self-critical attitude on the part of the researcher about how their own preconceptions affect the research (Thomas & Magilve, 2011).

As part of her reflexivity practice, immediately following each individual interview, the researcher recorded her feelings in writing regarding the insight, personal feelings, and biases she's detected in herself during the interview. The researcher's personal history of growing up in a family with an alcoholic adult informed her interest and compassion with substance addiction. Also, her experience nursing in a military hospital gave her insight into the effects of military on young conscripts. Being a volunteer herself in the community from which she recruited participants for the study, being closer to the participants than someone who is not familiar with the community, may have made her potentially more subjective in interpreting the results. She was also concerned that, as the participants were familiar with her, they knew that she was a student researcher, and this might have influenced their confidence in her ability to contain sensitive information that they might have otherwise shared. She was also concerned about the power dynamic at play on several levels. Firstly, she has only been a part of the community for a relatively short period of time herself, since 2015. On the West Coast, outsiders, or "inkommers" are viewed with distrust, and one would often hear locals refer to individuals who have lived in the community for decades as "inkommers" as the true locals have lived there for many generations. She felt that this might have prevented the participants from sharing information with her that they feel might taint

her opinion of the community. Similarly, in South-Africa, identities, especially in terms of race, social position, and academic attainment, can always influence power dynamics. As some of the participants may not have completed higher education, the researcher made sure to be as multiculturally sensitive and aware as possible. The researcher also made a conscious effort to follow, rather than lead the direction of the interviews by asking the participants for explanations of unfamiliar phraseology, words and metaphors. In this way she hoped to present an expansive view on the lived experienced of lay community healthcare workers, that produced new insights into the healthcare workers' perspectives on addiction and overcoming substance dependence, allowing for developing confirmability of the research and, overall, establish a sense of trust in the credibility of the results and applicability of the study.

Data Analysis

Thematic Analysis.

Thematic analysis is an analytical method frequently used in qualitative studies as method for identifying, analysing, and reporting patterns or themes within data (Braun & Clarke, 2006). Once the raw data have been collected from the transcripts of the interviews the data was organized into themes using *thematic analysis* with an emphasis on the qualitative evaluation of the data, looking for themes, patterns or common findings amongst the information from the interviews. According to Braun and Clarke (2006) there are six phases involved in thematic analysis:

Phase 1: Becoming familiar with the data: In this initial phase the researcher started off by familiarizing herself with the data and even before she made the transcripts of the interviews, she created a "start-list" of codes, that she entered in her journal with short notes on the meaning of the codes. After completing the transcriptions, she listened and relistened to the recording to confirm faultless transcripts. She then read and reread the transcripts, looking for patterns, making more detailed notes on these.

Phase 2: Generating initial codes: In the second phase the researcher generated codes by identifying patterns and seeing how they occur. During this phase reductionism techniques were used to create categories making the data more meaningful and manageable.

Phase 3: Searching for themes: The researcher then combined codes into overarching themes that accurately depicted the data. There are many ways of structuring themes during the analysis phase. The researcher used the participants' own words to

generate the initial themes from the participants' accounts. In some instances, strong subthemes were present, which was indicated and recorded as such.

Phase 4: Reviewing themes: The researcher then reviewed the themes to see how, or if, it supported the data and theoretical perspectives the research was based on. During the review process a new theme outside of the theoretical framework was identified. The researcher then went back to revisit the initial data, confirming the existence of the theme and repeated Phase 4 to ensure saturation.

Phase 5: Defining and naming themes: In this last phase, before producing the actual report the researcher defined each theme, identified which aspects of data were captured, and explained why specific themes were interesting. This phase was therefore a comprehensive analysis of the contribution of each theme to the understanding of the data.

Phase 6: Producing the report: The final research report clearly explains the results of the enquiry. The researcher did this by relating how the themes chosen contributed to understanding the data.

Advantages and disadvantages of thematic analysis

Two of the strongest advantages that thematic analysis provide to the field of qualitative research is firstly, the flexibility it allows researchers, in that multiple theories can be applied across a variety of epistemologies, and secondly, it allows for categories to emerge from the data and the interpretation of themes, supported by data. It is also well suited to large data sets as well as projects involving multiple researchers and it allows for the range of study to be expanded beyond individual experiences. As this researcher was specifically interested in aligning themes with a theoretical framework, this analytical method lent itself brilliantly to this aim. Although multiple theories were involved in the scope of the research around alcoholism and substance dependence as historical trauma response and the subsequent associated intergenerational trauma transmission this method allowed her to frame her research in her chosen model without excluding the ability to correlate alignments with complimentary models.

In the strength of thematic analysis lies its greatest weakness; reliability is a concern due to wide variety of interpretations from multiple researchers and its flexibility make it difficult to decide which aspects of the data to focus on. Because of the use of broad themes, nuanced data may be missed, and the discovery and verification of themes and codes may become enmeshed. If there is no theoretical framework associated with the analysis it may have limited interpretive power. It is also difficult to maintain a sense of continuity of data in

individual accounts. Understanding these weaknesses is central to preventing the influence thereof (Braun & Clarke, 2006). As this research is backed by a strong theoretical framework and as the researcher specifically searched for collective themes present across individual accounts, she avoided any lack of continuity. As the researcher was interested in finding unique elements and hidden influences concerning the origins, dynamics and recovery from alcohol and substance dependence, she paid particular attention to subtle nuances in the data.

Ethical Considerations

The main purpose of research ethics is the protection of the welfare of the research participants (Terre Blanche, Durrheim, & Painter, 2006). This research upheld ethical principles of good practice as stipulated by the Health Professions Council of South Africa (HPCSA) by practicing beneficence, nonmaleficence, respecting the rights of all participants, ensuring the fair treatment of all participants and to seek immediate council from her supervisor if she felt she has encountered an ethical dilemma at any time during the research process (Health Professions Council of South Africa, 2016). The following measures were implemented to ensure this:

Approval for research:

Approval for the research was granted by the Ethics Committee of the Department of Psychology of the University of South Africa on the 7th of November 2017, Ethical clearance reference number: PERC-17069. The letter of approval was shown to the respondents.

Relationship between the participants and the researcher:

The researcher lives in the community from which she has recruited her sample and has been a member of the Victim Empowerment Program (VEP) in the community since the start of 2017 and volunteered as a counsellor at the community school in 2019. As such she is on familiar terms with many of the respondents. However, as the VEP counselling process never involves more than one counsellor, she has never worked with any of the other members in a counselling scenario. Apart from monthly VEP meetings, and occasionally seeing each other in a shop or at a community event, the researcher has no personal relationship with any of the respondents.

Confidentiality and anonymity:

In order to maintain confidentiality of information collected from each participant, only the researcher and her supervisor had access to the original audio recordings and transcripts of interviews. The original and back-up audio files, as well as the original and back-up transcription files were password protected. To ensure anonymity no identifying

information was collected during interviews. Participants' names only appeared on informed consent forms. Unique identification keys were used to link each interview and audio recording to the identity of research participants and only the researcher had access to the identification keys. Every effort was made to prevent anyone outside of the researcher from connecting individual participants with their responses. This included changing or omitting all names, addresses, biographical- and other identifiers of participants and other individuals referred to in the interviews in the research report.

Voluntary Informed consent:

Research participants were informed of the voluntary nature of their participation and of their right to withdraw from the research project at any time. Research participants were asked to sign an informed consent form before commencing with the interviews. (See Appendix B)

Avoidance of harm:

All participants were adults who do not suffer from any psychiatric or psychological problems, do not have serious medical problems, are not mentally impaired or have any difficulty understanding English or Afrikaans. Interviews were arranged during daylight hours and were conducted in the Victim Friendly Room at the local Police station, to ensure the safety of research participants.

Risk or benefit considerations:

Research participants were not rewarded for their participation in the research process, nor were they, in any way, coerced to participate in the research process (Health Professions Council of South Africa, 2016).

Potential Challenges during data gathering and research

Jennifer Harris and Keri Roberts wrote a paper on the potential barriers faced by both researchers and participants in qualitative research. They feel that literature rarely addresses the difficulties that need to be overcome by both the interviewer and the respondents in the qualitative research process (Harris & Roberts, 2003). The researcher therefore thought it necessary and practical to acknowledge the potential difficulties she faced in this research project. Gary Partington (2001) briefly lists empathy and rapport, listening and questioning, restatement, clarification, and persistence as key issues for research success (Partington, 2001). However, he goes on to say:

"At issue in the interview is the responsibility of the interviewer to clarify the factors influencing the interviewee. If the latter is in an oppressed condition, it is unethical for the

interviewer to ignore that condition and leave him or her in it. The interviewer has an obligation to the interviewee to provide critical awareness through the research, thereby empowering the interviewee" (Partington, 2001, p.34). This potential challenge was addressed as discussed in the following section.

Racial Issues

As outlined in the literature review, the Coloured community as a collective, bears the deep scars of the oppressed. This researcher is aware that it is part of her historic privilege not to think of herself as white. So, subconsciously or consciously, she may be perceived as an oppressor. Partington uses the example of a child complaining about racism from other children, saying that it would be appropriate for the researcher to at the end of the interview discuss possible ways in which the child can handle the racist actions (Partington, 2001). As the researcher remained aware of this potential perception, she remained sensitive, never tried to make assumptions, and asked for clarification when necessary.

Transference

In any therapeutic relationship, the danger always exists of transference (Reber, Allen & Reber, 2009, p 829). Added to this is the very complex historical relationship between the Coloured community and for instance white farmers, where there existed an almost parent-child relationship, this is a very real potential challenge. The researcher remained aware of the potential of transference and attempted to manage the interviews delicately by listening with sensitivity, paraphrasing, not making assumptions, and asking for clarification where necessary.

Reluctance to share sensitive information

The researcher was concerned that the respondents may feel reluctant to share sensitive information relating to members of their community. Sharing sensitive information with a relative stranger in an open an honest fashion might be hard. In the literature review shame and embarrassment (Velleman & Templeton, 2003) were mentioned as some of the predominant feelings experienced by the family members of the alcoholic. Even though the participants were not directly related to the individuals whose stories they were telling, they were part of the same community, and they might have felt a sense of responsibility for the subjects of their interviews.

Between the time of having had her research proposal approved and starting the research, the researcher has completed training as a registered counsellor. She felt that it aided her to a certain extent, as she was able to hold space for the participants through

adhering to Partington's list of empathy and rapport, listening and questioning, restatement, and clarification. (Partington, 2001). She also tried to put emphasis on the positive aspects of the accounts during the interviews, focussing on the recovery from addiction, hoping that that would have made it easier for the participants to share sensitive information. From her results it appeared that she was not completely successful as she felt that some of the participants were indeed, consciously, or subconsciously reluctant to share sensitive information with her. This phenomenon contributed to the development of a theme separate from the thematic framework that was deductively developed from the findings of the literature review.

Significance of the Study

Alcoholism and drug dependency contribute to psychological, interpersonal, and socioeconomic difficulties in all communities all over the world. Yet comparatively little research considers the knowledge and perspectives of lay community healthcare workers concerning the origins, dynamics, and recovery from substance addiction, specifically in the South-African context. This research project explored substance addiction and recovery from this paradigm as a presentation of unresolved historical trauma, incorporating existing organic community support structures. Therefore, in addition to adding to the body of knowledge on this subject, it may also contribute to the development and improvement of related training and intervention programs, specifically targeted at rural communities. In addition, this research hopes to accentuate the underutilized wisdom and knowledge inherent in lay community healthcare workers.

Chapter Summary

This chapter provided an outline of the research methodology employed in this study. It started out with a discussion of the qualitative approach, and why this was chosen, followed by a discussion of the interpretive paradigm underpinning the philosophical viewpoint of the researcher. The aims and objectives of the study were repeated after which the inclusion criteria and selection process of participants were explained. This was followed by the data collection procedure and collection method chosen, and the steps taken to establish trustworthiness of data were discussed. Finally, the data analysis process was outlined and discussed, and the chapter concluded with the significance of the study.

Chapter 4: Research results

The aim of the study was to explore the perceptions of lay community healthcare workers concerning the origins and dynamics of, and recovery from alcoholism and substance dependence. This chapter reports on their impressions as to what contributes to the development of substance dependence, the overcoming of adversity and what supports thriving in adverse situations such as alcohol and substance abuse with specific theoretical focus on the transference of intergenerational trauma.

Participant 1:

Participant 1 is a 51-year-old female, working in her community as a lay counsellor after hours in conjunction with her church. She told the story of a female member of her church, Clarissa (name changed, for confidentiality), who has recovered from alcohol and drug dependency, specifically Mandrax. Participant 1 has been acquainted with Clarissa while she was still living on the Cape Flats but has become closer acquainted with her as she counselled Clarissa, since she has become a resident of her community on the West Coast. Participant 1's interview sketches scenes from a world where everyone belongs to a gang and the use of drugs is a normal part of life; *"*<They> *lived in a house where drugs were constantly smoked in the house, backyard, front yard, you name it."*

In her story we meet the young Clarissa who "*thought of herself as the ugliest person alive,*" and when a young man paid attention to her she quickly became involved with him, in spite of knowing that he belonged to a gang and used drugs:

"Then one morning on her way to school, there was this group of young men, skollies <vernacular for men, normally mixed race, who are seen as petty criminals> *as we used to call them, that stood on the corner and one of them called her and he said 'hey chocolate' and that made her feel so good as someone was finally paying attention to her. Then this used to happen every morning, and this made her feel quite flattered, because sometimes he would stand there alone, and she felt he was really into her. He was there alone again one morning and he took the opportunity to speak to her and this sent her right into the sense of well somebody wants her for her ugly self, quite impressively he asked her out and her knowing he was a gangster did not matter at all."*

It wasn't long before she was using drugs as well, joined the gang and fell pregnant with the young man's baby. Sadly, he was killed before the baby was born and at age 15 Clarissa was alone, pregnant, failing school and addicted: *"He was stabbed* <identifying

information omitted – several times> *with a knife at the age of 18, and she was 15 when she got pregnant. She was in grade 9 for the second time then."*

The account follows Clarissa as she went from one bad relationship to the next. Participant 1 relates how the older Clarissa, now with two children, had a *"vision of some sorts"* of what her future would be like, involving her children, that made her think of quitting for the first time. Clarissa adapted to the lifestyle in the gang and didn't take responsibility for her children; *"She became known as a bad ass in the community and everyone was afraid of her. She was selling drugs and partying all the time and for that reason her mother had to raise her two older kids who never used to call her Mommy but on her first name."*

Clarissa's relationships all involved drugs, as her partners all either used drugs with her or supplied her with drugs: *"The fighting between her and her new partner, Clinton* (name changed, for confidentiality), *got worse and she decided to call it quits because she said she felt that was going nowhere slowly. He hit her one night as she wanted to put her out of her house. That was the first and last time she said a man ever lifted a hand against her. But they had an on again off again relationship for a few years as she took him back every time he showed her a baggie of Mandrax, so I guess he knew her weakness."*

She didn't stop using drugs until she finally met her current husband and became a reborn Christian and her parents, who were both abusing alcohol, became involved with a church and stopped drinking. Participant 1 believes that it was through her religion that Clarissa found the courage and conviction to finally get clean and stay clean: *"She wanted to, but I think things were not right, until she got her heart right, when she gave her heart to Jesus. Then she got the strength from Him to leave the drugs."*

From Participant 1's interview, five themes developed: a **family of jolly alcoholics**; **true colours**; **the darkest place on earth**; **visions of a 'suiker huisie'** and f**inding freedom in religion and persistent struggle**. The five themes are expanded below:

Theme 1: A family of "jolly alcoholics"

In Clarissa's formative years Participant 1 tells us that in spite of the fact that she grew up in a loving home, she had a very poor self-image: *"She grew up in a loving home with a mom and dad and five other siblings. She was the second oldest and she said she always felt very self-conscious about her looks at the time as all of her friends in high school had boyfriends and she thought of herself as the ugliest person alive."* Her parents were both alcoholics; *"She and her dad* <referring to Clarissa's parents> *was what we would call jolly*

alcoholics." And it would appear that other members of her family were regular drug users as well: *"… as that was her place of birth and that was also the place where she first saw her drug of choice, because that was where her uncles and cousins used to smoke Mandrax themselves until they were out like candles."* And although with the best of intentions, her mother enabled her to carry on using by taking her in: *"..her mother begged her to stay at home and rather smoke her drugs at home,"* supporting her habit, *"She even supported her habit by giving her money to buy drugs,"* and allowing her to use at home: *"...she was sitting in her mom's yard smoking drugs."*

Theme 2: True colours

Although Clarissa's home life as a child would appear to have been relatively stable, this soon changed as she became involved with her first boyfriend: *"Her grades started dropping at school but the adrenaline of having that secret relationship just sent her into something, a state."* Her environment changed radically as: "*He came from family of a mom and dad and six other brothers who all turned out to be gangsters. His mom and dad were drug dealers and him and his brothers and most of the boys in their community in* <name of area removed> *belonged to this gang* <name of gang removed>*."* And in this new environment, drug use was the norm rather than the exception: *"He lived in a house where drugs were constantly smoked in the house, backyard, front yard, you name it. The drug of choice at the time was Mandrax. It gets smoked in a bottle top with dagga. He showed her his true colours the first day she went to his house, that this is normal to smoke this stuff. He offered her a puff, but she refused. But after three months of going to his house and hiding him from her mom and dad she finally gave in."* And it wasn't long before she was using drugs as well and then she fell pregnant: "*So she fell pregnant the first time they had sex and she couldn't stop using even through her pregnancy. Even on the night she gave birth she smoked like seven tablets."* And the young man she exchanged her loving home for, couldn't provide her security, as he was frequently in trouble with the law and eventually died violently: " *… during their relationship he went to jail frequently and he was in jail as she had the baby. He sadly died a few months before the birth of* <name of son removed>. *She was lucky actually because who knows where she would have ended up if she stayed with him. He was stabbed repeatedly with a knife at the age of 18, and she was 15 when she got pregnant. She was in grade 9 for the second time then."* And as if this was not enough, Clarissa's environment was politically designed to prevent her from thriving, placing her in a complete disadvantage to succeed against the odds stacked against her: "*You know as a*

Coloured girl the chances of you getting somewhere in the apartheid time was slim. In those days almost everyone ended up being part of the gangs, like she did."

Theme 3: The darkest place on this earth

In Participant 1's interview, we see that Clarissa's world and relationships are permeated with drugs, the need to get high and the turmoil caused by it. *"... Clinton* (name changed, for confidentiality) *moved into their house and quite constantly fed her habit. He also introduced her to some other drugs like Ecstasy and Cocaine. She eventually became pregnant with his child,* <name of daughter removed>. *But they constantly fought over how many drugs they used to smoke and her use of it while pregnant, but she couldn't care, even if there was no support from him to raise that little girl her goal was just to be drugged all the time and that's what she did."* Repeating this pattern in several of her relationships: *" ... she got involved with Colin* (name changed, for confidentiality), *who used to live on the factory grounds, and he would supply her with drugs and alcohol and she thought good shot, but later on he would only use her for sex."* Even when she chose a partner that wasn't a drug addict, he didn't contribute to her wellness: "*But then she met Charles,* (name changed, for confidentiality) *who wasn't a drug addict, but he could make her feel like she was nothing."*

Participant 1 summed up her life at that point by saying: *"So she just started using more and more drugs and ended up in the darkest place on this earth ..."*

Her lifestyle placed her in danger in more than one way: "*She was raped twice in her lifetime and for this she knew her mommy was right. She was very drugged on both occasions; thank God she didn't get pregnant. Both were times when she was drinking and doing drugs."* In this time her mother tried to help her, but in doing so she became Clarissa's enabler: "*For this reason her mother begged her to stay at home and rather smoke her drugs at home, and that is what she did. She even supported her habit by giving her money to buy drugs.*" The shy young girl eventually adapted to her dark world, sacrificing much, but she survived: "*She became known as a bad ass in the community and everyone was afraid of her. She was selling drugs and partying all the time and for that reason her mother had to raise her two older kids who never used to call her Mommy but on her first name*."

Theme 4: Vision of a 'suiker huisie'

But Clarissa did eventually manage to rehabilitate herself from her drug and alcohol dependency. From Participant 1's interview it became apparent that Clarissa's confidence grew and she became very secure in herself: *"She was so bad ass that if you just wanted to smoke a two men pipe, you would go to her as no one would try to push their luck when she*

was around." And although it took her years to finally get clean there seemed to have been a moment when the need to get away from that life registered as Participant 1 related how Clarissa had a "*vision of some sorts. She saw what would happen if she did not stop…*

She saw herself in her own house which she shared with another Tomboy friend of hers, it was like a 'suiker huisie' we used to call them, where all the gangsters could come and go as they please. She saw <name of son removed> *sitting and doing drugs with her and* <name of daughter removed> *being taken into some bedroom because they were all brothers and sisters and they had to share everything with each other even if that meant sharing her daughter with her so called brothers to have sex with her. And she said that planted the seed for her to stop using but she still didn't."* (Note: A 'suiker huisie' is a type of brothel where a number of girls often live together. Sometimes girls are lured in with free drugs. Once they are addicted, they have to pay their way. Men frequent these houses to sleep with the girls and pay for the sexual service.)

Even though her mother was enabling Clarissa in her drug use, she did offer her the security of a home as *"her mother begged her to stay at home and rather smoke her drugs at home, and that is what she did.*" Her mother then stopped drinking when she became involved with the church:*" Her mother turned her life around and started going to church and got saved."* And her living with her mother at that point appeared to have been the key to her joining the church her mother went to which eventually lead to her changing her life: "*She said she remembered seeing her mom come from church one day with this amazing glow around her, and she told her mom she wanted that. She invited her to go to church with her one Sunday. And on her very first visit to church in more than twenty years, she was nervous. And then the minister made the altar call, she said she doesn't remember how she got to the front of the church, but she remember that she couldn't stop crying and after they prayed for her, she remember feeling as a wave or rush of freedom over her and she felt everything was going to be ok."*

Theme 5: Finding freedom in religion and persistent struggle.

As Participant 1 described Clarissa a clearer picture emerges of the young woman who made a real change in her life for the positive. From the interview snippets of conversation revealed factors that supports her eventual maintenance of rehabilitation till today, twelve years later: This first step appeared to have been her mother's recovery: *Her mother turned her life around and started going to church and got saved*." Clarissa was alone with *"Just the support from her own mom and dad,"* when the change in her mother inspired

her to go to church where she experienced release, seemingly on a mental and emotional level: "*...she couldn't stop crying and after they prayed for her, she remember feeling as a wave or rush of freedom over her and she felt everything was going to be ok."* She made a good life decision in her new partner and husband: *"... the guy she is married to today. He took her in with two kids and took full responsibility for them."* But, as with all addicts, Participant 1 related that the struggle always continues: "... *she still struggles of course. Most of the time. She said to me once as she was talking about her time when she was using that she could still smell the drugs on a daily basis and when she stresses, she craves it. But she married* <name of husband removed> *and they had* <name of youngest daughter removed> *and she even stopped smoking cigarettes during her pregnancy.*"

In summary:

Participant 1 related the struggles of Clarissa with Mandrax and other drugs. Clarissa's early years growing up in a family of 'jolly alcoholics' is never cited by Participant 1 as a possible reason for her becoming addicted. This theme encapsulated the acceptability of alcohol use as well as the need to steer away from the ugliness of the fallout around the alcoholic. Participant 1's use of the words '**jolly alcoholics**' when describing Clarissa's parents seem to indicate a need to almost make light of the situation. This stands in dark contrast with her later stating that as Clarissa starting using more and more drugs, she ended up in '**the darkest place on this earth**,' which was developed as a separate theme from the account. Participant 1's use of the words 'true colours' is significant, as the world that Clarissa entered through her young man, promised her belonging and acceptance, but the true colours became visible once she entered his house, where drug use was the norm. His whole family were using, and his parents were selling drugs. The '**true colours**' of the dark world of gangs and drugs became even more vivid as Participant 1 related how Clarissa's young man was in and out of jail and eventually died violently, leaving her at the age of 15, alone, addicted and single parent of a fatherless child.

The nightmare of living with an addiction, where Clarissa's priority was '*to be drugged all the time*' is '**the darkest place on this earth**' where Participant 1 relates how Clarissa goes from one bad relationship to the next, just to be high and get drugs, her relationship with drug taking priority over all other relationships in her life, including that of her and her children. She successfully adapts to this dark world, becoming a 'badass' everyone is afraid of, sacrificing her relationship with her children in the process. Clarissa eventually reach a turning point when she has a '**vision of a 'suiker huisie**' where she sees

her children’s future with her, should she stay in the world of gangs and drugs. This together with Clarissa’s mother returning from church one day with ‘*this amazing glow around her*’ seemed to have acted as the catalyst for Clarissa to get herself free from drugs. Participant 1’s account produced the last theme of ‘**finding freedom in religion and persistent struggle**, as Clarissa, through a combination of finding religion, better life choices, and support from her parents and new partner recovered from her addiction, while she acknowledged that the struggle against addiction never stops.

Participant 2:

Participant 2 is a female lay preacher who has been actively working in community for the past thirty years. She runs a faith-based rehabilitation centre where she also facilitates weekly outreach programs. She also runs a feeding scheme and host a weekly community program similar to Al-anon for addicts, or family and friends of addicts. She is also active amongst the youth of the community, providing them the opportunity experience life on a farm. She also provides a service similar to an out-patient rehabilitation program. Most of these activities are free as she works on sponsorship programs and donations. She has a background in psychology but uses her interpretation of the Bible and her years of experience in the community to guide her in her work. Describing what she did in the community she said:

“I also have a passion for the down and outs, the gangs and the prostitutes and the prisons. I started working with them. I studied psychology, and I did all those things, but I couldn’t ... I couldn’t ... the academic approach work I can’t say it doesn’t work, it works, for certain people. For me faith-based interventions work. Jesus Christ. That is what we believe, we are totally Christian based.”

Her interview centres around a young man who came to the rehabilitation centre a few years ago and has subsequently became an integral part of the functioning of the centre as he remained on the farm after he completed the rehabilitation program, and is now in charge of running a large part of the day to day activities;

“Yes, and now I can trust Ryan (name changed, for confidentiality) *with this whole farm. I will trust Ryan with my life. It is difficult. For him. Between you and me I think it’s more difficult for him because he never, he never really left rehab.”*

With him, as with many of her other clients, she said that she believed the aetiology of substance dependence to be generational and often stemming from childhood trauma: *“I think*

addition starts with – its generational. The family, somewhere there. But it is also trauma. Lots that goes into it."

In her interview she often brought in parallel examples of other clients, and even discussed alternative programs, such as the 12 steps program, but made it clear that she feels there is only one way that works: *"Personally, I feel there is only one way. Yes, there's the Twelve Steps. I know a lot of people are not keen on the Twelve Steps, I like the Twelve Steps, because it comes out of the Beatitudes, it comes from the Gospels. Everyone saw it just worked. There are a number of different approaches. If you apply it correctly. What can I say?*"

And although they are Christian based, they do accept people from all faiths: *"I can't decide it for you, and I can't decide it for them, we get Muslims here, I can't tell him, you have to become a Christian, I have no right to say that to anyone. Because I mean, Jesus wouldn't have said it to anyone. So, I can't say it to anyone. But I think if I have to be honest, there is a subtle manipulation, because we are Christian based, so obviously, the books that I give him, we had a Muslim now recently and he converted radically."*

When asked if she thinks it is harder for people who return to their environments to maintain sobriety than those who do not she said: "*Yes, I think I kind of agree with that, but I also don't agree with that. It depends on this switch that has to be switched on. ... something inside has to change. It is that thing, you get to a crossroads, choose. But it is more difficult for people who return to the environments in which they have been addicts. The guys that go back to Mitchel's Plain. But a friend of mine lives in Mitchel's Plain, she was an addict. She is a Muslim woman who became a Christian, she went to 'Toevlug'* (a rehabilitation centre in Worchester, Western Cape) *for six weeks before. But six weeks is too short. They can't, I don't know. Some people, you know it's very difficult to say this is how it's supposed to work. For one guy it works like that. For another it doesn't."*

She said that although she feels psychologist has a place in the treatment of addicts, they are often unsuccessful and find herself grateful that she can be on site with the addicts during their recovery process: *"But it's also difficult with the psychologist, because .. remember they arrive at the psychologist when they're high. And on their way back they go in there again. And you know Corna, I think part of that is ... I'm very privileged to live with them. Because there's a different scenario when you live with them, than when they come to see you. ... But this is what I'm saying, I live with them, so I can see. I watch them. I am among them all the time. So, I watch them, I can see when they digress. And then I'm on the spot. It's like on-the-spot-counselling if there is something like that."*

When asked about her opinion on the influence of apartheid on the eventual presentation of addiction or substance abuse she said: *"...some of what happened then in those days probably has part in what eventually leads them to drug use. But listen, here with them, this country can get a few lessons from drug addicts. There's no racism between drug addicts. Nothing. 'Niks'. There's no colour thing, it's amazing actually. But you know it's interesting, what you do get, not Afrikaners, the English, they still carry the wounds form the Anglo Boer war. And the English still have this attitude. This one guy, I'm not making him bad, he's very sweet, but he had this attitude. And there was a bit of an incident between him and a young Xhosa guy. But we handled it quickly – I said to him, look you're looking down on this guy, because of his skin. And we've never had anything like that."*

In Participant 2's interview five central themes, with three subthemes under one of the themes were identified as follows: **What my father does affects me**; **life is so overwhelming**; **you get to a crossroads, choose**, under which three subthemes of: **master manipulators**; **the fifth time they fly** and **I know what I'm doing** emerged; then **a better chance to recover from addiction** developed as theme 4 and with last theme, **he's so hungry to, to not go back to that again**. Excerpts from the interviews delineating these five themes are recorded below:

Theme 1: What my father does affects me

In the interview, Participant 2 frequently referred to the aetiology of substance abuse and dependence being in the family supporting her impression of the relevance of the formative years on the future addict: *"I could see the generational thing; it came from people in his family, who were also addicts,"* also saying: *"I think addition starts with – its generational. The family, somewhere there."* She believed that the Bible supported this, saying: "*I mean the Bible talks about it. What my father does affects me, what I do affects my child. What my child does will affect her child. Definitely, umm, but, many of them is just not ... they say, what I'm doing, my child is going to do it worse than me. So this generation is not just on alcohol only, they are also on tik"* (Note: Tik is the street name for Methamphetamine when smoked in a globe. The powder or crystals are placed in a light bulb after the metal threading has been removed and heated. The name comes from the 'tik-tik' sounds the crystal meth makes when heating and being smoked).

Speaking about the lack of purpose she sees in the people in rehabilitation she again repeated the impact she felt parents have on these individuals: *"But* <they are> *lazy! And they*

have no integrity, there's nothing. But remember – bad parenting, that's also what brings them here."

Theme 2: Life is so overwhelming

During the interview Participant 2 never referred to specific traumatic events contributing to any of her clients' addiction, or if she did only in the briefest sense, but instead made statements such as: *"Yes, there is something that happens. There is a lot of pain in life,"* and *"... you know the levels of trauma and the levels of hurt in people. Things people go through are horrific."* She alluded to trauma contributing to Ryan's addiction by saying: *"And he was – he was finished. I think addition starts with – its generational. The family, somewhere there. But it is also trauma. Lots that goes into it."* Speaking in general and then referring to a different addict who was in the rehabilitation centre she said: "*So they will go to high school, they are bored, there's trouble between mom and dad, or let's take a specific incident, for example dad leaves, and then they are rattled. And then something comes in there. Specifically, one guy that we are having a lot of difficulty with, that is back I don't now for how many times now, and his father, for example, was addicted to prescription medicine, and he's a heroin addict. His parents got divorced, and he never processed this. Eventually his dad died of an overdose, but he refuses to acknowledge this. He never wants to talk about that."* And then specifically talking about Ryan she said: *"But also, what happened to him, at thirteen he started going to parties, mom and dad gets divorced, he has this thing that slumbers in his generations, they get divorced, the buy him a car, he's fifteen, he drives illegally, those things, and all he does is goes to parties. He's smart, he passes his school subjects, life is good."*

In her interview she also talked about a friend of hers from Mitchell's Plain who was an addict, and had struggled with relapse after relapse because of stressors but finally recovered: "*What happened to her, when she went back to Mitchel's Plain, and life is so overwhelming, then you have responsibility. Those little children of yours still have to be fed. It was like that in her case. The kids need food, and everything was too much, and she relapsed. But then she stood up. And she stood up in those circumstances, it took her a while. It took time. But she's off the drugs. It's now six years later."*

Theme 3: You get to a crossroads, choose

From her account is appeared that Participant 1 felt that the incentive to change must come from the individual, but that the circumstances outside of rehab have a determining effect when it comes to motivation to change and maintenance: "*Yes, something inside has to*

change. It is that thing, you get to a crossroads, choose. But it is more difficult for people who return to the environments in which they have been addicts." Describing Ryan before he came to the rehabilitation centre, she said: *"... when he came here, oh it was bad, he smelled so bad, you know it's actually really bad when I think about it now. He smelled of alcohol, you can't smell tik, but with that he drank alcohol, he drank anything he could get his hands on, and he smelled like old wine. Then this young man would come in here and he would smell like old wine. I remember he was standing there one day, someone was cleaning the pig sties, and I stopped next to him, and he smelled so bad, and I was thinking to myself this cannot go on like this. He's going to die."* And then he *"... arrived here five years ago. And he was – he was finished."* She often spoke about choosing: *"It is that thing, you get to a crossroads, choose,"* and said about Ryan specifically: *"And then he came back three days later and said no I can't. I can't go. I want to stay here. And he stayed. And he – he first made a choice."* Under this theme three subthemes developed relating to recovery and maintenance: **Master manipulators**; **the fifth time they fly** and **I know what I'm doing**:

Subtheme 3.1: Master manipulators

Speaking in general about individuals at rehab: *"When they arrive here, they are very ... purposeless. All they can think about is drugs and looking for drugs and getting drugs."* And speaking about how parents often, despite their best intentions acts as enablers: "*Look they are master manipulators. Like yesterday a guy came back, he's, you know, if only the parents don't want to lie with them. Then I'm thinking how can you ... then I come, he had to come in the previous night, and he didn't and then I knew already. So, we come back from church, and they are busy with these things here. And when I saw him, I thought, oh no. So I thought I'm not going to deal with that now. So I spoke to the mother first, mother says nothing. Normally if the mother is really serious about this she'll tell you. And his eyes struck me. And I ask him, if your face looks like this now? Mmm? Why does your face look like this? And then he's like, no I had a relapse. But she (the mother) covered it (up)."*

Describing the ends to which the addicts will continue using she said: "*An alcoholic is sneakily deceptive. An alcoholic and a heroin addict. Not that there's really a difference between the two but they are deceptive in a different way from a tik addict. They are cunning. I always say in their DNA there must be a sneaky kink that must come out."*

Subtheme 3.2: I know what I'm doing

Participant 2 explained how one of their biggest problems are that alcohol is often seen as acceptable, as it still poses a real danger to the recovered addict as it can lead to

relapse: "*Because you know we South Africans, when we braai they will … their mentality is when you're on alcohol it's not so bad. Just don't be on drugs. And they say man, rather have a drink. But they can't. And for two years solidly, he had a bit of wine here and a bit of this there, and then the last six months he would go to parties, and then a joint goes around and he has a puff on the joint. And he said and then he said it started going worse and worse. Look, their resistance – that's the whole thing. Then it starts again."*

She also felt that cannabis, although often described as harmless, is a real problem: "*If they are very young, they are clever. Oh, you don't really know what you're talking about. I know what I'm doing. You understand? And then they are so clever, and they have read about weed and how good it is for you and they will tell you these things. And you know, you know,* <used her own name>*, you can stand on your head, you're not going to get through to these guys. He won't believe you. He's so convinced of his own story. … But weed is dangerous. The most psychotic people we've had here were weed users. That's the thing, I can smoke weed and I won't get psychotic, but if you smoke it, you'll get psychotic. And to get them back takes years."*

Subtheme 3.3: The fifth time, they fly.

Participant 1 is clear in her opinion that rehabilitation is not one-size-fits-all: *"Time. I believe you can't put a time on recovery. You can't put time on a person's recovery."* She explicitly stated that six weeks is too short a time: *"…she went to 'Toevlug'* (a rehabilitation centre in Worchester, Western Cape) *for six weeks before. But six weeks is too short. They can't, I don't know."* She related instances where individuals came back again and again, to eventually recover successfully without relapsing: *"…we've had people come back four or five times, and then it's as if, the fifth time, they fly."* Talking about a specific individual: *"He was here five times. I was thinking, dear Lord, I don't know if this guy is going to make it. You know, he now sponsors other kids to come here. There's the saying of fall seven times and stand up eight. But he kept on coming back."* And then : *"There's Thomas (name changed for confidentiality), there's not a rehab that Thomas wasn't in. He's been to rehab for the first time when he was 11. The nicest guy. By the time he got here I said to him, Thomas I can't believe it. And he said, well this place – and I don't think we did it, all those other places, all those other rehabs also helped. He's a psychologist now."* And sometimes, all that is necessary, is once: *"Then there's another guy, Ben (name changed for confidentiality), Ben has been here for three months – a heroin addict. He said after three months, ok I'm leaving now. And I thought I saw change. But I wasn't sure, and I said to him,*

I can see you changed, but don't you think you just want to stay another month? To put the stamp on? No, I've got to go, he said That was three four years ago. He started an NPO <Non-profit Organization> for skaters in Mitchel's Plain, and he does amazing work. It grows from strength to strength."

Theme 4: A better chance to recover

Participant two listed several things she felt was important to support recovery. She indicated that although the addicts often resist coming to the rehabilitation centre, she illustrated the sense of security the individuals experience once they arrive at the rehabilitation centre after resisting admission by saying: *"What normally happens then they resist heavily. And they resist until the parent drives off. And then, I always say it's as if they then say <sighs dramatically> 'Thank you I am safe.'"* She felt that in recovery it is important for the addict to regain a sense of purpose: *"I think the thing that happens when people come here is that they get hope, they get purpose. They realize that there is something more. That it's not just empty words."* Participant 2 also expressed that she believes that *"... each person is sent here with a purpose. And each person is chosen to come here."*

She expanded on her conviction that religion, specifically Christianity, is key to recovery, admitting to her bias yet stressing the importance of a relationship: *"Look I am obviously biased, I think as a Christian you have a better chance to recover from addiction. But at the end of the day it is about a relationship. I can't say, now I am a Christian and now He is going to do it for me. You have to keep the relationship. You have to hold on to that relationship."* When referring to Ryan specifically, she illustrated that he had the support of his mother, but Participant 2 herself also acted as a support for him, again, indicating that in order for a successful rehabilitation there needs to be a relationship, relating her words when Ryan's mother asked her to admit him: *"And then I said to her, come let us try to build a relationship with him."* Participant 2 also related how an unpleasant experience, such as incarceration can be motivational to rehabilitation by referring to another client of hers saying: *"I am thinking now specifically about Christopher* (name changed, for confidentiality), *he had a fright. Because what they do with the weed they, sometimes they mix a tiny bit of heroin in with the weed, so that the guy, you see the dealers want them to come back. So, when he was tested, he tested positive for heroin. So, his parents had a big fright. And he went back. And you know he's young. At the end he ended up in jail. And then he had a bad fright and then he recovered."*

Theme 5: He's so hungry to, to not go back to that again.

Participant 2 displayed deep insight into elements that contribute to maintenance in the individuals who are recovering addicts. For example, when she described the way Ryan had changed, she said: *"He completely changed, from his promiscuous life to this life that he wants to live. I can't think, it's not easy for him. Not at all. But he does well. He's very teachable."* She also relates how heart-breaking it is for her to see his fear of relapse: *"This morning I was showing him something, and how he just takes it in. It makes me sad. You know I sit with this child's life in my hands. He sucks up everything I tell him. He's so hungry to, to not go back to that again. Yes, that's him.*" Her interview contained volumes of information on personal attributes she believes to be necessary for recovery from addiction, such as what she calls radical honesty:

"You know he, with him, he was radically, blatantly honest with himself. I always said to him don't be embarrassed in front of me, don't be ashamed. I have my own things. I can't do this work if I judge you. So, don't be ashamed. For him it worked, but it doesn't work for everyone."

She also identified balance, routine and discipline as important elements necessary to build and maintain resilience: *"... routine and discipline. You know it's like, when you get home at six in the evening, you're tired, you don't feel like reading the Bible. So do it in the morning. That kind of thing. The guys that stand by that, they last."*

"And the guys for who the program works, they hold on to their routine, to that balance."

"He realises of course that he can never touch alcohol again. We prefer that they don't. We recommend that they don't."

She also refers to accountability on several occasions: *"Look I can give them accountability here. But the moment he's back there, when he's out again, then it is difficult."* Talking about another addict who successfully recovered she said: *"His grandmother, everyone rejected him. So I said, look you have to stand. But he does it. He went and he found himself a church and he found himself a small group of friends. But he has accountability."* And when speaking about Ryan: *"He doesn't complain. It goes well. But he does it well. And he is still looking for accountability. He wants that."*

In summary:

The interview with Participant 2 provided a wealth of insights from her years of experience in the recovery environment. She felt strongly that the origins of addiction are in

the family as theme one, **'What my father does affects me'**; illustrated. She has seen and expressed her views of addiction being 'generational,' but more than that, she feels that poor parenting is almost always behind the development of an addiction, as what the father does affects the children and in her opinion, the poor coping mechanisms of the previous generation is not only repeated, but intensifies with each generation. Her deep compassion for addicts and her understanding of the difficulties faced by individuals, who already possess limited coping skills, is captured in the theme **life is so overwhelming.** From her account it seemed that she felt that it is not just trauma and painful experiences that cause people to become addicted or relapse, but sometimes the demands of regular life just becomes too much.

She is very clear on her stance that recovery is a choice; "**you get to a crossroads, choose**," she said, and these words developed into a theme under which three subthemes of: **master manipulators**; **I know what I'm doing** and **the fifth time they fly** emerged. These three subthemes expanded on her views of certain characteristics underlying the choice to change. According to her, the duplicity of addicts, and their enablers, who manipulate and deceive to get access, to or to hide substance use and the lack of earnestness with which society at large view alcohol and cannabis use are both factors that impede potential recovery. While the incredible resilience of individuals who return to rehab again and again following recurrent relapses shows the determination required for recovery. Participant 2's interview also delineated her strong belief in the importance of finding purpose and developing meaningful relationships, especially with God, for **a better chance to recover.** The last theme, **he's so hungry to, to not go back to that again**, developed around certain aspects named by Participant 2 such as blatant honesty, accountability, routine and discipline that she said were critical in preventing relapse and maintaining recovery.

Participant 3:

Participant 3 is a female in her 40s who is a lay counsellor working with addicts and youth, specifically adolescent girls in her community as part of an NPO (Non-Profit Organization). She started studying psychology in 2019. She is married with children and has a history of recreational drug use. Participant 3 spoke fast and passionately, with a pragmatic no-nonsense attitude, saying for example: *"I struggle to understand why anyone can become addicted to anything. To me it is as simple as going I am not going to do it anymore. But then again, I haven't got an alcoholic mother, so it is. So, I maintain that I have that spark too should I ever have I ever it was easy enough to pull myself out of it. I just believe that if*

anybody if you can just take responsibility for your life." She admitted to having had poor coping skills herself at some point: *"Look, I smoked, it is not like I am sitting here on my pillow saying I never used to have hideous coping mechanisms. But there comes a point like with the smoking I was just like I am not going to do it anymore and every time I wanted to I'm like no, if I can just get through this craving or this, but it wasn't even a craving it was; I'm having a glass of wine I want a cigarette. To me addiction is almost a ritual,"* referring to her recreational drug use: *"… it would get to the point in the evening – we've had too many drinks and someone would go 'do you want a line of cocaine?' and, 'sure, good idea' and then I fell pregnant and it was like actually this is not working for me anymore. And I have never gone back. I think the mind is such a powerful, powerful thing and I think that if somebody can just get their head right."*

The person she talked about is James (name changed, for confidentiality) whom she had known from school. He is in his late 40s and has been clean for seven years. When the researcher asked her asked who her account was about, she, in her typical style, summed up James' entire history in one breath by saying: *"About James, a few years older than me, 48, I think next year, he is gay – his parents were divorced at a young age, his mother and his aunt was an alcoholic. On his dad's side, his granny was an alcoholic, who drowned herself in her furs and diamonds and a glass with whatever she was drinking, he found her in the pool. He was also sexually molested by his grandfather. Clear alcoholism in the family."*

As the interview progressed, the picture of James became clearer as a person who never seemed to have a problem: *"You see this is the thing, I didn't ever think. Because when he was drinking – we were all drinking together. You know and I didn't see in the next morning that perhaps when he woke up and had another drink. All of that was kept very hush hush, and he was holding down a job and was very successful. You know it didn't look like there was any problem."* Participant 3 referred to James as a "*functional alcoholic*," who managed to keep up appearances, until he got divorced: *"… he had a fantastic job, he got married, everything was normal, but then they got divorced. And James spiralled completely out of control."*

It was only when the researcher probed deeper that more of James' past was revealed, from his turbulent childhood; *"I kind of got the impression that James was taken away in the middle of the night and moved to Cape Town,*" having been molested by his grandfather, *"I know it went on for quite a while… It was when he was little,"* a controlling mother, "*I thinks she sucks her children dry, all her kids are slightly damaged because of her influence"* to being a gay military conscript, *"He said it was not that you were not allowed to be gay, but*

you were not allowed to say that you were gay. And he was quite open about it, and he said they did correctional therapy or something like that on him, or at least they tried. Of course, it didn't work." When asked if she thought he was affected by his time in the military she said: *"Yes, how could he not have been?"* after telling the following story: *"There is one story that he tells a lot, one of the soldiers shot himself in the shower and one of the troops came running into the medics place, camp hospital or whatever, shouting medic, medic, you've got to come quick! And one of the medics said, "I'm a Jewish doctor, I don't do house calls." It is funny how he tells the story, as a joke. It's not about the poor guy who shot himself, or how it must have been for them to have gone to help or the other guys there, it was a joke."*

When asked what drugs he used she said: *"Pretty much everything, started in high school, started with Thinz* <diet pills> *and over the counter medication and at the end it was cocaine predominantly."* When James finally "*spiralled completely out of control"* he ended up "*being picked up by the cops for possession, obviously drinking as well, and he bribed the cops, as he was working for* <name of company removed> *and if he was arrested he would lose his job. And he basically woke up the next morning and said, 'not doing this anymore,' he went to his first AA meeting.*" James then stuck to his decision and is still sober and clean today, "*... kudos to him, one morning he woke up; 'no more' he is going to meetings 2 or 3 times a day. He is even running some of his own, he is now doing co-dependency <support> groups, he is running his own group and that has become his sort of life."*

In her interview she also talked about why she believed James managed to maintain his recovery *"I think it is taking responsibility and being able to man up and say to yourself this is my life – it has been crap and all these things happening to me I am either going down this path and end up sleeping on the street or I am going to rise above it."* Saying how some of the individuals she works with therapeutically " *... sits and complain about their circumstances and their stepparents and what's happened to them in life and it is so easy to just focus on that but if you keep focusing on that – that's where you are going to be and you are not going to get past it."*

In Participant 3's interview, five themes emerged to organise the data. These were: **imperfect childhood**; **damage**; **its fine, if there is a problem, he will come to us**; **his whole family is turning over new leaves** and **man up and say to yourself - this is my life**. Excerpts from the interviews delineating these five themes are recorded below:

Theme 1: Imperfect childhood

As outlined in the summary of the interview above, James did not have the ideal childhood as Participant 3 named several family member with alcoholic problems: *"... his mother and his aunt was an alcoholic;" "On his dad's side, his granny was an alcoholic,"* summing it up as: *"Clear alcoholism in the family."* In addition his home life was not very stable as Participant 3 related: *"... his parents were divorced at a young age;"* and when asked if the divorce was amicable she said: *"... I kind of got the impression that James was taken away in the middle of the night and moved to Cape Town. And so that kind of hostility, and dad would come out and a lot of fighting;"* and summing up the influence of James' mother on her family as: *"I think all her kids are slightly damaged because of her influence."*

Theme 2: Damage

In her first sentence Participant 3 already portrayed James as a damaged youngster: "*his granny was an alcoholic, who drowned herself in her furs and diamonds and a glass with whatever she was drinking - he found her in the pool. He was also sexually molested by his grandfather."* Then there was also the potential damage from the divorce as quoted in the previous section and then his mother: *"... remarried* < name of stepfather removed > *and had children, but James and* < name of stepfather removed > *never got along."* As it was a legal requirement for white men during apartheid, James was conscripted to do military service after school, where the hurt continued: *"I think he had trouble in the military, he never really spoke about it, but he said, how did he put it? He said it was not that you were not allowed to be gay, but you were not allowed to say that you were gay. And he was quite open about it, and he said they did correctional therapy or something like that on him, or at least they tried. Of course, it didn't work.*"

In the military there were no doubt more traumatic events as he was in the South African Defence Force Medical Services as Participant 3 related: *"There is one story that he tells a lot, one of the soldiers shot himself in the shower and one of the troops came running into the medics place, camp hospital or whatever, shouting 'medic, medic, you've got to come quick!' And one of the medics said, "I'm a Jewish doctor, I don't do house calls." It is funny how he tells the story, as a joke. It's not about the poor guy who shot himself, or how it must have been for them to have gone to help or the other guys there, it was a joke."*

And then, the last proverbial straw appeared to have been the dissolution of his marriage: *"but then they got divorced. And James spiralled completely out of control."*

Theme 3: Its fine, if there is a problem, he will come to us

Initially it appeared as if James withdrew from Participant 3 and his other friends: *"It spiralled, he retracted quite substantially away from his family and friends. So obviously he was embarrassed about what he was doing.*" She said she believed that he would have asked for help if he needed it, but he didn't: *"He has no kids, he is out there burning off steam and would come to us, you know – its fine, if there is a problem he will come to us. Which he never did."*

Finally he was not able to deny the problem anymore: *"I think his turning point was being picked up by the cops for possession, obviously drinking as well, and he bribed the cops, as he was working for* <name of company removed> *and if he was arrested he would lose his job. And he basically woke up the next morning and said not doing this anymore, he went to his first AA meeting."*

Theme 4: His whole family is turning over new leaves

Participant 3 related several supporting elements in James' live contributing to his maintenance of abstinence from addictive substances, starting with the support from his family in terms of his sexual orientation: *"He is very happily gay, as far as I am concerned he should be, he has always been. From little his mom knew he had dolls and he has never hidden it and he didn't have to; his family was always very accepting of it.*" And his father specifically, always seemed to have been supportive: *"... his dad has always been a stable sort of guy and always there for him."* Several of his family member had since also recovered from alcohol abuse: *"His mom has gone to AA and is now sober, his aunt went to AA and is also now sober. Basically, his whole family is turning over new leaves, basically on the straight and narrow."* And James himself appears completely committed, as seven years of abstinence would support, to sobriety: *"... he is going to meetings 2 or 3 times a day. He is even running some of his own, he is now doing co-dependency groups, he is running his own group and that has become his sort of life."*

Theme 5: Man up and say to yourself - this is my life

In her interview Participant 3 not only talks about characteristics in James that she believes helped him to not only recover but also maintain abstinence for so long: "*I think it is taking responsibility and being able to man up and say to yourself this is my life – it has been crap and all these things happening to me I am either going down this path and end up sleeping on the street or I am going to rise above it,"* and *"..it is what stops people from crossing that line, like you get some people that will start stealing for money for drugs or for*

booze, and yet James knew that he had to carry on working. You know there is things you need to hold on to," but also give examples form her own experience with herself; "*I just believe that if anybody, if you, can just take responsibility for your life… . I think the mind is such a powerful, powerful thing and I think that if somebody can just get their head right.*" Talking about other individuals she has been working with saying: "*You got to sit and go, ok fine, shit happened, rise above it let it go and move on and I think if that spark of something, that is it. … that's exactly it, I think that is the critical – there is people that can get over it and carry on with life or keep going back."*

In summary:

From Participant 3's account it was learnt that James had an **imperfect childhood** with a controlling mother, several instances of alcoholism in his family, and a volatile divorce. A clearer picture emerged further as **damage** developed as a strong second theme; not only was James sexually molested, he also found his grandmother after she apparently committed suicide, and on top of that he was conscripted to the military, which, according to Participant 3 "*he never really spoke about."* This theme of not communicating when in need was developed into a third theme, **its fine, if there is a problem, he will come to us**. This theme attempted to point out how Participant 3 and reportedly all his friends and family through he was fine and handling things, because they thought, surely, if there was a problem, he would have spoken to them about it. Fortunately he managed to get himself into an Alcoholics Anonymous support group and, whether he was the initial catalyst for the entire family system to eventually get help and rehabilitate, that is what happens and the theme **his whole family is turning over new leaves** developed around this support. The last theme **man up and say to yourself - this is my life** developed around Participant 3's opinions on what is required for successful rehabilitation and maintenance.

Participant 4:

The interview was arranged with the wife of a husband-and-wife partnership running a women's shelter as a non-profit organization (NPO) in their community. At the last minute she was called away and she suggested that the researcher interview her husband instead. He then became Participant 4. As he explained what they do he said that, although they are Christian based, he felt science has its place: *"The Bible does say it is a lack of knowledge why people perish – so we want to teach people. Teach them the truth – they are then able to understand themselves better – their identity better and call things for what they are – so let's take my own life – I am a recovered heroin addict."* The researcher was not aware of this and

asked him if he would feel comfortable talking about addiction, and he said: *"No, no, that's cool, that's what I do."*

Participant 4 was active in the music industry where he was a DJ in his younger years, and his interview was unique in that he spoke uninterruptedly for long periods of time, in the style of a spoken word artist, paraphrasing Bible quotes with his own personal style, for example saying: *"… and there's a place where God is like, hey, change your thinking, change your thoughts."*

From the voluminous interview an image appeared of a complex young person who was already in trouble, at a really young age: *"I was actually 13 when I started using LSD."* This pattern continued after school as he joined the music industry and became part of his identity: *"I don't know how but I also got into the places and that was really like a lifestyle, or sort of lifestyle, that kind of helped me to escape. Find my identity – have a good time – obviously growing up with just social issues – with my family and also just seeking to enjoy life – you know, you want to have fun. And it seemed like – hey this was the way to have fun… And obviously experiments, call it experimenting, but it was just like using. Cocaine, it progressed, it was a progression over let's say 6-7-8- years… The thing is it was just like a lifestyle. Until one day I realised I can't stop, and it was when I started using heroine."*

He related how he realised he was addicted: "*. And it wasn't like instantaneously knowing like, hey I am hooked – how I realised was, I need to use every day, and I was going to buy every day. So, when I decided like, hey, I need to not use, then it was like, I just couldn't. I had to go and buy, and I just think ag I will do it tomorrow and tomorrow and tomorrow."* He finally hit rock bottom when he, in an attempt to get something to sell to feed his habit, was caught with stolen vehicles: "*The breaking point was, I was caught with the cars, it was either, I was going to jail, or I have to go to the whole court procedure, but then thankfully the company I was working for, sort of agreed that if I go for help, because it was a drug related incident, and I needed help and stuff like that. I went to rehab."*

The rehabilitation centre he went to, called 'Noupoort,' where *"there was only one pill and that's the gospel,"* brought him to terms with the reality of being a drug addict: *"…it made me question life issues, made me question like my purpose what I do, how can I land up being a drug addict? … like reality, hey, reality hit me that I'm, yo man, that I'm a drug addict. And I needed to change, I got desperate. I, freaking, I broke down, you know. And some people call it a mental breakdown, some people call it crying. A grown man crying, and I just wept."*

The NPO he is co-founder of, has the word “hope” in their name, in his interview the term ‘hope’ came up several times as an important factor in recovery from addiction, saying that going to Narcotics Anonymous (NA) meetings didn’t give him hope: *“I went to NA meetings, and they said I’ve got a disease and I’ll be sick for the rest of my life and I’ve got to manage this – they gave no hope hey.”* And when asked if he could say what changed in him during his time at the rehabilitation centre, he said: “*Well, what changed was that …well, look hey, I didn’t wanna die. I wanna live. You know, and, umm, and you know, look here, what happened was, I needed hope. And you know when you kinda read scripture, and you, it says the word is alive. When you go and read the scripture, and listen to it, and you read it, there’s hope there.”*

It became clear that although he believes there is space for other programs in rehabilitation; *“I think we can bring other methods – we can bring in other programs - we can bring in steps and all this sort of stuff and I think there is life management – and I think it is sustainable for a period of time and I think some people live out their whole life just managing it – but fulfilled ? Who knows?,”* his own approach is strongly rooted in his faith: *“Being faith based, it goes deeper than just saying hey, let’s get this person off drugs – let’s get them clean – you know we are ministries. So* <name of NPO removed> *being a faith based is, we are ministries, so if we are, obviously, kinda look at what scriptures says, scriptures says that we actually got to go out and share the gospel – spread the good news, heal the sick and look after orphans and loved ones … Now that doesn’t mean that we exclude, phycology and behavioural problems but the reality is that when you actually, when you actually come to scripture and understanding the word of God – it actually deals with those issues.”*

He appeared to avoid talking about his parents in reference to his childhood, only saying that they were aware of his drug use: *“Obviously my parents saw the effect, they saw me deteriorate but it never kind of came out that, hey, I was an addict.”*

Participant 4 appears to draw on his own experience when he talked about the individuals they work with: “*Because we deal with people who come here and they’re like umm, I’m here for a drug problem. And I’m like, no, you’re not. You’re here because you’ve got a life problem. You’ve got an identity problem. Some people just want to work on the “I use drugs” problem.” But that’s not their problem, that’s the tip of the iceberg. That’s why for some people you get rid of the drugs, and woof out pops this freaking iceberg, and there’s their real problem. And they’re like no, no, no, I don’t want to deal with that, let’s put drugs back. So I’d rather manage my drug problem, the rest of my life because I will I don’t want to*

go back to that place, because I've been molested, I've been raped, and that's the thing hey, everyone's different."

His understanding of the addict's reluctance of acceptance of reality is apparent when he said: *"Which ... you know we deceive, people don't wanna hear that so we kinda cushion it in nice ways, you know, cos what is real counselling then, counselling is navigating a person through a situation that they can't see properly and the problem is that they believe things that isn't true."* And he captured the essence of trauma transmission when he said: *"... you know, hurting people hurt people. Dysfunctional people are just going to give off dysfunction."* From his interview five themes developed, **yaas ou, it was crazy**; **hurting people hurt people**; **a personalized sort of battle**; **relationships, hope and purpose** and finally **I let God change the way I think.**

Theme 1: Yaas ou, it was crazy.

Participant 4's early years were turbulent featuring a volatile home life, alcoholic parents and an environment where alcohol use was part of his father's business and by the age of 13 he was a regular drug user: *"My dad had a bar, my parents had a drinking problem, ahhh there was always arguing there was always fighting, to such a point where as I grew up where alcohol was just like, yaas ou, it was crazy. The verbal abuse, and stuff like that."* And by the age of 13 he was already at risk: *"So I kind of grew up – that was like – I was actually 13 when I started using LSD. So a friend of mine became schizophrenic from using the LSD but we kind of pushed him aside and we carried on with taking LSD ourselves and taking ecstasy – so that was like 13 – 14. Obviously being drunk and stuff before that but the real hook was that that I started going clubbing and stuff when I was also 13."*

Theme 2: Hurting people hurt people.

Participant 4's interview displayed his understanding of the impact of generational trauma where he spoke about a traumatic incident from his childhood: *"Until there was an incident where umm, my parents were fighting and all this sort of stuff, and there was a moment where my dad had a gun and he shot and all this kind of stuff. So, he shot. So that was a traumatic experience. But obviously this was all stuff that I had to deal with on my own."* And then explained the trauma that his father experienced saying: *"... my dad was in the military. He was in the special forces. He never, never talked about it."* And went on to talk about his dad's childhood: "*Hey, look going back further, my dad was actually in boarding school, he was in reformatory. And that was because his father died and when he was eight years old, he went to a reformatory. Now I know things happened there. Thank you,*

God, that He gives us wisdom, discernment, and I can now realise that things happened to my dad, ok and then yes, obviously my dad went through, ja, look my dad has got his life experience. The reality is, and so does our country" Saying about his own self-analysis: *"Ok, and the thing is when I look into this, I'm like ok, what was it? What is it there? It's just like, the reality, you know, hurting people hurt people.*

Theme 3: A personalised sort of battle.

A strong theme in Participant 4's interview was the insolation he felt, as his addiction became the focus point of his life. It initially seemed as if the drug use was part of the lifestyle he chose: *"…the sort of lifestyle obviously went hand in hand with smoking marijuana to drinking to recreational drugs. So, at the time it was ecstasy and LSD and all that other stuff."* Until he became addicted and: "*Getting high was the aim of your everyday existence – it as like, hey, get high, get high, you know, and, hey, let's get high today, let's get high, and until it gripped me, and started affecting, all my money was just going to it."* He became alone: *"So what I did was totally withdrew from my friends, I became very withdrawn very isolated."* And he lived from hit to hit: *"I was what you would call a functioning addict. I was just using to function. I wasn't even really using to get high – I was using to get through my day;"* and, *"I started to have no social life, because I just lived for functioning through the day and I needed the substance."* Then the crisis came when he was caught with the vehicles that he stole: *"… it wasn't my intention, but you're just in this crazy - addiction is terrible – you go through this serious mental, yo, agony because you're battling with so many different thoughts – obviously suicide was an option and all these sort of factors."*

At several points in his interview, he talks about how people do not talk about addiction or the difficulties associated with it: *"So, a friend of mine became schizophrenic from using the LSD but we kind of pushed him aside and we carried on with taking LSD ourselves."*

"And at the time addiction wasn't spoken of in our sort of social group and stuff."

"At the time I never knew about rehab, it wasn't ever mentioned by the people I was associated with at first but when I became very withdrawn it became a very sort of personalised sort of battle."

"…it never kind of came out that, hey, I was an addict – those were just words never mentioned – so I couldn't even label myself at the time because it was something never really spoken about. It was always like, hey, those were things kept secret – if that was dealt with

then – it was back then – you keep it quiet. Even when my friend, he went to rehab – I never even knew he went to rehab, because it was just dealt with, privately. This is the upper-class snobs – so it was always this thing, this stigma, so they kept it quiet. In my own addiction it was just hard for me to then, open up about it, or talk to anyone."

Theme 4: Relationships, hope and purpose

Participant 4's interview refers to relationship building as an important factor in recovery: *"That's why we're not like a first in first out, we wanna build relationships with people. Because if each one has a specific identity, each one's coming from a different background each one responds to things, you know, like, differently, you know and holds on to things differently."* Not just relationships with people but building a relationship with God: "*I want to have a heart relationship with God you know, and, umm, I want to fulfil that purpose, it's really a desire you've got."* He felt that God will also help restore relationships: "*And that's the cool thing and that's the promise form God also, he says hey, he'll restore also, he'll restore the relationships and stuff like that.*

Participant 4 also felt that having hope is important in recovery: *"And you know when you kinda read scripture, it says the word is alive. When you go and read the scripture and listen to it, and you read it - there's hope there. There's life. It says that, hey, I'll give you new life. There's a place where it says, hey, I'll heal you, I'll restore you, I'll take you out of that place. I'll separate you from your sins as far as the East is from the West and if I never told people I was a heroin addict they wouldn't know."* And lastly, Participant 4 mentions 'purpose' fifteen times in the interview, emphasising the importance of purpose in recovery :

"Ok so, I think, like, we approach an individual to help them, we always got to look at the view that this is a person created by God, and they're created for a purpose and so forth and until that person comes to that point of realising, hey, that purpose come into the right standing with God."

<Talking about Noupoort, the rehabilitation centre he was in> "… *and as hard as they seemed, and as tough as what it is for some people, it really helped me, it made me question life issues, made me question, like, my purpose, what I do."*

"You know, I can't give you something I don't have. You know, so, that's kind of like, you know, where I just want to impart and give - and that's why it's important for, I guess, for us in this position to grow also. You know, to fulfil our purpose. It's one thing to go like hey, you've got to fulfil your purpose and you've got a purpose. And here we sit, and just idolise and just go through mundane trivial stuff and we're not really fulfilling our purpose."

"I believe that each person has a purpose, same with you, You have a purpose, that God has for you. I don't find it a coincidence that you are here. You know what I'm saying. I don't find it a coincidence that you're hearing stuff. And the same thing from me. We can all learn stuff. And the reality is like, so I believe that, I believe I had a purpose. And so every situation, every corner, I have to look and say hey, is this fulfilling that purpose? Is this going to glorify edify my life is it is going to lead me down on that path?"

Theme 5: I let God change the way I think.

From the interview it became clear that Participant 4 has a great desire to live the way he believes is optimum, having a strong relationship with God and to fulfil his God given purpose: "*I want my heart to be in it. I want to have a heart relationship with God, you know, and, umm, I want to fulfil that purpose."* He also believes that it is possible to break from his past through forgiveness and understanding: *"You know that generational stuff is to say hey, I cut that loose, God now reveals truth and I don't have to go back and still be like hard on them you know. He gives you understanding, compassion, umm, grace and mercy. So, I can be like graceful and merciful and compassionate and understanding. To realise like hey I can understand now, we almost become like by-products of our upbringing."* And emphasised the importance of changing the way one looks at the world: *"...he said don't conform to the ways of the world. But be transformed through the renewing of your mind. So, God obviously says let me, let me change the way you think and that's what it is hey. It's really come to a point where I let God change the way I think."*

In summary:

From Participant 4's interview his chaotic childhood as the son of the owner of a bar who was already using hard drugs at the age of 13 yielded the first theme, **yaas ou, it was crazy.** His understanding of the driving factors from his father's youth causing a lot of the turmoil in his own life is developed in the second theme of **hurting people hurt people.** In the third theme his own personal struggles with addiction developed as **a personalized sort of battle** relating to his life as an addict with the singular purpose to get high and the isolation he experienced in that time. In stark contrast with the isolation of his battle with addiction stands his views that elements essential to recovery are relationships, with God and others, a sense of hope and finding a God-given purpose developed into the theme **relationships, hope and purpose**. His own strong faith and belief in God frequently featured in his interview and his views that he was able to recover and is able to maintain abstinence yielded the final theme **I let God change the way I think.**

Participant 5:

Participant 5 is a female lay counsellor in her late 50s, working predominantly with hospice patients. But she also does volunteer work for CANSA, and volunteers as part of the SA Police Force's Victim Empowerment Program. She is divorced and has been working in her community for more than twenty years. She tells the story of a woman, (name changed, for confidentiality), who has recovered from heroin addiction. She is acquainted with Cindy but has a therapeutic relationship with Cindy's mother as lay counsellor. Cindy's mother and Participant 5 were also in the same community school as children. Participant 5 started off by saying that a therapist explained to her, that addiction is inherited and then said, *"... because her father, her biological father, was also an addict, but I will tell you about him later.*" She explained how much stress the mother experienced, *"You know, it was her* <Cindy's> *mood swings, and then the watching, because she sold anything she can get her hands on, and it affected the other kids, and her relationship with them, and her mother's relationship with her boyfriend - the whole house.*" Cindy, it transpired, was the eldest of four children, but had a different father from the other three. Cindy's mother realized something changed in Cindy when she was about 16 but was in denial for a long time: *"She always made excuses. The stuff disappeared from the house, her CDs, her ring, but she kept denying it. She just didn't want to believe it."* She explained how this is common: *"You don't recognize it, you know, you don't know, you think, oh maybe she's just down, or oh maybe she's just sad, or oh maybe she's just stressed. But you should actually think, oh, she's just used, or oh she needs to use."*

But once she's recognized what was happening, Participant 5 related that: *"Cindy's mother just couldn't deal with it, so she went to see the doctor here, and he said to her to let Cindy come there. And she said look, she'll not come. But she took her chance, when Cindy complained about her back, and she had her talk to the doctor by herself. Later of course she learnt that that was one of the signs of withdrawal from Heroin, but at that time she didn't know."* That was the first time Cindy went to rehab, but it didn't work: *"It was a waste of money. They put her in the outpatient rehab, because she was doing so well at college. It was money spent, money spent, money spent, but it just never got better.*"

Participant 5 related how when Cindy was caught with drugs at her college, although the college gave her another chance, Cindy's mother gave her an ultimatum: *"She said, you have two choices, you're going to pack your bags and you're going to leave. You're not going to do this to us anymore, I don't care where you go, she said. Or you're going to the clinic. And Cindy just burst out crying and said I want to go to the clinic, mom."*

The interview follows the tough journey of Cindy's mother, as she attends Al-Anon groups: *"I'm not sure it was so good for her, but she has learnt a lot, about addicts, and sharing with other parents who are going through the same thing she was, but I remember her telling me in tears, after she's been to one of these, that her daughter has a 6% chance on survival, because heroin is so hard on your body. The withdrawal can kill you."*

Unfortunately, Cindy started using again. *"Three weeks after she came out of rehab, <Name of mother removed> had to go fetch one of the other kids from school, and when she got home, Cindy was missing…she didn't know if she was alive, if she OD'd. But she found her and took her back to the clinic where she stayed for another ten days."* But even then, she relapsed again. *"And then it was an ongoing thing. And her mother realized that she cannot stop her from using. They need to hit rock bottom. They need to get to a point where they almost destroy their whole life, their whole self, everything around them, that they realize that lower they cannot go, okay?"*

Participant 5 then related how Cindy managed to live with her addiction: *"She had a really good job; she ran a restaurant in Cape Town. She married, she had a child, and she somehow managed to keep her using separate from her child. She managed, look Cindy is very vain, she's Leo, her image was important to her. And as much as she could, she tried to uphold that image through all of that kak."* Participant 5 explained how Cindy's mother handled her daughter's addiction: *"She was very angry at first when the people at Al-Anon told her that she's enabling her daughter, but then she saw how she was doing it, and that trying to save her, she stopped. She said she'll be there for her, she'll help her as far as she can, but she will no longer enable her."* She said: *"I don't know what is harder, trying to save them, or not trying to save them. I think trying to save them is easier, than giving them tough love, of not saving her. Of letting her fall."*

Once Cindy's mother found out that Cindy's husband is abusing her, she did go and fetch her and brought her home. *"She stayed by her for quite a while, but then she went back to the husband, but that didn't last. She left the husband and* <name of son removed> *came and stayed here in the community with her and she basically raised him while Cindy carried on working and doing whatever."* Participant 5 thought that Cindy really tried to stop using, but she couldn't: *"Cindy would come here for a few days, and then her mother would be on high alert again and hide all her things, and then she fell apart every time Cindy leaves. We here in the community stood by her and we said to her, I said to her, Cindy will change."*

And then the change came: *"She was 31, when she came home again to her mother's house here, she rocks up here, four, no five years ago, she was as skinny as anything. You*

could see in the way she talks, the grinding of her jaw, those are all signs of using, and thin thin thin. Now she's been using for sixteen years. She's here and she's craving for naartjies and she's craving for naartjies and I say to her mother, she's pregnant."

Participant 5 elaborated on the new boyfriend, a Muslim man, and they've been together for a few years. *"She didn't tell him that she was pregnant, because she didn't know what she was going to do, because remember, she was an addict."* And then, the unbelievable happened: *"So, she was obviously going through withdrawal, and she's pregnant, and her mother was thinking how is she going to deal with this. But now we're in* <name of community removed> *so, it's not very easy to get heroin here. And she stayed. And she stayed. And she stayed."*

Participant 5 became teary when she explained how Cindy's boyfriend arrived here after having been in rehab and *"... she flipping stuck it through. Okay, she went through that pregnancy, came clean in that pregnancy, after sixteen years."*

She then told the story of Cindy's father, describing the volatile environment Cindy spent her first few years of life in: *"Her biological father was a very handsome man, he was an A grade student, head boy. He had so much potential, that guy hey, and flipping sexy as hell, fuck he was beautiful. And then he went to the army, and then him and Cindy's mom got together, and umm, she fell pregnant when she was in matric. He was two years ahead of her, so he was just finishing Army, when she was writing matric, not knowing she's pregnant. And they got married, and they had Cindy, but when he finished with the border, and he was a Recce, when he finished with the border, he was not the same guy at all. What she didn't know was that he was on drugs. She knew he was on cough mixtures, like out of it sometimes. Like he would wake Cindy's mother up in the middle of the night because the devil was standing in the corner and she had to go put on the light. He became extremely aggressive – never physically – but she got scared, extremely scared. I mean jealous, possessive, oh my word. He threatened to kill himself, never her, himself ... She was too scared to leave him too scared to stay. And then, it was December, Cindy was about six months old or so, her mom got a permanent job offer, and she went home, and she bought a plane ticket, and she took Cindy, she got on the plane and she disappeared. And she went to Bloemfontein, Welkom, to be exact, and she called the lawyers from there to arrange for a divorce and a restraining order."* She related several incidents where her ex-husband threatened them*:" ... she was locked in the bathroom, crying, asking him to leave, he's outside of the house crying, he jumps over the wall and he leaves."*

Cindy's father just disappeared; they didn't see him for years. Her second husband adopted Cindy: *"... and Cindy never knew that he was her father, I mean she was small. When Cindy was about 8, her mother gave her biological father a chance to get to know her, but he wasn't allowed to tell Cindy that he was her father. Then one day Cindy's mom got home, and there he was. He got into their house and was passed out on the couch. He was out of it. And then he woke up and he was crying and saying how sorry he was and begging her to take him back, and then he threatened to kill himself again. So she took the kids over to her mom's, and she went back, and she took her gun out of her cupboard and she loaded it and she gave it to him and said, shoot yourself. There you've got a beautiful daughter that you've just met, but you want to kill yourself? So now he was really crying, and she walked up to him, and she kicked him in the groin, hit him over the head, and climbed over his body, and she said to him, I'm now leaving, and I'm calling the police, and when I get back you must be gone.' And she didn't see him for years and years."*

Participant 5 then closed off her interview by saying how Cindy asked to meet her father when she was around 16. Cindy's mother arranged for them to meet, they had a massive argument, and Cindy refused to speak to him again. And he died a few weeks later. *"It came out later that they were connecting quite nicely, talking about the past, he was talking about his mistakes. But the reason why they fought, was he got into a fight, and he had a knife wound on his arm or something, and he wouldn't have it seen to. So, he landed up in hospital with blood poisoning, and he had a massive heart attack in hospital."*

From Participant 5's interview five themes the following five themes emerged: **She was 16, she was angry, and her friend said to her, try this**; **when he finished with the border he was not the same guy at all**; **they don't have to worry about their life, they just have to worry about their fix**; **getting clean at her mother's house** and **you can never say you're not an addict. Never ever.** These five themes are expanded below:

Theme 1: She was 16, she was angry, and her friend said to her, try this.

Although Participant 5 didn't tell us much about Cindy's world as a young girl with reference to her, she told us a lot about Cindy's childhood from the point of view of her mother. What we do know is that Cindy, like most of the other addicts in the different accounts had a troubled childhood. Participant 5 also pointed out early on in the interview that Cindy had a family history of addiction: *"Her father, her biological father, was also an addict."* Her parents were divorced when she was very young: *"She was a baby when her mother divorced her father. I don't think she was a year old."* And she started using drugs at

a young age: *"The first time she used, she had an argument with her mother, and she climbed through a window and went to a party, and she was 16 years old, and she was angry and her friend said to her, try this, and she said it was the most amazing, amazing feeling."*

Theme 2: When he finished with the border, he was not the same guy at all.

Although Cindy only discovered her biological father's identity when she was older, he nevertheless played a role in her life in her early life and later when she met and formed a relationship with him. Participant 5 alluded to trauma experienced by Cindy's father when she said: *"… but when he finished with the border, and he was a Recce, when he finished with the border, he was not the same guy at all. What she* <Cindy's mother> *didn't know was that he was on drugs."* Painting a picture of a disturbed man: *"She had to beg him not to kill himself, and tell him that it's okay, and that there are no devils in the corners."* Which made for an insecure home: "*He became extremely aggressive – never physically – but she got scared, extremely scared. I mean jealous, possessive, oh my word. He threatened to kill himself, never her, himself … She was too scared to leave him too scared to stay."*

Theme 3: They don't have to worry about their life, they just have to worry about their fix.

A strong theme of enabling and the role of the enabler in the addict's life formed part of Participant 5's account. Participant 5 related how both Cindy's mother and Cindy herself denied her drug use: *"When her mother found drugs in her room, she denied that it was hers and said it belonged to a friend of her, we realised later was her user buddy."* And when she relapsed after the first time in rehab: *"While going to out-patient rehab, she got caught with drugs at college. But they gave her another chance, because she was doing so well.,"* she didn't get the help and support she needed: *"Her father didn't want to pay for her to go to secondary care. He believed she's been to rehab and now she's cured."*

Participant 5 displayed an understanding of the role of the enabler when she explained: *"You're enabling them by looking after them. You give them bus money and you give them food money; you need this, you make their lives easy. So, they don't have to worry about their life, they just have to worry about their fix. But if you take all that away, they have to worry about their fix and their life. So, if you don't sort their lives out for them, and make them fall, it makes it more difficult for them to keep using,"* advocating a tough-love approach: *"From a co-dependent's side, the sooner a co-dependent realizes that you enable them, as much as that hurts, and the second important thing is, you can't stop them, you can't force them.*

Apart from the environmental contributing factors, emotional factors also count against the user, as Participant 5 explains: *There are lots of emotional things that you don't face, because you use, to escape these things,"* saying the user keeps using because: *"I don't think she had the motivation, it was easier to use and get rid of the pain."* And the physical body is also craving the drugs: *"No matter how much she wants to stop, her body is telling her to keep using."*

Theme 4: Getting clean at her mother's house

The importance Participant 5 contributed to Cindy's mother no longer enabling her, but instead supporting her with a 'tough love' approach came through clearly when Participant 5 illustrated how Cindy's mother helped her by not helping her: "*…and that trying to save her, she stopped. She said she'll be there for her, she'll help her as far as she can, but she will no longer enable her."* And when the time was right, Cindy's mother could be there for her: "*... and she is getting clean at her mother's house, living on, she bought a box of naartjies every single day*," saying how Cindy's mother's house was her sanctuary *".. and she had a safe haven here, she always had a safe haven where she could come,"* while her boyfriend recovered from addiction as well: *"Now he was in rehab…"*

Participant 5 also talked about the importance of self-awareness as she said about Cindy: *"She knows where her triggers are. And that is so important. It's like not keeping quiet about it and having somebody to actually go to and – just rant and rave, you know, and not actually go and pick up."* And in getting clean she ended up being a motivation and support for others: *"The other day, when somebody else was in a state of wanting to use, I phoned Cindy, I phoned Cindy, and I said to her, please, please, here, speak to them. I said to her, she wants to use, and I said speak to her. So, the two of them had a long conversation, and it was on speaker phone, and Cindy said to her, don't think it's easy. Even today it's difficult. It will never get easy."*

Theme 5: You can never say you're not an addict. Never ever.

A final theme in Participant 5's interview was the enormity of the struggle of getting clean and staying clean, saying of Cindy's self-rehabilitation: *"but she did the most difficult thing in her life, while being pregnant, here in the community."* She included Cindy's now husband and his child she fell pregnant with as motivational factors in her eventual maintenance: *"They have been in love with each other for years, and they thought they couldn't get married, because he was Muslim, and it took* <name of child removed> *for them to get married, and it took* <name of child removed> *for them to get clean. And they have*

both been clean for all these years. <Name of child removed> turned four in August, so five years, they've been clean." She eluded to the fact that it is a constant battle: "*The day you tell yourself, it will never come back, is the day it come and bites you … you always have to admit you're a recovering addict. You can never say you're not an addict. Never ever."* When the researcher asked Participant 5 if she there was a specific characteristic she thought helped Cindy most in her recovery and maintenance she said: *"I think what could have happened to the baby if she used, could've played a role, but she is an incredibly strong person. But if I really have to think about it, the thing that got her clean, wasn't really any characteristic, it was her strength. To be able to do it."*

In summary:

Cindy, as with almost all the other addicts in the different accounts from the participants had a difficult childhood and started using drugs at a young age. The theme **she was 16, she was angry, and her friend said to her, try this** developed from the data as a fusion of elements that eventual brought Cindy in contact with drugs that lead to her addiction. In her interview Participant 5 placed a lot of emphasis on the role of Cindy's father on her eventual addiction, both from a biological perspective in terms of his own addiction and psychological in terms of his emotional disturbances. As she was more familiar with Cindy's mother, than with Cindy herself, a picture of Cindy's father developed almost from the mother's perspective into the theme **when he finished with the border, he was not the same guy at all**. Participant 5 also felt very strongly about the damaging role the enabler plays in the addiction and this developed into the theme **they don't have to worry about their life, they just have to worry about their fix**. Participant 5 appeared to have been close to Cindy's mother during Cindy's recovery process as she spoke with great detail about the time Cindy spent **getting clean at her mother's house**, and how this support eventually helped her to support others. Participant 5 displayed her deep understanding of the difficulty of recovery and successful maintenance and developed into the last theme **you can never say you're not an addict. Never ever.**

Chapter Summary

In this chapter the data analysis from the five semi structured interviews were presented. Each participant and their accounts were briefly introduced and outlined followed by separate unique themes developed from each individual account. Participant 1, a lay counsellor, told the story of Clarissa, a lady she was familiar with before they entered into a therapeutic relationship, who has recovered from alcohol and Mandrax dependency. From her

interview five themes developed namely **a family of jolly alcoholics**; **true colours**, **the darkest place on this earth**, **vision of a suiker huisie** and **finding freedom in religion and persistent struggle**. Participant 2, a lay preacher and owner/manager of a rehabilitation centre related the story of Ryan who recovered from alcohol and tik addiction. As she is the owner of a faith-based rehabilitation centre her interview was unique in that she often brought in parallel examples of other clients in relation to rehabilitation in general. From her interview five broad themes developed with three subthemes as follows: **What my father does affects me**; **life is so overwhelming**; **you get to a crossroads, choose**, under which the three subthemes of: **master manipulators**; **the fifth time they fly** and **I know what I'm doing** emerged; then **a better chance to recover from addiction** developed as theme 4 with the last theme, **he's so hungry to, to not go back to that again**. Participant 3 is a lay counsellor who related the story of James, an individual she has know from her school days who has recovered from alcohol and cocaine addiction. From her interview five themes developed as **imperfect childhood**; **damage**; **its fine, if there is a problem, he will come to us**; **his whole family is turning over new leaves** and **man up and say to yourself - this is my life**. Participant 4, a lay counsellor and co-owner of a women's shelter surprised the researcher when he stated at the start of his interview that he himself was a recovered drug addict. He recovered from a heroin addiction and his recovery became the subject of his interview. As he also had a great deal of exposure to addiction in the women's shelter his account also included references to clients from the shelter and other addicts that he was in contact with. From his interview five theme developed namely **yaas ou, it was crazy**; **hurting people hurt people**; **a personalized sort of battle**; **relationships, hope and purpose** and finally **I let God change the way I think.** Participant 5, a lay counsellor, related the story of Cindy who has also recovered from a heroin addiction. Cindy is the daughter of a schoolfriend of hers who she ended up counselling. From her interview five themes developed as **she was 16, she was angry, and her friend said to her, try this**; **when he finished with the border he was not the same guy at all**; **they don't have to worry about their life, they just have to worry about their fix**; **getting clean at her mother's house** and **you can never say you're not an addict. Never ever.**

Chapter 5: Discussion

In this chapter the results from the data analysis were explored and the information from the interviews discussed in relation to the relevant literature. The aim of the study was to explore the perceptions of lay community healthcare workers from a rural West Coast community, concerning the origins and dynamics of, and recovery from substance addiction with an interest in the transference of intergenerational historical trauma seen against the theoretical framework of Engel's biopsychosocial model.

The results from the data analysis in chapter 4 yielded the following individual themes from the interviews: From Participant 1: **A family of jolly alcoholics**; **true colours**, **the darkest place on this earth**, **vision of a suiker huisie**; and **finding freedom in religion and persistent struggle**. From Participant 2: **What my father does affects me**; **life is so overwhelming**; **you get to a crossroads, choose**, with three subthemes: **master manipulators**; **the fifth time they fly** and **I know what I'm doing** as well as **a better chance to recover from addiction** and **he's so hungry to, to not go back to that again**. From Participant 3: **Imperfect childhood**; **damage**; **its fine, if there is a problem, he will come to us**; **his whole family is turning over new leaves** and **man up and say to yourself - this is my life**. From Participant 4's interview came: **Yaas ou, it was crazy**; **hurting people hurt people**; **a personalized sort of battle**; **relationships, hope and purpose** and **I let God change the way I think.** Finally**,** Participant 5's interview yielded: **she was 16, she was angry, and her friend said to her, try this**; **when he finished with the border he was not the same guy at all**; **they don't have to worry about their life, they just have to worry about their fix**; **getting clean at her mother's house** and **you can never say you're not an addict. Never ever.** The factors identified by Engel in the biopsychosocial framework were used to structure the themes developed from each individual participant's interview against this theoretical model, operating in the different domains. The results are summarised in Tables 2 to 6. As indicated in the literature study, these factors and domains overlap and are not exclusive (Griffiths, 2005).

Table 2: Participant 1's themes in framed in the biopsychosocial model

	Biological Domain	***Psychological Domain***	***Social Domain***
Predisposing factors	A family of jolly alcoholics	A family of jolly alcoholics, true colours	A family of jolly alcoholics

Precipitating factors	A family of jolly alcoholics, true colours	True colours	True colours
Perpetuating factors	The darkest place on this earth	The darkest place on this earth	The darkest place on this earth
Protective factors	Finding freedom in religion and persistent struggle	Vision of a suiker huisie, finding freedom in religion and persistent struggle	Vision of a suiker huisie, finding freedom in religion and persistent struggle
Predictive factors	Finding freedom in religion and persistent struggle	Finding freedom in religion and persistent struggle	Finding freedom in religion and persistent struggle

Table 3: Participant 2's themes in framed in the biopsychosocial model'

	Biological Domain	***Psychological Domain***	***Social Domain***
Predisposing factors	What my father does affects me	What my father does affects me	What my father does affects me
Precipitating factors	Life is so overwhelming	Life is so overwhelming	Life is so overwhelming
Perpetuating factors	Life is so overwhelming, master manipulators, I know what I'm doing	Life is so overwhelming, master manipulators, I know what I'm doing	Life is so overwhelming, master manipulators
Protective factors	The fifth time they fly, a better chance to recover from addiction	The fifth time they fly, a better chance to recover from addiction	A better chance to recover from addiction
Predictive factors	He's so hungry to, to not go back to that again	He's so hungry to, to not go back to that again	He's so hungry to, to not go back to that again

Table 4: Participant 3's themes in framed in the biopsychosocial model

	Biological Domain	***Psychological Domain***	***Social Domain***
Predisposing factors	Imperfect childhood	Imperfect childhood	Imperfect childhood
Precipitating factors	Damage	Damage	Damage
Perpetuating factors	Damage, if there is a problem, he will come to us	If there is a problem, he will come to us	If there is a problem, he will come to us

Protective factors	His whole family is turning over new leaves	His whole family is turning over new leaves	His whole family is turning over new leaves
Predictive factors	Man up and say to yourself - this is my life	His whole family is turning over new leaves, man up and say to yourself - this is my life	His whole family is turning over new leaves, man up and say to yourself - this is my life

Table 5: Participant 4's themes in framed in the Biopsychosocial model

	Biological Domain	***Psychological Domain***	***Social Domain***
Predisposing factors	Yaas ou, it was crazy	Yaas ou, it was crazy	Yaas ou, it was crazy
Precipitating factors	Hurting people hurt people	Hurting people hurt people	Hurting people hurt people
Perpetuating factors	a personalized sort of battle; relationships	Hurting people hurt people, a personalized sort of battle; relationships	Hurting people hurt people, a personalized sort of battle; relationships
Protective factors	Relationships, hope and purpose	Relationships, hope and purpose	Relationships, hope and purpose
Predictive factors	Hope and purpose, I let God change the way I think	Hope and purpose, I let God change the way I think	Man up and say to yourself - this is my life

Table 6: Participant 5's themes in framed in the Biopsychosocial model

	Biological Domain	***Psychological Domain***	***Social Domain***
Predisposing factors	She was 16, she was angry, and her friend said to her, try this	She was 16, she was angry, and her friend said to her, try this	She was 16, she was angry, and her friend said to her, try this
Precipitating factors	When he finished with the border he was not the same guy at all	When he finished with the border he was not the same guy at all	When he finished with the border he was not the same guy at all
Perpetuating factors	They don't have to worry about their life, they just have to worry about their fix	They don't have to worry about their life, they just have to worry about their fix	They don't have to worry about their life, they just have to worry about their fix
Protective factors	Getting clean at her mother's house	Getting clean at her mother's house	Getting clean at her mother's house
Predictive factors	You can never say you're not an addict. Never ever	You can never say you're not an addict. Never ever	You can never say you're not an addict. Never ever

Looking at these themes in combination against the theoretical framework backing this research, five overarching themes were formed. Firstly, the theme of **formative years developed.** This theme strongly related to *predisposing factors* in the biopsychosocial model. The second theme, **trauma exposure and contributing stressors**, related very strongly to *precipitating factors*. Here, however, the way in which the factors overlap, and are not exclusive became evident, as indicated in the literature (Griffiths, 2005), as **trauma exposure and contributing stressors** are also associated with *predisposing* and *perpetuating factors*. A third theme, **catalysts** developed. C**atalysts,** where they are **inhibiting change** relate to *perpetuating factors*, while catalysts acting as **incentives to change** relate to *protective factors*. The two subthemes, **inhibiting change** and **incentives to change** developed organically under this theme. **Motivational elements underlying maintenance** also relate to *protective factors* and finally **fundamentals of resilience** relate strongly to *predictive factors* but are also associated with *protective factors* the biopsychosocial model. These five themes and two subthemes are framed in the biopsychosocial model in Table 7 below.

Table 7: Five overarching themes framed in the biopsychosocial model

	Biological Domain	***Psychological Domain***	***Social Domain***
Predisposing	Formative years;	Formative Years;	Formative Years;
Precipitating	Trauma exposure and contributing stressors	Trauma exposure and contributing stressors	Trauma exposure and contributing stressors
Perpetuating	Trauma Exposure and contributing stressors	Catalysts as mechanisms inhibiting change	Catalysts as mechanisms inhibiting change
Protective	Motivational elements underlying maintenance, fundamentals of resilience	Catalysts as incentives to change, motivational elements underlying maintenance, fundamentals of resilience	Catalysts, incentives to change, motivational elements underlying maintenance
Predictive	Fundamentals of resilience	Fundamentals of resilience	Fundamentals of resilience

A final, hidden, sixth theme was developed from the collective body of data as a whole, using inductive analysis namely **complicit silence**.

Theme 1: The Formative Years

The first theme that emerged from the data was **the formative years**. With this theme the image of the addict as a product of their home environment and upbringing was created

by the participants' words without much prompting from the researcher, Participant 4 expressed it as:" … *we almost become like by-products of our upbringing."* This theme is consistent with *predisposing factors* in the biopsychosocial model, that contribute to vulnerabilities that increase risk of addiction. The degree to which the parental relationships and the environmental factors at play in the formative years of the addict have affected the probability of them becoming addicted to substances later on in life, has been established (Brown & Abrantes, 2006; Stanton & Shadish, 1997; Velleman & Templeton, 2003). This was supported by the data, as most of the accounts shared the common threat of formative years featuring family history of addiction and absentee parents in chaotic environments in the following individual themes: **A family of jolly alcoholics**; **what my father does affects me**; **imperfect childhood**; **yaas ou, it was crazy** and **she was 16, she was angry, and her friend said to her, try this.**

It was as if all the participants instinctively knew that the accounts had to have a beginning, and in the beginning of a story about addiction, there is almost always a parent who created the model of maladaptive coping skills for the future addict: Participant 5's said of her subject: *"Her father, her biological father, was also an addict."* Participant 3's subject also had a family history of addiction: *"... his mother and his aunt was an alcoholic,"* as did the subject of Participant 1's interview: "*She and her dad* <parents> *was what we would call jolly alcoholics.*" While Participant 2, who has been involved in rehabilitation of addicts for over thirty years said: *"I could see the generational thing; it came from people in his family, who were also addicts."* Interestingly, Participant 2 stated that she believed that, not only are the children likely to repeat the behaviour patterns of the parents, but they are likely to escalate it: "… *they say, what I'm doing, my child is going to do it worse than me. So, this generation is not just on alcohol only, they are also on tik."* The data from the interviews therefore strongly support *genetic theories* believing substance dependence to be the result of biologically inherited mechanisms underlying the predisposition to become a substance dependent (Heyman, 2013; Patriquin et.al., 2015). It also aligns with Family Studies showing that first-degree relatives of alcoholics or substance abusers or dependents are three to five times more likely to develop alcoholism or substance abuse or dependence problems than individuals from families where there is no alcoholism or substance abuse (Schukit, 1999). The data most importantly illustrated the lay community healthcare workers' innate understanding of the contribution of the addicts' family history to their own addiction.

As much as the accounts of the participants supported their impressions of the importance of the parental history of addiction, they also agreed on the influence of parental

relationships and the environment in which the subjects of their accounts grew up, on their entanglement with substances. The accounts all shared elements of absentee paternalism and chaotic home environments: Participant 5 said of her subject: "*She was a baby when her mother divorced her father,* "and of her subject's parents: "*He became extremely aggressive … She was too scared to leave him, too scared to stay."* Participant 4's interview echoes this when describing his own childhood, he said: *"my parents were, they had a bar. … ahhh there was always arguing there was always fighting, to such a point where, as I grew up, where alcohol was just like, yaas ou, it was crazy … The verbal abuse, and stuff like that."* And Participant 3's subject's childhood followed this trend: *"…his parents were divorced at a young age … <he> was taken away in the middle of the night and moved to Cape Town. … And so that kind of hostility, and dad would come out and a lot of fighting. … I think all her kids are slightly damaged because of her influence."*

These fragments of the stories are consistent with the family systems theory that identifies a relationship between alcohol-related coping behaviours and psychological- and relationship distress (Kahler, McCrady & Epstein, 2003). Lederer (1991) proposes that reciprocal extremes of behaviour between family members, lack of a model of normality, and power imbalances within the family system that are typical of an alcoholic household, predisposes the individual to addiction later in life. The participants' accounts support their understanding of this and is encapsulated when Participant 2 said: *"… bad parenting, that's also what brings them here."*

The factors contributing to, or predisposing the individual to addiction in later life, operate in all three domains of the Biopsychosocial model. In the biological domain, involving genetics and developmental and temperamental aspects of the individual. In the Psychological domain, relating to cognitive style, intrapsychic conflicts, defence mechanisms, coping strategies, and personality. And in the Social Domain, where social relationships, environmental influences, cultural elements, and social risk factors e.g. living conditions and finances, contribute to the likelihood of the individual developing an addiction in later life.

The literature study confirms that having an alcoholic parent not only predisposes an individual to addiction on a biological level through genetically inherited mechanisms (Heyman, 2013; Patriquin et.al., 2015), but also on a psychological level as individuals from families where there is substance abuse become compulsively dependent on similar destructive behaviour patterns of their own (Sheridan & Green, 1993) as well as on a social level through cumulative reinforcement from drugs or activities associated with drug use

(Bevins & Murray, 2011; Kourrich, Calu & Bonci, 2015). The same applies to historical and intergenerational trauma (Sotero, 2006) as complex post-traumatic stress disorder, neurological and epigenetic mechanisms is at play in predisposing affected individuals to addiction on biological, psychological and social levels.

The data from the research - the subjects of the interviews' parental history of addiction, the parental relationship and early childhood environment, seen against the biopsychosocial model - confirms that it is fundamental to consider the impact of the formative years of the individual when attempting to gain understanding of the origins, dynamics and potential for recovery from addiction in the biological, psychological and social domains. In the light of especially Participant 1, Participant 4 and Participant 5's accounts one can possibly infer a relationship between intergenerational trauma and addiction, and it is therefore also important to consider this in the context of this research.

Theme 2: Trauma Exposure and contributing stressors

The second theme that emerged from the data was "*Trauma Exposure and contributing stressors*." Several factors contributing to the likelihood of the individual becoming addicted or relapsing after recovery, has been identified from the data. This theme aligns with **Precipitating Factors** in the biopsychosocial model relating to life events or stressors in any of the Biological, Psychological or Social domains having a time-relationship with the onset of symptoms of addiction or that may serve as a trigger for relapse (Borrell-Carrió, Suchman & Epstein, 2004). This is supported by the data as apparent in the following individual themes: **True colours**; **life is so overwhelming**; **damage**; **hurting people hurt people** and **when he finished with the border, he was not the same guy at all.** Out of the five accounts, only one did not contain direct references to either personal experiences of trauma or intergenerational trauma, and three of the accounts, Participant 1, Participant 4 and Participant 5 were related to historical trauma. More touching than the accounts of parental substance abuse in the stories are the horrific accounts of trauma visited on these individuals and their parents and their parents' parents, tracing scathing paths of pain through the panels of the unfolding of understanding. In Participant 2's words: *"Yes, there is something that happens. There is a lot of pain in life… you know the levels of trauma and the levels of hurt in people. Things people go through are horrific."*

Trauma exposure, and the traumatic effects of parental addiction and chaotic environments, acts as precipitating factors causing stress on biological, psychological and social levels, exacerbating the individual's problems, rather than solving them, increasing the

likelihood of addiction or relapse after recovery (Griffiths, 2005). As some researchers feel that the lack of success in intervention programs for alcoholism and substance dependency is due to the lack of understanding of the aetiology of alcohol and substance abuse as a Historical Trauma Response (Heart & DeBruyn, 1998; Brave Heart, 2003) it is important to note that the lay healthcare workers displayed a deep understanding of this contributor. It is interesting to note how Participant 4, in relating how, understanding that his father's exposure to trauma contributed to how he acted, also related this understanding to the South-African context as a collective: "*Now I know things happened there. Thank you, God, that He gives us wisdom, discernment, and I can now realise that things happened to my dad, ok and then yes, obviously my dad went through, ja, look my dad has got his life experience. The reality is, and so does our country."*

Historical trauma response is identified in the literature study as a collection of symptoms or behaviours presented as a result of historical trauma, typically including depression, self-destructive behaviours, suicidal thoughts and gestures, low self-esteem, anger, anxiety, difficulty identifying or expressing emotions and substance or alcohol dependence (Heart, 2003).The literature study revealed that the people of South Africa share a history of oppression, victimization, and massive group trauma exposure as legacy of the Apartheid regime in South Africa (Mohatt, Thompson, Thai & Tebes, 2014). The history of the Coloured communities of the Western Cape in South Africa specifically left them a heritage of dispossession, displacement, discrimination, disrespect, disillusion, and despair as more than half a million Coloured people were forcibly relocated after the Group Areas Act of 1950 (Mitchell, 2001). Participant 1 displayed her understanding of the impact of history as a precipitating factor when she said: "*You know as a Coloured girl the chances of you getting somewhere in the apartheid time was slim. In those days almost everyone ended up being part of the gangs, like she did."*

The literature study also outlines the influence of the apartheid era's oppression on the oppressors, where most of the scars of the White communities come from the conscripts in the "Bush War" or "Border War." (Baines, 2008). Participant 3's subject was a conscript himself and both subjects featuring in Participant 4 and Participant 5's interviews had fathers who were conscripts. One of the main premises of historical trauma theory is that the psychological and emotional results of traumatic experiences are transmitted to next generations through neurological, environmental and social pathways causing an intergenerational cycle of trauma (Sotero, 2006), indicating that the precipitating effects of trauma exposure operates in the Biological, Psychological and Social domains. Sheridan and

Green (1993) as well as Schäfer (2011) tells us that these experiences cause maladaptive social- and destructive behaviour patterns that are designed to relieve the pain of the trauma victim. But instead of relieving the pain it precipitates the damage as these behaviours eventually form the behaviour patterns upon which co-dependency or dependency disorders are founded. Whether or not substance dependence existed in the nuclear family, co-dependency is a deeply rooted compulsive behaviour that is born out of a dysfunctional family system as many co-dependents develop dependencies themselves, becoming compulsively dependent on behaviour patterns like those modelled to them (Brown & Wolfe, 1994).

In the section on liberation psychology in the literature study it is noted that understanding of collective trauma is often not recognised. Watkins and Shulman (2008) stated that colonialists avoided seeing the suffering they imposed for centuries, normalising it, and this inability, or resistance to recognize the severity of the impact of oppression on the oppressed by the privileged, becomes part of the pathology of collective trauma. The data reflected this in Participant 2's noncommittal downplayed response when asked if she thought that Apartheid played a role in the rising instances of addiction and she said: "... *some of what happened then in those days probably has part in what eventually leads them to drug use. But listen, here with them, this country can get a few lessons from drug addicts. There's no racism between drug addicts. Nothing. Niks."*

But from the accounts, where individual personal trauma exposure included rape, incestuous molestation, corrective therapy, exposure to violence, and historical trauma exposure included political oppression, forced removals and war, it was confirmed that the lay community healthcare workers were mostly aware that trauma exposure through parental substance abuse, personal exposure to traumatic events, or the transmission of historical trauma through intergenerational trauma transmission mechanisms precipitated the likelihood of addiction forming in the already predisposed individual. As indicated in the literature review, the factors and domains in the biopsychosocial model overlap. Although trauma exposure and contributing stressors are strongly associated with *precipitating factors*, it can also act as *perpetuating factors*.

Theme 3: Catalysts.

The third collective theme that emerged from the data was "*Catalysts*." In this theme factors acting as catalysts, either as incentives to change or mechanisms inhibiting change, were identified from the accounts of the participants. The individual themes informing this

overarching theme are: **The darkest place on this earth**, **you get to a crossroads, choose**, with three subthemes: **master manipulators**; **the fifth time they fly** and **I know what I'm doing** as well as **its fine, if there is a problem, he will come to us**; **a personalized sort of battle** and **they don't have to worry about their life, they just have to worry about their fix**. This theme has therefore been divided into two subthemes, namely *"Incentives to Change,"* and "*Factors Inhibiting Change."*

Subtheme 3.1: Factors Inhibiting Change:

This theme aligns with **Perpetuating Factors** in the biopsychosocial model relating to ongoing life challenges and sources of need, that are challenges instrumental in keeping the addict in their state of disempowerment. The individual theme **the darkest place on this earth** is a typical illustration of the myriad of challenges facing the addict, holding them captive in a place of victimhood as seemingly insurmountable challenges add to the load of the individual, already lacking in healthy coping skills, perpetuating the addiction as a means of coping. Where the substance use becomes a form of self-medicating to help ease the pain of the individual's 'normal' life.

In family systems theory the dysfunctional family dynamics typifying the alcoholic home is of described using the FACES (Family Adaptation and Cohesion Scales). In the cases of extremely high cohesion, the family members become enmeshed (Olson, 2000). In enmeshed families it often happens that a non-addicted member enables the dependent by shielding them from the negative consequences of their actions. The individual theme **they don't have to worry about their life, they just have to worry about their fix** specifically relates to enablers in the family systems model. Participant 5 elaborated on the role of the significant others in the addict's life as enablers. *"From a co-dependent's side, the sooner a co-dependent realizes that you enable them, as much as that hurts."* The subtheme **master manipulators** intimated the way in which the addict controls the enablers. Participant 2, with years of experience in a rehabilitation centre said: "… *if only the parents don't want to lie with them. Then I'm thinking how can you!?"* And Participant 4, who is a recovered addict and is currently running a women's shelter said: *"...parents think, hey, I'll send my child to rehab, they'll come back. While they're part of the problem."* All of the participants appeared to favour the 'tough love' approach, but understood how difficult it must be, as Participant 2 displayed her compassion for the parent of the addict when she said: *"I don't know what is harder, trying to save them, or not trying to save them. I think trying to save them is easier, than giving them tough love, of not saving her. Of letting her fall."*

The data also further supports the family systems model in that is shows in several instances how, in families with substance abuse and dependence, feelings of shame and guilt (on the side of both the abuser and the family members of the abuser) causes the family system to become a closed system, where the family member do not talk to outsiders about the problem they are hiding within their system, and in most cases they do not acknowledge the problem to themselves (Minuchen,1979). The individual themes **its fine, if there is a problem, he will come to us**, **I know what I'm doing** and **a personalized sort of battle**, dealing with the isolation of the addict as well as an inability or denial to acknowledge the existence of a problem, stand in strong support of this. In this way the likelihood of the dependent getting help decreases as for the problem to be addressed it first needs to be acknowledged.

Subtheme 3.2: Incentives to Change:

In all the interviews the participants recounted catalytic moments in the accounts of the subjects of their stories, where the individual came to realise that their habits are no longer serving them. Some of the moments were positive and heart-warming, others chilling, as the moments of crisis forged change. With the emergence of this subtheme the individual instances of crisis that brought about change varied from having experienced a "*vision of some sorts*," having a run-in with the law, or deciding to get clean for the sake of a close relationship as supported by the individual themes **vision of a suiker huisie**, **you get to a crossroads, choose** and **the fifth time they fly**. Social Support theorists believe that humans have an instinctive need to connect and bond with something and that substance dependence occurs due to a lack of bonding (Wodak, Drummond, Reinarman & Cohen, 2002). In their interviews three of the participants' subjects started thinking about change, or did indeed change, due to a connection or bond with someone who replaced their bond with the substance, they were essentially in a relationship with up to that point.

In Participant 1's story, Clarissa first had her "vision" of what the future would look like for her two children should she continue using drugs and later she managed to get clear when she "*gave her heart to Jesus"* and entered into a relationship with her current husband who *"took her in with two kids and took full responsibility for them."* In Participant 4's case, he also found religion and through that experienced the need to have another relationship: "*I want to have a heart relationship with God you know."* Cindy, the subject of Participant 5's interview, finally managed to get clean – without going to a rehabilitation centre, but by staying in her mother's house in the small community on the West Coast that Participant 5 is

from, while her boyfriend, and father of her unborn child went to a rehabilitation centre. Participant 5 frequently said that she thinks Cindy came back to her mother's house every time, because she wanted to stop using, but she couldn't. But then, when she had the motivation of the pregnancy and her boyfriend getting clean, together with her mother's support, the need to change overshadowed the need to use.

But Participant 5 also said: "*They need to hit rock bottom. They need to get to a point where they almost destroy their whole life, their whole self, everything around them, that they realize that lower they cannot go ...*" And that was the case in the other two cases. Participant 2 didn't elaborate much on the crisis that eventually brought her subject to her rehabilitation centre, but she did say: *"Ryan arrived here five years ago. And he was – he was finished,"* from which one could infer that Ryan too had hit rock bottom before arriving there. Participant 4 and Participant 3's subject both had a run-in with the law which were the catalysts to their recovery. Participant 4 recalled: "*The breaking point was, I was caught with the cars, it was either, I was going to jail ...*" and Participant 3 related: *"I think his turning point was being picked up by the cops for possession, obviously drinking as well, and he bribed the cops .. And he basically woke up the next morning and said, 'not doing this anymore', he went to his first AA meeting."* This links with the moral model where theorists believe a recovery consists of strengthening one's will to do the right thing, which is strongly linked with the way in which the criminal justice system approaches substance dependence (Horvath, Misra, Epner & Cooper, n.d.). The second subtheme of **incentives to change** strongly relate to *protective factors* the individuals employ on a psychological level often rooted in their biological makeup or temperament with the support of their social environment to motivate them to take on the task of recovery.

Theme 4: Motivational factors underlying maintenance

The third theme that emerged from the data was "*Motivational Factors Underlying Maintenance*." This theme aligns with Protective Factors in the biopsychosocial model where elements such as functional strengths, skills, talents, interests, assets, work and supportive elements of the person's relationships supported them in their rehabilitation and helped them maintain abstinence, essentially acting as protection against the predisposing, precipitating and perpetuating factors in their lives that are placing them at risk for addiction and relapse. The individual themes from the data relating to motivational factors underlying maintenance are: **finding freedom in religion and persistent struggle**, **a better chance to recover from addiction**; **he's so hungry to, to not go back to that again**, **his whole family is turning**

over new leaves, **relationships, hope and purpose** and **getting clean at her mother's house.**

Once an addict has overcome addiction, relapse is a constant source of dread. Maintaining sobriety is a challenge faced by all recovered addicts and the participants embellished on these motivational factors contributing to the fourth theme.

Several motivational factors were listed by the participants relating to the successful maintenance of sobriety and a drug free existence of the addict. These frequently included having had a religious epiphany or deeply spiritual experience, supported by Participant 1's account: " *… and after they prayed for her, she remember feeling as a wave or rush of freedom over her and she felt everything was going to be ok.*" This support and comfort derived from religion or spirituality is supported by research that reports positive correlation between levels of spirituality and prognosis for substance dependence recovery and maintenance as supported by the individual theme **finding freedom in religion and persistent struggle** (Avants, Warburton & Margolin, 2001).

Participants also described parental love as motivation for maintenance. This is supported in Bowen's family systems theory where the healthy emotional interdependence family system evolves to promote the cohesiveness and cooperation families require to protect and shelter their members (Bowen, 1974). We see therefore that religion and strong family ties are identified as protective factors, in the biological sphere, when we consider the physical wellbeing promoted by a safe, stress-free dopamine inducing environment, a psychological sphere in the emotional wellbeing and in the social sphere where the healthy family is part of an open system. In this way the whole family can rely on outside input to aid in its elaboration of structure and differentiation of function and roles to cope with adapting to challenging situations (Sheridan & Greene, 1993). The individual themes **a better chance to recover from addiction**; **his whole family is turning over new leaves** and **getting clean at her mother's house** .strongly support the literature holding that social, significant other and parental support are crucial protective factors to prevent relapse and sustain maintenance of abstinence.

In several of the accounts the participants spoke about 'hope' and 'purpose' as motivational factors for maintenance. Participant 2 said: *"I think the thing that happens when people come here is that they get hope, they get purpose. They realize that there is something more,"* while Participant 4 said: *"...I needed hope… read the scripture and listen to it and you read it there's hope there."* One begins to understand the importance of these two constructs when one considers the viewpoint of liberation psychology where a disintegration

of the belief in the community as an effective source of support and a space of belonging leads to a sense of defeat and hopelessness (Watkins & Shulman, 2008), which is exactly what happened to these addicts as they often tend to withdraw from family and friends as they struggle to come to terms with their addiction or because they are simply overwhelmed by stressors and other perpetuating factors. Almost all the participants described the addicts withdrawing from their natural support circle. Participant 3 described: *"It spiralled, he retracted quite substantially away from his family and friends,"* and Participant 4 recalled: *"but it obviously started having an effect on my work, family, I started to have no social life because I just lived for functioning through the day and I needed the substance."*

The importance of relationships were also iterated by all the participants, and both Participant 2 and Participant 4 who works with addicts on a regular basis felt that establishing a strong relationship with the addict is important for rehabilitation, while strong social support is important for maintenance and this came out strongly in the individual theme **relationships, hope and purpose.** This concurs with literature that treating alcoholism and substance dependence within the context of social networks and family relationships yielded lower incidents of relapse and longer periods of sobriety (Bezuidenhout, 2008).

In all the accounts, the participants related how much the addicts wanted to recover, and how this effort was met and encouraged by their friends, family and communities. The individual theme **he's so hungry to, to not go back to that again** illustrated this clearly and Participant 4 recalled: *"... look hey, I didn't wanna die. I wanna live..."* People have an inherent desire to solve their own problems. And rural communities are very capable of finding their own solutions to the problems they face (Marianne Bojer et.al., 2008). Nowhere is it more apparent than in the way in which this small rural community displayed a drive for autonomy and self-determination in the spontaneous creation of community support groups and unofficial structures operating within communities without any aid or input from the government such as the rehabilitation centre Participant 2 started 30 years ago, the women's' shelter Participant 4 and his wife operates, NGOs and NPOs where volunteer and lay community healthcare workers provide lay counselling and support where and when needed, often without any formal training. As we saw from the data gathered from the interviews, these protective factors indeed counteracted the predisposing, precipitating and perpetuating factors these individuals faced, to overcome their addictions.

Theme 5: Resilience characteristics

The fifth theme to have emerged from the data was that of "Resilience Characteristics." Almost all participants either ended their stories, or included, somewhere in their accounts, factors that they thought was the reason for the addicts remaining clean or sober after recovery. This theme aligns with Predictive Factors in the biopsychosocial model relating to factors predicting a favourable prognosis for positive change or maintenance of recovery. These factors are often directly opposing the factors in theme 3.1, that are inhibiting or preventing change. The individual themes relating to predictive factors in the biopsychosocial morel are **finding freedom in religion and persistent struggle**, **he's so hungry to, to not go back to that again**, **man up and say to yourself - this is my life**, **I let God change the way I think** and **you can never say you're not an addict. Never ever.**

Truth, honestly, and willingness to acknowledge and accept the undeniable existence of being a life-long addict in recovery are the factors counteracting the reluctance or inability to talk to outsiders and acknowledge the addiction, typical of the closed system in the family systems Model (Minuchen, 1979). Almost all the subjects of the interviews are part of Alcoholics Anonymous, Narcotics Anonymous, Al-Anon or have a church or other support group where they regularly talk to others about their addiction. They also all acknowledge that addicts will always be addicts in recovery: *"He realises of course that he can never touch alcohol again."* Participant 2 said, and Participant 5 concurred when she said: "*The day you tell yourself, it will never come back, is the day it come and bites you … you always have to admit you're a recovering addict. You can never say you're not an addict. Never ever."*

The participants also agreed that one of the things that lead to addiction is a mindset of not having control over your life or not taking responsibility for your life. Participant 2 talks about 'accountability': *Look I can give them accountability here. But the moment he's back there, when he's out again, then it is difficult."* Mary Watkins and Helen Schulman (2008) listed 'fatalism' as one of the psychological wounds of the victims of oppression and it can be seen how it is important to counter this feeling of lack of control, as the addict is completely controlled by their cravings. "*I just believe that if anybody, if you, can just take responsibility for your life…. I think the mind is such a powerful, powerful thing and I think that if somebody can just get their head right,*" Participant 3 said. And Participant 4 confirmed: "*God obviously says, let Me, let Me change the way you think and that's what it is hey. It's really come to a point where I let God change the way I think."*

But all participants also listed aspects of the individuals' characters which they thought was essential to them successfully recovering and eventually maintaining their

sobriety. One characteristic all participants agreed on was strength. Participant 5 said: "*I think what could have happened to the baby if she used, could've played a role, but she is an incredibly strong person … But if I really have to think about it, the thing that got her clean, wasn't really any characteristic, it was her strength."* And Participant 3 simply stated: "*He was exceptionally strong, that's what he had to be to have stayed clean."*

Finally, all participants related that the subjects, where they previously withdrew from society and their social support circles, reconnected with family, friends and larger community groups, either through church or through social support groups such as Al-Anon and AA. Here, the participants, in perfect alignment with asset based community development (ABCD) principles draws attention to social assets: the gifts and talents of individuals, and the social relationships that provide protective factors needed to reinforce resilience (Mathie & Cunningham, 2003).

Theme 6: Conscripted Silence

Through inductive analysis, a hidden theme emerged collectively from the data as that of **conscripted silence**. The researcher found that in all the interviews she had difficulty eliciting deep and meaningful data from the participants. Participant 2, for example, although she spoke at length - her interview transcript covered well over 12 pages - and in great detail, about the dynamics of addiction and the process around recovery, she shared very little personal information about her subject, his childhood, causes of his addiction and traumatic experiences, or any crisis surrounding his motivation to enter rehab. The researcher lives in the community where she conducted her research, and it may be that Participant 2, as she is familiar with the researcher, knows that the researcher knows her subject, Ryan, as well as Ryan's family.

Participant 4 in turn, although he spoke enthusiastically, and verbosely elaborated on the work he does, his recovery and his views on recovery and addiction, never spoke about his own childhood. It was only deep into the interview, after the researcher pointedly asked him if he think there might be factors from his childhood that might have contributed to his eventual addiction that he disclosed that his childhood was not ideal; The excerpt from the interview went as follows:

Researcher: "Do you think that there is something in your childhood that eventually lead you to becoming an addict?"

Participant 3: "Yes." <Note the monosyllabic answer>

Researcher: "Do you want to tell me about it? If you don't want to it is fine."

Participant 4: "No it's cool hey. It's not gonna be <pause> *I* <pause> *Really, it's a lack of truth.* <Long pause> *The lack of impartation, of my identity, of truth being spoken over my life. It's the lack of, you know, or maybe it's the being exposed to the, how can I say, the dysfunctions of society lived out in your own home."* It was only then that he regained his eloquence and continued, as previously, with a deluge of information.

A reluctance or resistance, to go too deep, to have the story that is being told, become real, be facts, appear to have created a need to avoid intense emotions. Speaking about alcoholics, even if they are not of one's immediate family, invokes pain. Miriam Greenspan (2004), in her book dealing with grief and transformation argues that the avoidance of "dark emotions" contributes to the escalating levels of depression, addiction, anxiety, and senseless violence in the U.S. and throughout the world. When the pain is too much, an impenetrable wall of silence forms around the person, around the family and around the community, which evokes images of the closed family system, not allowing input from the outside world, not letting anything from the inside slip out. The mechanisms theorized by the family systems model therefore appear to be at play here, where the closed-ness of the family system, or even the community, caused rigid boundaries. From the perspectives of the participants, the researcher is an outsider, although she shared working environments with the participants in the local school, through her interactions with local NPOs and as part of the VEP volunteer group, she remains an outsider. Not only is she an outsider, she is a white outsider.

Once the researcher identified this theme, she noticed marked differences in the nature of these silences. There were the heavy toxic silences carrying the mute burden of shame: The legacy of apartheid and the brutal dehumanisation of the people of South Africa, as Mary Watkins and Helen Schulman (2008) posited victims, bystanders and oppressors, is much like alcoholism in a family system - not talked about. Like the burden of shame carried by the family of the addict in the family system, the people of South Africa carry the burden of shame in silence, as a historical coping mechanism. Getting on with life after the trauma with the toxic silence as the norm. The young white men who were conscripted to the border war, where they were turned into oppressors, victims and silent bystanders, were burdened with the shame of their actions, silenced by the inability to rage against the schizophrenic splitting of themselves between their loyalty to the apartheid government, that they saw as 'their country' (Baines, 2008) and the reality of the brutalisation of a whole people they were party to. One can posit that the same conscription happens to the family members of the alcoholic or drug addict, where they are carrying the burden of associated shame in toxic silence, while silently raging against their schizophrenic selves divided by loyalty and shame.

Then there were stoic, almost proud silences. Strong stillness demanding neither sympathy nor justice. Standing strong, neither claiming victimhood nor seeking revenge. Instead this silence stood quiet witness, rejecting the possibility of rights, not asking for explanations. It was as if the meaningless atrocities of apartheid left wounds that cannot be exorcised through words. And as a white South African, the researcher is aware that she might subconsciously stand in the space of the oppressor. Many of the challenges faced by mental health practitioners in post-apartheid South-Africa comes from the legacy of apartheid (Arcot, 2015). In addition to this, the researcher's own personal history and the characteristics she presents as an adult child of an alcoholic, might have contributed to the conscripted silence, where talking about alcoholism is painfully close to home, no, to the heart. And therefore, she might have kept the level of exploration shallow, light, factual and manageable.

Chapter Summary

This chapter brought the results from the data analysis together in six central overarching themes: **formative years**, **trauma exposure and contributing stressors, catalysts**, **motivational elements underlying maintenance**, **fundamentals of resilience** and **conscripted silence**. The way in which the first five themes aligned with the 5 Ps from the biopsychosocial model were explored and the information from the interviews discussed in relation to the relevant literature. It was found that **the formative years** strongly aligns with *predisposing factors*, **trauma exposure and contributing stressors** aligns with *precipitating factors*, as well as *predisposing* and *perpetuating factors,* **catalysts** where they are **inhibiting change** relate to *perpetuating factors*, while **catalysts** acting as **incentives to change** relate to *protective factors*, **motivational elements** also aligns with *protective factors*, and lastly, **resilience characteristics** strongly aligns with *predictive factors* but are also associated with *protective factors* in the biopsychosocial model.. The sixth theme, **conscripted silence** was induced from the body of data as a whole. This final theme has strong links with unresolved intergenerational and historical trauma.

Chapter 6: Conclusion

This final chapter acts as a reflection of the researcher on her journey in this research project and in the process answers the two research questions: What are lay community healthcare workers' perspectives on the origins and dynamics of substance addiction and recovery, and do the accounts of volunteer community healthcare workers support a relationship between alcoholism or substance dependence and unresolved historical or intergenerational trauma? The researcher also reflected on the suitability of the biopsychosocial model as an appropriate model for understanding the origins, dynamics and recovery from substance addiction. To this end the chapter started with a comprehensive summary of the results obtained from the participants' interviews. The researcher also reflected on the strengths and limitations of this study. Finally, recommendations pertaining to future research and applications were made based on the researcher's own impressions and experiences.

Perspectives on the origins, dynamics and recovery from substance abuse

In an attempt to meet the aim of the study, namely to "explore the perceptions of lay community healthcare workers from a rural West Coast community, concerning the origins and dynamics of, and recovery from substance addiction with an interest in the transference of intergenerational or historical trauma seen against the theoretical framework of Engel's biopsychosocial model," six themes that developed using inductive and deductive analysis of semi-structured interviews, were discussed in chapter 5. The findings from the data analysis were brought together in six central overarching themes: **formative years**, **trauma exposure and contributing stressors, catalysts**, **motivational elements underlying maintenance**, **fundamentals of resilience** and **conscripted silence**. The manner in which the first five themes aligned with the 5 Ps of the biopsychosocial model were explored and the information from the interviews discussed in relation to the relevant literature (Borrell-Carrió, Suchman & Epstein, 2004).

The first theme, **the formative years,** established the addict as a product of their home environment and upbringing. This theme is consistent with *predisposing factors* in the biopsychosocial model, that contribute to vulnerabilities that increase risk of addiction. The degree to which the parental relationships and the environmental factors at play in the formative years of the addict have affected the probability of them becoming addicted to substances later on in life, has been established by literature (Brown & Abrantes, 2006; Stanton & Shadish, 1997; Velleman & Templeton, 2003) and was supported by the data, as

most of the accounts shared the common threat of formative years featuring a family history of addiction and absentee parents in chaotic environments, and a parent who created the model of maladaptive coping skills for the future addict. Accordingly, the data from the interviews strongly supported *genetic theories* that believed that substance dependence was the result of biologically inherited mechanisms underlying the predisposition to become a substance-dependent substance (Foxcroft & Low, 1992; Rossow & Lauritzen, 2001). It is also consistent with family studies that show that first-degree relatives of alcoholics or substance abusers or dependents are three to five times more likely to develop alcoholism or substance abuse or dependence problems than those of families without alcoholism or substance abuse (Schukit, 1999). The data most importantly illustrated the lay community healthcare workers' innate understanding of the contribution of the addicts' family history to their own addiction.

As much as the accounts of the participants supported their impressions of the importance of the parental history of addiction, they also agreed on the influence of parental relationships and the environment in which the addicts grew up, on their entanglement with substances. This is consistent with the family systems theory that identifies a relationship between alcohol-related coping behaviours and psychological- and relationship distress positing that reciprocal extremes of behaviour between family members, lack of a model of normality, and power imbalances within the family system that are typical of an alcoholic household, predisposes the individual to addiction later in life (Brown & Abrantes, 2006; Stanton & Shadish, 1997; Velleman & Templeton, 2003). The participants' accounts supported their understanding of this.

The data from the interviews also support literature positing that having an alcoholic parent not only predisposes an individual to addiction on a biological level through genetically inherited mechanisms but also on a psychological level as individuals from families where there is substance abuse become compulsively dependent on similar destructive behaviour patterns of their own as well as on a social level through cumulative reinforcement from drugs or activities associated with drug use (Foxcroft & Low, 1992; Rossow & Lauritzen, 2001). From the parental history of addiction present in several of the accounts, the maladaptive parental relationships and chaotic early childhood environments, seen against the biopsychosocial model - confirmed that it is fundamental to consider the impact of the formative years of the individual when attempting to gain understanding of the origins, dynamics and potential for recovery from addiction in the biological, psychological and social domains. A possible relationship between intergenerational trauma or historical

trauma and addiction could be inferred based on the accounts of especially Participants 1, 4 and 5, and it was therefore considered important to take the contribution of unresolved intergenerational or historical trauma into account in the context of this research.

The second theme that emerged from the data was **trauma exposure and contributing stressors**. Several factors contributing to the likelihood of the individual becoming addicted or relapsing after recovery, has been identified from the data. This theme aligns with *precipitating factors* in the biopsychosocial model relating to life events or stressors in any of the biological, psychological or social domains having a time-relationship with the onset of symptoms of addiction or that may serve as a trigger for relapse. This is supported by the data as out of the five accounts, only one did not contain direct references to either personal experiences of trauma or intergenerational trauma, and three of the accounts, Participant 1, Participant 4 and Participant 5 were related to historical trauma. Trauma exposure, and the traumatic effects of parental addiction and chaotic environments, acts as precipitating factors causing stress on biological, psychological and social levels, exacerbating the individual's problems, rather than solving them, increasing the likelihood of addiction or relapse after recovery (Heart & DeBruyn, 1998). As several literature sources claimed that lack of success in intervention programs for alcoholism and substance dependency is due to the lack of understanding of the aetiology of alcohol and substance abuse as a historical trauma response (Brave Heart, 2003; Heart & DeBruyn, 1998), it is important to note that the lay healthcare workers displayed a deep understanding of this contributor. One of the main premises of historical trauma theory is that the psychological and emotional results of traumatic experiences are transmitted to next generations through neurological, environmental and social pathways causing an intergenerational cycle of trauma indicating that the precipitating effects of trauma exposure operates in the biological, psychological and social domains. In the section on liberation psychology in the literature study it was noted that understanding of collective trauma is often not recognised. It has been stated that colonialists avoided seeing the suffering they imposed for centuries, normalising it, and this inability, or resistance to recognize the severity of the impact of oppression on the oppressed by the privileged, becomes part of the pathology of collective trauma (Watkins & Shulman, 2008). From the accounts, where individual personal trauma exposure included rape, incestuous molestation, corrective therapy, exposure to violence, and historical trauma exposure included political oppression, forced removals and war, it was established that the lay community healthcare workers were exceptionally aware that trauma exposure through parental substance abuse, personal exposure to traumatic events, or the transmission of

historical trauma through intergenerational trauma transmission mechanisms precipitated the likelihood of addiction forming in the already predisposed individual. As indicated in the literature review, the factors and domains in the biopsychosocial model overlap. Although trauma exposure and contributing stressors are strongly associated with *precipitating factors*, it can also act as *perpetuating factors*.

The third collective theme that emerged from the data was ***catalysts***. In this theme factors acting as catalysts, either as incentives to change or mechanisms inhibiting change, were identified from the accounts of the participants. Two subthemes developed organically from this theme, namely **incentives to change**, and **factors inhibiting change**.

Catalysts inhibiting change aligns with *perpetuating factors* in the biopsychosocial model relating to ongoing life challenges and sources of need, that are challenges instrumental in keeping the addict in their state of disempowerment. This theme related to the myriad of challenges facing the addict, holding them captive in a place of victimhood as seemingly insurmountable challenges add to the load of the individual, already lacking in healthy coping skills, perpetuating the addiction as a means of coping. In this instance, the substance use becomes a form of self-medicating to help ease the pain of the individual's 'normal' life.

All of the participants appeared to favour the 'tough love' approach but understood how difficult it must be and displayed compassion for the significant others in the addicts' lives. The data from the interviews supported the family systems model in that is showed in several instances how, in families with substance abuse and dependence, feelings of shame and guilt (on the side of both the abuser and the family members of the abuser) causes the family system to become a closed system, where the family member do not talk to outsiders about the problem they are hiding within their system, and in most cases they do not acknowledge the problem to themselves (Sheridan & Green, 1993). Individual themes dealing with the isolation of the addict as well as an inability or denial to acknowledge the existence of a problem, stand in strong support of this. In this way the likelihood of the dependent getting help decreases as for the problem to be addressed it first needs to be acknowledged.

In all the interviews the participants recounted catalytic moments in the accounts of the subjects of their stories, where the individual came to realise that their habits are no longer serving them. Some of the moments were positive and heart-warming, others chilling, as the moments of crisis forged change. With the emergence of this subtheme the individual instances of crisis that brought about change varied. Social support theorists believe that

humans have an instinctive need to connect and bond with something and that substance dependence occurs due to a lack of bonding (Wodak, Drummond, Reinarman & Cohen, 2002). In their interviews three of the participants' subjects started thinking about change, or did indeed change, due to a connection or bond with someone who replaced their bond with the substance, they were essentially in a relationship with up to that point.

In the moral model theorists believe a recovery consists of strengthening one's will to do the right thing, which is strongly linked with the way in which the criminal justice system approaches substance dependence (Little, 2005). The second subtheme of **incentives to change** relates strongly with *protective factors* the individuals employ on a psychological level often rooted in their biological makeup or temperament with the support of their social environment to motivate them to take on the task of recovery.

The third theme that emerged from the data was **motivational factors underlying maintenance**. This theme aligns with *protective factors* in the biopsychosocial model where elements such as functional strengths, skills, talents, interests, assets, work and supportive elements of the person's relationships supported them in their rehabilitation and helped them maintain abstinence, essentially acting as protection against the predisposing, precipitating and perpetuating factors in their lives that are placing them at risk for addiction and relapse.

Once an addict has overcome addiction, relapse is a constant source of dread. Maintaining sobriety is a challenge faced by all recovered addicts and the participants embellished on these motivational factors contributing to the fourth theme.

Several motivational factors were listed by the participants relating to the successful maintenance of sobriety and a drug free existence of the addict. These frequently included having had a religious epiphany or deeply spiritual experience. This support and comfort derived from religion or spirituality is supported by research that reports positive correlation between levels of spirituality and prognosis for substance dependence recovery and maintenance. Participants also described parental love as motivation for maintenance. This is supported in Bowen's family systems theory where the healthy emotional interdependence family system evolves to promote the cohesiveness and cooperation families require to protect and shelter their members (Foxcroft & Low, 1992; Rossow & Lauritzen, 2001). Religion and strong family ties are identified as protective factors, in the biological sphere, when considering the physical wellbeing promoted by a safe, stress-free, dopamine inducing environment, a psychological sphere in the emotional wellbeing and in the social sphere where the healthy family is part of an open system. In this way the whole family can rely on outside input to aid in its elaboration of structure and differentiation of function and roles to

cope with adapting to challenging situations. This theme strongly supported the literature holding that social, significant other and parental support are crucial protective factors to prevent relapse and sustain maintenance of abstinence (Rossow & Lauritzen, 2001)

In several of the accounts the participants spoke about ‘hope’ and ‘purpose’ as motivational factors for maintenance. One begins to understand the importance of these two constructs when one considers the viewpoint of liberation psychology where a disintegration of the belief in the community as an effective source of support and a space of belonging leads to a sense of defeat and hopelessness (Watkins & Shulman, 2008) which is exactly what happened to these addicts as they often tend to withdraw from family and friends as they struggle to come to terms with their addiction or because they are simply overwhelmed by stressors and other perpetuating factors. Almost all the participants described the addicts withdrawing from their natural support circle.

The importance of relationships were also iterated by all the participants, and both Participant 2 and Participant 4 who works with addicts on a regular basis felt that establishing a strong relationship with the addict is important for rehabilitation, while strong social support is important for maintenance. This concur with literature on the subject showing that treating alcoholism or substance dependence within the context of social networks and family relationships yielded lower incidents of relapse and longer periods of sobriety (Bezuidenhout, 2008).

In all the accounts, the participants related how much the addicts wanted to recover, and how this effort was met and encouraged by their friends, family and communities. From the data gathered from the interviews, it became apparent that these protective factors indeed counteracted the predisposing, precipitating and perpetuating factors that these individuals faced, to overcome their addictions.

The fifth theme to have emerged from the data was that of **resilience characteristics.** Almost all participants either ended their stories, or included, somewhere in their accounts, factors that they thought was the reason for the addicts remaining clean or sober after recovery. This theme aligns with *predictive factors* in the biopsychosocial model relating to factors predicting a favourable prognosis for positive change or maintenance of recovery. These factors are often directly opposing the factors in theme 3.1, that are inhibiting or preventing change. Truth, honestly, and willingness to acknowledge and accept the undeniable existence of being a life-long addict in recovery are the factors counteracting the reluctance or inability to talk to outsiders and acknowledge the addiction. Almost all the subjects of the interviews are part of Alcoholics Anonymous, Narcotics Anonymous, Al-

Anon or have a church or other support group where they regularly talk to others about their addiction. They also all acknowledged that addicts will always be addicts in recovery.

The participants also agreed that one of the things that lead to addiction is a mindset of not having control over your life or not taking responsibility for your life. 'Fatalism' is listed by liberation psychologists as one of the psychological wounds of the victims of oppression (Watkins & Shulman, 2008) and it can be seen how it is important to counter this feeling of lack of control, as the addict is completely controlled by their need to use. But all participants also listed aspects of the individuals' characters which they thought was essential in their successfully recovery and the eventual maintenance of their sobriety. One such characteristic all participants agreed on was inner strength.

All participants related that the subjects, where they previously withdrew from society and their social support circles, reconnected with family, friends and larger community groups, either through church or through social support groups such as Al-Anon and AA. Here, the participants, in perfect alignment with asset-based community development (ABCD) principles draws attention to social assets: the gifts and talents of individuals, and the social relationships that provide protective factors needed to reinforce resilience.

The last theme developed through inductive analysis. This hidden theme emerged collectively from the data as that of **conscripted silence.** The researcher found that in all the interviews she had difficulty eliciting deep and meaningful data from the participants. Participant 2, for example, although she spoke at length - her interview transcript covered well over 12 pages - and in great detail, about the dynamics of addiction and the process around recovery, she shared very little personal information about her subject, his childhood, causes of his addiction and traumatic experiences, or any crisis surrounding his motivation to enter rehab. The researcher lives in the community where she conducted her research, and it may be that Participant 2, as she is familiar with the researcher, knows that the researcher knows her subject, Ryan, as well as Ryan's family and subconsciously tried to protect them from the feelings of shame often associated with having a drug addict or alcoholic in a family. In this way it was as if Participant two became a conscript of Ryan's family system.

Participant 4 in turn, although he spoke enthusiastically, and verbosely elaborated on the work he does, his recovery and his views on recovery and addiction, he never spoke about his childhood. It was only deep into the interview, after the researcher pointedly asked him if he think there might be factors from his childhood that might have contributed to his eventual addiction that he disclosed that his childhood was not ideal.

This theme encapsulated a shared reluctance or resistance, to go too deep, to have the story that is being told, become real, be facts, appear to have created a need to avoid intense emotions. Speaking about alcoholics, even if they are not of one's immediate family, invokes pain. Miriam Greenspan (2004), in her book dealing with grief and transformation argues that the avoidance of "dark emotions" contributes to the escalating levels of depression, addiction, anxiety, and senseless violence in the U.S. and throughout the world. When the pain is too much, an impenetrable wall of silence forms around the person, around the family and around the community, which evokes images of the closed family system, not allowing input from the outside world, not letting anything from the inside slip out. The mechanisms theorized by the family systems model therefore appear to be at play here, where the closed-ness of the family system, or even the community, caused rigid boundaries. From the perspectives of the participants, the researcher is an outsider, although she shared working environments with the participants in the local school, through her interactions with local NPOs and as part of the VEP volunteer group, she remains an outsider. Not only is she an outsider, she is a white outsider.

Once the researcher identified this theme, she noticed marked differences in the nature of these silences. There were the heavy toxic silences carrying the mute burden of shame: The legacy of apartheid and the brutal dehumanisation of the people of South Africa, as Mary Watkins and Helen Schulman (2008) posited victims, bystanders and oppressors, is much like alcoholism in a family system - not talked about. Much like the burden of shame carried by the family of the addict in the family system, the people of South Africa carry the burden of shame in silence, as a historical coping mechanism. Getting on with life after the trauma with the toxic silence as the norm. The young white men who were conscripted to the border war, where they were turned into oppressors, victims and silent bystanders, were burdened with the shame of their actions, silenced by the inability to rage against the schizophrenic splitting of themselves between their loyalty to the apartheid government, that they saw as 'their country' (Baines, 2008) and the reality of the brutalisation of a whole people they were party to. One can posit that the same conscription happens to the family members of the alcoholic or drug addict, where they are carrying the burden of associated shame in toxic silence, while silently raging against their schizophrenic selves divided by loyalty and shame.

Then there were stoic, almost proud silences. Strong stillness demanding neither sympathy nor justice. Standing strong, neither claiming victimhood nor seeking revenge. Instead this silence stands quiet witness, rejecting the possibility of rights, not asking for

explanations. It is as if the meaningless atrocities of apartheid left wounds that cannot be exorcised through words. The dynamic between the researcher, the participants and to a certain extent the individuals who were the topics of the participants' narratives, many of whom were not of the same racial grouping as the researcher and therefore, the researcher, as she is inexperienced, was probably unable to bridge the historic gap caused by their shared history of oppression; One wearing the mask and the scars of the oppressor, the other the mask and scars of the oppressed. The researcher hopes fervently that additional experience in research will enable her to navigate this difficulty she encountered in their shared socially constructed reality.

Many of the challenges faced by mental health practitioners in post-apartheid South-Africa comes from the legacy of apartheid (Arcot, 2015). In addition to this, the researcher's own personal history and the characteristics she presents as an adult child of an alcoholic, might have contributed to the conscripted silence, where talking about alcoholism is painfully close to home, no, to the heart. And therefore, she might have kept the level of exploration shallow, light, factual and manageable. This final theme has strong links with unresolved intergenerational and historical trauma.

This study was conducted to record and relate the accounts of lay community healthcare workers' experiences with recovered alcoholics and substance dependents concerning the origins, dynamics of, and recovery from substance dependence. The study also explored these accounts for patterns or themes correlating with Engel's biopsychosocial model, with a special theoretical interest in addiction as a presentation of unresolved historical trauma. The five themes developed through deductive analysis demonstrated that the biopsychosocial model is a good fit in the understanding of the origins, dynamics of, and recovery from substance dependence as **the formative years** strongly aligns with *predisposing factors*, **trauma exposure and contributing stressors** aligns with *precipitating factors*, as well as *predisposing* and *perpetuating factors,* **catalysts** where they are **inhibiting change** relate to *perpetuating factors*, while **catalysts** acting as **incentives to change** relate to *protective factors*, **motivational elements** also aligns with *protective factors*, and lastly, **resilience characteristics** strongly aligns with *predictive factors* but are also associated with *protective factors* in the biopsychosocial model. Through inductive analysis a sixth theme was developed, as a result of the dearth of emotional depth in the accounts of the participants as *complicit silence*. Using the results of the study as summarized above the research questions can now be answered:

What are lay community healthcare workers' perspectives on the origins and dynamics of substance addiction and recovery?

From the results it was learnt that the lay community healthcare workers felt that the *formative years* of the recovered alcoholic or addict were typified by a chaotic environment, often with absentee parent or parents, and they were often raised by grandparents or nonfamily members. Their accounts often spoke of personal *trauma exposure* and almost all of the addicts in the accounts shared the commonality of historical trauma experienced by their immediate family members, either as being historically disadvantaged through the forced removals during the apartheid era, through historical and ongoing discrimination as being part of a marginalised socio-political grouping, or as the oppressors in post-Apartheid South-Africa, who bear their own scars, both physically and psychologically, from their time as conscripts in the so called "Bush War." In additional almost all of the accounts related themes of parental alcoholism and substance abuse, predisposing the subjects of the accounts to becoming substance dependents themselves, precipitating the potential for substance dependence through *contributing stressors*, and perpetuating the substance dependence by creating additional challenges.

The participants' accounts also indicated that they believe that the addict must *'hit rock bottom,'* for them to be truly motivated to change and that *'tough love'* is essential, especially from the friends and family who often act as enablers to the addict, as *catalysts* for change. Hope, purpose, relationships with loved ones and religion were reported as further specific *motivational elements* underlying successful rehabilitation and maintenance. Several *resilience characteristics* were listed as predictors for a successful recovery and maintenance such as responsibility, accountability and inner strength.

Do the accounts of volunteer community healthcare workers support a relationship between alcoholism or substance dependence and unresolved historical trauma?

As almost all of the accounts featured instances of unresolved historical trauma as contributing or causal factors, a relationship between unresolved historical trauma and substance dependence can be inferred. There appeared to be a particularly strong link between unresolved intergenerational and historical trauma and the sixth theme of **conscripted silence**.

Limitations

Few studies consider the experiences, impressions and opinions of the lay community health workers on the issues surrounding alcoholism, drug abuse, addiction and recovery in

South-African. There are even fewer studies exploring addiction as a presentation of historical and intergenerational trauma, and none could be found with a specific focus on the rural communities of the Western Province of South Africa, with the result that comparisons to other supporting research on alcoholism and addiction in these communities as historical trauma presentation was unavailable. In addition, this research has been undertaken in a village with less than 10 000 inhabitants and a comparatively low alcoholism and addiction rate, with the result that the experiences of the participants in this study may not be comparable to those in bigger cities. The transferability of this study is therefore in question. The results would have been more informed if more participants from larger communities were included in the research. Furthermore, the research has been conducted by a student researcher with no notable prior experience as the research was part of her master's degree.

The lack of experience on the student researcher's side not only relates to the potential impact of the quality of the research but also on the quality of the results obtained from the participants, as the participants knew that the researcher was only a student, and this might have influenced their confidence in her ability to contain information they could potentially share with her. Lastly, a researcher that appears as a white person in the South African context where a portion of the participants or subjects under discussion was from a different racial grouping, might again, have influenced the quality of the data. The researcher hopes fervently that additional experience in research will enable her to more effectively navigate this difficulty in the shared socially constructed reality.

Strengths

Using a qualitative approach allowed the researcher to obtain information with more depth and detail than what would have been possible if a quantitative approach were used. The qualitative approach encouraged the participants to expand on their responses, expanding on areas not initially considered. This not only enabled a deeper understanding of the link between Engel's biopsychosocial model and the participants' lived experiences they related in their interviews but also lead to the discovery of the hidden theme of **complicit silence**.

In addition, the researcher is a resident in the community where she conducted the research. As such, many of the participants are familiar with the researcher as a volunteer community care worker herself, and they may have felt more comfortable with her, than they would have an independent researcher with a more objective viewpoint. Rural West Coast communities are well known for viewing "inkommers" – people coming from the outside - with a measure of distrust.

Finally, the researcher was surprised to find herself emotionally connected to the research as she identified with the participants and found herself wanting the world, or at least more people than just herself, to hear their words, to listen to these accounts, to know their plight, to see their hearts and understand the enormity of the incredible work that they do and the support they give to individuals battling against the overwhelming odds of negating the impact of their shared historically traumatic past.

Recommendations

In order to confirm and support the findings in this research report, it is suggested that additional research should be conducted by more experienced researchers over longer periods of time on larger sample sizes including individuals from busier centres. It is also recommended that more studies focusing on addiction as a historical trauma presentation in communities, be conducted by skilled researchers across all provinces in South-Africa. More objective data might be gleaned by independent researchers and larger, longitudinal studies with more representative samples, will be able to yield data that can be generalized across all populations, improving the transferability of the research. Quantitative research on this topic will also be able to confirm the statistical fit of the biopsychosocial model as a suitable framework for the substance dependency construct in this context.

Further research aimed at supporting lay community healthcare workers, utilising their knowledge and experience for the development of context specific programmes is also suggested. Researchers who may want to build on this data may consider developing a specific program aimed at supporting the lay community healthcare workers in their already established community support structures, or alternatively utilising their knowledge and experience in the developing of appropriate programs uniquely aimed at and designed for the particular community's context.

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Appendix A: Semi-structured Interview Schedule

Preparation:

1. Ensure that the participant is comfortable and calm.
2. Confirm that the participant is familiar with informed consent form, understands it and has signed it.
3. Explain that participation is voluntary and that the participant can choose to withdraw at any point during or after the interview.
4. Request permission to record interview.
5. Proceed with questions.

Interview questions:

1. Please tell me a little bit about yourself and what you do in your community?
2. You have indicated that you can tell me about a person in your community that you are familiar with, who has recovered from drug or alcohol addiction. Could you tell me their story now please?

If any of the following questions were not dealt with during the interview, as a natural part of the flow of the conversation ask:

3. Can you tell me a little bit about their childhood?
4. Is there anything that you would say contributed to them becoming an addict?
5. Are there things that prevented them from breaking free from the addiction?
6. What do you think helped or motivated them to decide to get clean / sober?
7. Can you think of any of their personal characteristics, something inside of them, that helped them to get clean / sober?
8. What do you think helped them not to relapse?
9. Do you think apartheid had any influence on them becoming an addict?
10. Is there anything else that you think you should add to help me better understand addiction and recovery or the struggles around it?

Appendix B: Informed Consent Forms

Dear Sir or Madam

RESEARCH INTERVIEW RELATING TO INDIVIDUALS FROM YOUR COMMUNITY WHO HAVE RECOVERED FROM ALCOHOL OR DRUG DEPENDENCE

This form will provide you with information about the research that will help you to decide if you wish to participate. If you agree to participate, please be aware that you are free to withdraw at any point throughout the duration of the research process without any repercussions

For this research, I would like to record an interview of approximately 60 minutes with you, where we talk about individuals from your community who have recovered from alcohol or drug dependence. All information you provide will remain confidential and will not be associated with your name. If for any reason during this study you do not feel comfortable, you may say that you no longer want to participate, and your interview will be stopped and deleted.

If you have any further questions about this research at any time please feel free to contact me through email: corna@########## or phone: 084#######

Please indicate with your signature on the space below that you understand your rights and agree to participate in this research project.

Your participation is strictly voluntary. All information will be kept confidential and your name will not be used anywhere.

Thank you so much

Corna Olivier (Research student UNISA)

______________________________ ______________________________

Signature of Participant Print Name